Purple Solutions

A Bipartisan Roadmap to Better Healthcare in America

Coauthored and edited by

Daniel Sem

Remedium eXchange

Contents

SECTION 3

Drug Prices

SECTION 4

A Healthcare Safety Net

Introduction

I should tell you that I began writing this book while I was teaching in Shanghai, China, in mid-December of 2019, just as (unbeknownst to me) the coronavirus pandemic initiated. China, an autocratic society, dealt effectively with the epidemic; but as a society, the country has little freedom, suffers from human rights violations and, while capitalistic, is ironically also socialist. As I write this, the jury is still out as to whether the United States, a country that rightfully values freedom, liberty, and human dignity, will deal as efficiently with the pandemic. What we do know is that another Asian country, Singapore—whose healthcare system delivers quality care at 2.5% GDP versus the United States' 18%—set a shining example of success in controlling Covid-19 and is discussed in this book as an example of how creatively implemented market forces can be channeled toward positive ends. So is the better solution to effective healthcare socialism or market forces? What, if anything, can be learned from other countries, and what should be uniquely American? Well, if you are curious, please read on.

This book is about finding bipartisan, or *Purple* (i.e., red and blue) solutions to healthcare problems in the United States. It begins with the premise that the best healthcare reform—and likely the only viable healthcare reform, from a political perspective—will require Democrats and Republicans to roll up their sleeves and compromise to find the best path. Hard to imagine, I know. Our country seems irreparably polarized, as are most of us—even within our respective families.

I come from a family of five, and we all shared a father who was a staunch Republican—albeit not a fan of some of our current political theatrics. Ever since my father passed away in November of 2016, the five of us have gathered every November in Florida for family-bonding time and to remember Dad. This last November, after sharing my plans for this book, I discovered that we are as divided as any American family. About half of us generally vote on the Red side, and the other half on the Blue side. As the fifth child of a (loving) father with strong and sometimes polarizing political views, my role in life has evolved into being the peacemaker and the person looking for reasonable and compromise solutions. Such was the nature of our family discussion in Florida last November. I mostly listened as my siblings debated in sometimes heated ways the benefits of essentially single-payer

healthcare versus free markets. Where do I stand? I try to stand for reasonable compromise, for Purple solutions. While I confess I have somewhat libertarian leanings at times, in practice I end up voting pragmatically, almost as often for Democrats as Republicans. So, I suppose, I stand in the middle. In our polarized political world, that probably means I may be in the minority. Please hear me out.

I am certain that you—the reader—are equally familiar with this heated political debate about healthcare in America, and perhaps you have strong opinions. In writing this book, when I speak in the *first person* to "you" (*second person*), I am speaking directly to *you* as a healthcare consumer. I suspect that you may believe that our healthcare delivery system is broken, and that the cost is too high for what you get in terms of medical outcomes. You probably feel the increasing pain of paying more and more out of pocket for your healthcare, through high deductibles and co-pays, and you likely feel powerless to do anything about it. As a country, we spend $3 trillion per year for healthcare, and per person we spend around $10,000 per year (see chapter 1), with the total cost such that 20 cents of every dollar we earn in the economy is going to healthcare. This is more than any other developed country.

So, what is the solution? Those on the Red side of the political aisle may say "repeal and replace" the Affordable Care Act (also known as Obamacare) and let market forces sort things out, because only a free market can address all the moving pieces of the healthcare market and set prices to reasonable and accurate values. Advocates for a free market solution would silence skeptics by saying *the current system we have does not function like a free market yet and should be given a chance to truly compete*. Those on the Blue side of the aisle may say that the market is cold and heartless and does not apply to something like healthcare. So, they say, we need a simpler single-payer system paid for by the government, like Canada has. On one end of that spectrum is "Medicare for All," fully government sponsored, which would expand what some view as an already-successful Medicare program. The more moderate camp on the Blue side may suggest we keep private insurance companies and private provider options while also expanding a form of Medicare. So, which side of the political aisle has the correct solution to America's healthcare dilemma? Or is it possible the best solution(s) would be a compromise between both proposals, which I will call Purple solutions.

While our politicians are more polarized than ever before, I would like to believe that the average American citizen is more reasonable and

open-minded. Is that true? I'm not sure. We did elect our leaders, so perhaps we are also just as polarized? I hope not. Only *we*—as citizens, consumers, everyday folk—can drive the kind of change and compromise that is needed to create a healthcare system that actually works and reflects what is good about America. That is the purpose of this book. It is a call to action. Maybe even, in the words of John Torinus, a call for a grassroots healthcare revolution. It is a roadmap to assist American consumers as they search for and discuss intelligent and informed solutions to healthcare that are not all Red or all Blue but are more likely to be Purple solutions.

This brings me to the central thesis of this book. I truly do believe that each side of the political aisle brings some value to the healthcare reform debate. In fact, we need both sides to balance the other and offer solutions to the blind spots that each may have.

I believe we need some sort of competitive market to foster innovation and produce realistic pricing and value in what everyone agrees is an incredibly complex system of services. This is the topic of section 2 of this book, which is on the Red side of the discussion. I also believe we need some sort of safety net to protect the poor as well as all of us against catastrophic events, like an expensive cancer treatment, infusion therapy, or even costly end-of-life care. With regard to the latter, a majority of those in nursing homes end up on Medicaid, which can only happen when you reach poverty level (i.e., all your assets have been depleted by our healthcare system). That is not a good way to end one's life with dignity. This safety net discussion is the topic of section 4 of this book, which is on the Blue side of the debate. Section 1 of the book provides an introduction to the current state of healthcare in America, and section 3 provides on overview of high drug prices.

So where do we point an accusing finger for the creation of our dysfunctional healthcare system in America? It is likely true that for the most part those in government and those in the medical provider world sincerely want to help patients and provide quality, accessible healthcare. They likely have good intentions. But there are dysfunctional incentives in our system, and there are also those who are gaming the system for financial gain. Is it big government or big corporations at fault? Perhaps both. Too much concentrated power and decision-making in government or large corporations is equally bad. We need power and decision-making in the hands of patients and the providers (e.g., physicians, nurses) who directly help them and are on the frontlines of healthcare delivery. This book presents a case for Purple solutions that aim to empower the consumers of healthcare (the patients)

and the providers (physicians, nurses, and the like), rather than big government or big corporations, with the clear goal of providing more accessible, higher-quality, and more affordable healthcare. Unfortunately, there is no powerful lobby group for this goal.

Finally, what was the inspiration for this book and the source of information for it? It is a product of the *Rx Think Tank* (RxThinkTank.org). In full disclosure, a fraction of the profits from this book will go to support the activities of the Rx Think Tank, whose mission is "to increase Quality, Access, and Affordability of healthcare for all, in a patient-centered and consumer-driven healthcare delivery model." The Rx Think Tank at Concordia University has held *Healthcare Economics Summits* for four years, hosting discussions with the brightest minds in healthcare policy, from physicians to hospital CEOs to healthcare delivery entrepreneurs to those in the pharmaceutical supply chain, to state and federal politicians. The content of this book is informed by those speakers, as well as discussions with the hundreds of Rx Think Tank members, attendees, and panelists who have participated in these summits over the years, along with research into the healthcare policy literature. While this book is largely my writing, based on research and insights from these many scholars and practitioners, there are also many guest-expert-authored chapters. For these chapters, I typically provide a preface that provides context, and there is a brief biography of each author at the end of the book. Many of these guest authors are of differing political views and might be opposed to what other authors have submitted and written; but the goal of this book is to provide a diversity of perspectives. I attempt to provide a common thread and coherence between, before, and after chapters. And at the end of each section, a roadmap for compromise—*Purple solutions*—is also presented, so that we can have better-informed, intelligent, and respectful conversations about healthcare in America.

You may wonder if I am qualified to write and edit a book on this topic? Probably no more than a lot of other people. I do have a PhD, MBA, and a JD degree, so you would think I might know a thing or two about law, regulations, pharmaceutical science, business, and healthcare. I even started several biotech companies, and now I serve as a dean and professor of business, with a passion for healthcare policy. But I am finding there is far more that I do not know than what I do. I learned this lesson especially when I decided to take on this project, asking, "What is wrong with healthcare in America, and how do we fix it?"

Healthcare administrators often say "healthcare is complicated," then they go on to use complicated terminology only they understand, like ICD-10

codes, CPT codes, reimbursements, chargemasters, risk pools, capitation, value-based care, stop loss insurance, population health, EHRs, RVUs, and of course they reference the giant tome we call the Affordable Care Act, which few people have ever read. These administrators get paid big salaries to use these terms and to master their small siloed piece of this large healthcare system. No degrees helped me understand this healthcare system. I just talked to a lot of smart people working in the field, outside the field, and even some looking to disrupt and change the field. I have to confess that last group was the most fun. This book is an attempt to summarize the gems of those conversations as well as some relevant healthcare policy and medical-business literature.

When we are told that "healthcare is complicated," we often throw up our hands and say, "I'm just glad someone else smart is handling this." Please don't do that. Healthcare is not so complicated that we can't discuss how it all works at a high level and identify the problems. The last time somebody told me something was complicated, and they talked fast with a lot of confusing words and asked me to trust them, I found out they were embezzling money. Sometimes I wonder if healthcare is like that. This book is an attempt to explain healthcare in America, and I am certain it is not so complicated that you can't understand it. Read this book cover to cover, or just use it as a reference and move between chapters depending on what interests you. I have tremendous respect for the intellect of Americans, even if our politicians do not speak to us as if we are intelligent. Let's rise above their low expectations and characterization of us and push them to find effective bipartisan solutions to America's broken healthcare system.

I am looking forward to my family discussions this next November, and then for all of us to vote our consciences for what we think makes the most sense for healthcare reform. I hope we elect politicians who can rise above the current political theatrics and dysfunction, with the courage to reach across the aisle to find ways to fix healthcare in America, using truly bipartisan Purple solutions that work.

SECTION 1

Where Are We Now?
The Good and the Bad

CHAPTER 1

Why Healthcare in America Is More Expensive Than It Needs to Be

DANIEL SEM

This chapter provides an introduction and a broad overview of the history of healthcare and insurance in America and how and why it is so expensive compared to other countries. The chapter is really a foundation for the rest of the book, which includes a wide range of guest authors who are experts and leaders in their fields and who go deeper into different aspects of the issues that I present in this chapter. Guest authors in subsequent chapters sometimes take differing views on the problems and solutions to healthcare cost and access problems, but that is the goal of this book—to explore a range of bipartisan, Purple solutions.

Who Pays for Healthcare in America?

Before addressing the cost of healthcare, we should consider first how we pay for healthcare in America because that affects the cost. Although *price* is probably the more accurate term because price is what you or some surrogate acting on your behalf pays, irrespective of what it actually costs. You might say that your employer, your insurance company, or the government pays for your healthcare, and then you contribute something in the form of a co-pay and deductible. You, of course, also pay insurance premiums. Well, actually, you are paying for all of it, either directly or indirectly. Right now, $18 of every $100 you earn at your job goes to healthcare, while in many other countries that have better health outcomes the amount is much less (typically half) per person. So, the real problem with healthcare in America is not who pays for it (you, your company, the government, or your insurance) but the actual cost. Ultimately, though, you are paying no matter what. If the cost keeps increasing without justification, you pay. As a result of inflated prices, which may or may not be the result of increased real costs, others who are part of what has been referred to as the Medical-Industrial Complex benefit (see chapters 4 and 5) (Relman, 1980). How did we get to this state of affairs, and why is it this way? To address this question, let us briefly review the history of healthcare delivery and insurance in America

over the last 100 years. After that, we will return to this topic of cost (and the price you must pay), which is the real and more significant problem.

The History and Role of Healthcare Insurance

The way we deliver and pay for healthcare in the United States has changed a lot over time. So has the cost. Going back only as far as 1960, we spent a modest 5% of gross domestic product (GDP), or $146 per person on healthcare, versus 18% of GDP and $10,739 per person now (Amadeo, 2020). How was this paid then and now? There was a time at the beginning of the twentieth century when people paid cash for healthcare and did not rely on insurance. So it all started with us paying for healthcare directly, and healthcare was not that expensive (less than 5% of GDP). I am not suggesting we should return to those days, but it is interesting to note and remind ourselves that *healthcare and access to healthcare is not the same as insurance*. News flash: You actually can get (typically lower cost) healthcare without using insurance! This is called *self-pay* or *direct pay* healthcare, and it is a growing trend among consumers who cannot afford high co-pays and deductibles, even with Affordable Care Act (ACA) plans (Parnell, 2014). As healthcare consumers, we typically assume that the only way to get healthcare is with insurance and that access to good healthcare is synonymous with access to good insurance. That, after all, is what the ACA is all about. It is about making sure that everyone has insurance, not necessarily about making sure everyone has access to good healthcare. But these are different concepts, even if you do not see that yet. Please bear with me on this, as a central thesis of this chapter is that how we *do* insurance, by letting surrogates act on our behalf, is at the root of why healthcare is so expensive in America.

What Is Insurance?

It seems simple enough—the insurance company, our surrogate—reimburses us for medical expenses. This is for everything from routine checkups to emergency room (ER) visits, to open-heart surgery to infusion therapy for cancer. But how does most insurance, outside of healthcare, work? Think of your car or home insurance. If you totaled your car or your home was destroyed in a fire, insurance pays to help you recover from these rare but catastrophic and financially devastating events. For more routine problems, like a dead battery or alternator in your car, or a broken water heater in your home, you pay for those directly with cash or credit. Healthcare insurance is not like that. It is not like insurance at all. We expect healthcare insurance to pay for everything, even routine doctor visits that would cost less than $100 if we paid cash but will be billed at much higher prices if we

use insurance. But then why do we care as long as it is reimbursed, right? That is a problem that I will get to later, but for now suffice to say that the prices charged to insurance companies are highly inflated and do not likely reflect actual costs, so you do not ever want to pay those prices. And yet you typically probably do pay those inflated prices as you work toward hitting your deductible if you use insurance. On the positive side, though, you think that everything is largely free for you after that deductible. Many of us go on a healthcare spending spree at the end of the year after we have hit our deductibles—and why not? Of course, now that we have increasingly large deductibles and co-pays, we are actually starting to care and would like to avoid these large price tags for doctor and especially ER visits altogether. Interestingly and surprisingly, the co-pays or deductibles that we pay are typically larger than if we used a self-pay approach, but we do not do that because we believe that it is not possible to not use insurance and instead pay directly since we wrongly believe that all healthcare *must* be "purchased" using insurance. The point is, healthcare insurance is not insurance in the way we typically think of insurance, and we have become so accustomed to this idea that we as healthcare consumers are paralyzed in the absence of insurance, even when the most logical thing to do is to not use it. Unfortunately, the healthcare system is not currently set up to let us easily purchase without insurance, often forcing us to pay the inflated prices that providers charge insurance companies and not telling us, up front, what things would cost if we did want to pay cash. That is changing now. This phenomenon, and the potential solution of paying directly and only using insurance for expensive needs, is the central thesis of a 2013 book by David Goldhill entitled *Catastrophic Care*. Goldhill argues that we would be better off treating healthcare insurance like other forms of insurance and paying for routine healthcare needs using cash, perhaps from health savings accounts (HSAs) paid for by employers and others. This leverages market forces to control cost and makes the patient the real customer rather than some disinterested surrogate (government or insurance company). Goldhill is probably in large part correct, but I am getting ahead of myself. Back to the history of healthcare delivery and insurance in America.

The History of Healthcare Insurance

During World War II, President Franklin Delano Roosevelt (FDR) passed the Stabilization Act (1942) as part of his wartime effort to control inflation by freezing wages, salaries, and prices. To deal with a labor shortage, companies needed to find creative ways to attract employees, and since they could not offer increased wages or salaries, they offered benefits in the form

About the Authors

David Balat is the director of the Right on Healthcare initiative with the Texas Public Policy Foundation. He is a former congressional candidate in the 2nd congressional district in Texas and a seasoned hospital executive with more than 20 years of healthcare industry leadership and executive management experience, with special expertise in healthcare finance.

Catherine Bodnar was a research associate and is currently an MBA student at Concordia University and a medical student at Medical College of Wisconsin. She has interests at the interface of science, medicine, and business.

Murray S. Feldstein, MD, is currently a Visiting Fellow for Health Care Policy at the Goldwater Institute in Phoenix. Dr. Feldstein started his urology practice in Flagstaff, Arizona, in 1974 and practiced there until 2000. He then joined Mayo Clinic Arizona as a urologic consultant and engaged in clinical, educational, and research activities. Retiring in 2015 as an assistant professor of urology, he remains on the emeritus staff. Dr. Feldstein was also twice elected to the Flagstaff City Council and served as vice-mayor for two years.

Anne Marie Finley, MS, RAC, is a former policymaker with 25 years of experience at the Food and Drug Administration (FDA), the Department of Health and Human Services (HHS), and Congress. She served in the administration of President George H. W. Bush as special assistant for Legislative and Public Affairs in the Office of the Commissioner, U.S. FDA. More recently, she served as vice president of Government Relations and Public Policy at Celgene, and VP of Regulatory Policy at GE Healthcare. In 2014, she was named a top 50 Thought Leader in Orphan Drugs and Rare Diseases. Currently, she is president of Biotech Policy Group LLC, a healthcare government relations and regulatory policy consulting firm.

Curt Gielow holds an undergraduate degree in pharmacy, a graduate degree in healthcare administration from the Washington University School of Medicine, and an honorary doctorate from Concordia University in Ann Arbor, Michigan. He was the founding dean of the Concordia University School of Pharmacy and served 13 years in elected office as a local alderman, mayor, and Wisconsin State representative. A Republican, Gielow is the 2005 coauthor, with Representative Jon Richards (D), of the Wisconsin Health Plan, a bipartisan attempt to create a universal healthcare plan that failed consideration in the Wisconsin state legislature during his tenure.

Robert Graboyes is a senior research fellow and healthcare scholar at the Mercatus Center at George Mason University. Author of *Fortress and Frontier in American Health Care*, his work asks, "How can we make healthcare as innovative in the next 30 years as information technology was in the past 30?" Previously, he was the healthcare adviser for the National Federation of Independent Business, economics professor at the University of Richmond, and regional economist/director of education at the Federal Reserve Bank of Richmond.

Eric Haberichter is a serial healthtech entrepreneur with 25 years of medical imaging and health business experience, specializing in market-based healthcare solutions for providers, self-insured employers, and those looking for quality-assured, high-value alternatives. Haberichter is CEO and cofounder of Access HealthNet, which develops episodic case rates (i.e., procedural bundles) for employers, health plans, and providers. Previously, he cofounded Smart Choice MRI, which brought affordable and transparently priced MRIs, at less than $700, to Wisconsin.

Naomi Lopez-Bauman is the director of healthcare policy at the Goldwater Institute. Previously, she served as the director of research and the director of health policy at the Illinois Policy Institute. Before that she worked as an entitlements policy analyst at the Cato Institute. She also served as special policy adviser to the state of Michigan's Secchia Commission, which provided recommendations for state government reform. A frequent media guest and public speaker, Lopez-Bauman has authored hundreds of studies, opinion articles, and commentaries.

Barbara L. McAneny, MD, FASCO, MACP, is a board-certified medical oncologist/hematologist from Albuquerque, New Mexico. She draws on her personal experience from the oncology medical practice group she founded in 1987, and as managing partner, since 1999, of the New Mexico Cancer Center, which she built as the first physician-owned multidisciplinary cancer center in the state. She became the 173rd president of the American Medical Association in June 2018. *Modern Healthcare* ranked Dr. McAneny no. 5 on its list of most influential clinical executives for 2019.

Katie Nemitz is a doctoral student at Concordia University Wisconsin, and is passionate about healthcare, healthcare quality, and healthcare transformation. She started her career as a registered nurse and discovered that while patients were getting care, there were many opportunities to deliver both better care and a better patient experience, while keeping in mind that those providing the care need to be considered as well. After finishing her doctorate, she hopes to continue writing, researching, teaching, and working as a consultant to healthcare organizations trying to change the way they deliver healthcare.

Elizabeth O'Connor is originally from Long Island, New York. As an undergraduate, she attended Manhattan College, where she studied government, international studies, and economics. Following her undergraduate career, Elizabeth chose to attend the Bush School of Government and Public Service at Texas A&M University for a master of public service and administration. There, she focused

her studies on public policy analysis and public management in a state government context. While at the Bush School, she had the opportunity to spend a summer in Wales at the Wales Centre for Public Policy as a visiting fellow.

Stephen Pickett is a healthcare economist for the Right on Healthcare Initiative at the Texas Public Policy Foundation. Prior to joining the foundation in October 2019, Stephen worked in the health insurance industry. There, he primarily researched the relationship between different insurance products and healthcare utilization and outcomes, as well as alternative provider reimbursement strategies. His research during graduate school focused on the impacts of the Affordable Care Act's marketplaces on Texans and how providers change their behavior when alternative payment models are introduced. Stephen is a native Texan. He received his BBA in business fellows and mathematics in 2013 from Baylor University and his PhD and MA in economics in 2018 from Rice University.

David Riemer, JD, has worked closely with both Democrats and Republicans to create path-breaking public policy at the state level and influence national policy. A graduate of Harvard College and Harvard Law School, Riemer held administrative, legal, and policymaking positions with the mayor of Milwaukee, two governors of Wisconsin, and the late Senator Edward Kennedy's health subcommittee. He was the policy expert who worked with Curt Gielow to draft the bipartisan legislation presented in chapter 20, which would have created universal healthcare in Wisconsin. Active in politics as both an adviser and candidate, Riemer has focused for the last decade on advocacy and writing that aim to reshape the role of government in ensuring economic security, equal opportunity, and an effective market economy.

Christina Sandefur, JD, is the executive vice president of the Goldwater Institute. Sandefur develops policies and litigates cases advancing healthcare freedom, free enterprise, private property rights, free speech, and taxpayer rights. She is a co-drafter of the 41-state Right to Try initiative, now federal law, which protects terminally ill patients' right to try safe investigational treatments that have been prescribed by their physician but are not yet FDA approved for market. Sandefur is a frequent guest on national television and radio programs, has provided expert legal testimony to various legislative committees, and is a frequent speaker at conferences.

Daniel Sem, PhD, MBA, JD, received his PhD in biochemistry from the University of Wisconsin–Madison and his MBA and JD degrees from Marquette University. Currently, he is dean and professor of business, professor of pharmaceutical sciences, and director of technology transfer at Concordia University in Wisconsin. He also serves as director of the Rx Think Tank, focused on healthcare policy reform. Dr. Sem has 25 years of experience in healthcare innovation and 10 issued patents and has published over 60 papers. Previously, he cofounded four drug discovery and development companies (Triad, AviMed, Estrigenix, and Retham) and one social venture (Bridge to Cures). Triad was voted one of the top 10 biotech startups in the United States in 2001 by Drug Discovery Today, and licensed drug leads to Novartis. Dr. Sem's passion is leading healthcare

innovation and policy initiatives with the goal of achieving better healthcare outcomes for patients, whether through development of new medicines or new ways to deliver healthcare.

Charles P. Stevens, JD, is an employee benefits attorney and a partner in the Milwaukee, Wisconsin, office of the law firm of Michael Best & Friedrich, LLP. He represents employers and benefits plans in court and is an expert at fixing problems in healthcare benefits plans. He counsels on Affordable Care Act compliance and has litigated before the U.S. Court of Appeals. He was named a "Leader in the Field" by Chambers USA.

James J. Tarasovitch, CPA, is regional chief financial officer for the south market of Ascension Wisconsin. As one of the leading nonprofit and Catholic health systems in the United States, Ascension is committed to delivering compassionate, personalized care to all, with special attention to persons living in poverty and those most vulnerable. Before joining Ascension, Tarasovitch was the regional CFO for Mayo Clinic Health System Minnesota and the CFO for Bradford Regional Health System. He is also an adjunct faculty member at Concordia University Wisconsin.

John Torinus is former CEO and now chairman of Serigraph Inc., a manufacturing company with about 550 employees. The company and its coworkers spend about $6 million per year on healthcare. He has written two books with a company perspective on healthcare reform and cost containment and how to provide better care: *The Grassroots Health Care Revolution* and *The Company That Saved Health Care*.

Greg Watchmaker, MD, is a graduate of Washington University School of Medicine and a practicing hand surgeon at the Milwaukee Hand Center. His outcomes research in carpal tunnel syndrome received the top editorial honors by the *Journal of Hand Surgery* in 2020 for the most impactful published work in the field of hand surgery. Though a practicing surgeon, Dr. Watchmaker started his education in the field of computer science, developing financial software for UW-Madison in the 1980s and later heading a team that developed medical software to map abnormal heart rhythms during open-heart surgery. He has developed applications used to facilitate quality reporting between hospitals and the federal government and, more recently, patient-facing web-based outcomes assessment tools.

Tyler Watts, PhD, is an assistant professor of economics at Ferris State University and an adjunct faculty member at Concordia University. Previously, he was an assistant professor of economics at Ball State University and a visiting assistant professor of economics at Grand Valley State University. Watts earned his PhD in economics at George Mason University in 2010 and a master of finance from Colorado State University–Global Campus in 2019. While at George Mason, he was a Mercatus Center PhD Fellow. His research has appeared in the *Eastern Economic Journal*, *Independent Review*, *Review of Austrian Economics*, and *Journal of Private Enterprise*.

Index

Page numbers followed by *f* or *t* indicate a figure or table