

SPECIAL
REPORT



HEALTHCARE



A HEALTHCARE FREEDOM AGENDA

NEW APPROACHES TO HEALTHCARE FOR THE PALMETTO STATE

MARCH 2019



**PALMETTO
PROMISE**
INSTITUTE

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EXECUTIVE SUMMARY

Most South Carolina families and employers find themselves in a healthcare No Man's Land: They earn too much to qualify for Medicaid but struggle to pay healthcare premiums that seem to rise every year.

What can be done? Some politicians tell us—with a straight face—that the time has come for the government to increase its role, promising that Washington or Columbia can do healthcare better than the private sector.

But we know better.

This report explores the free market alternatives better positioned to lower our healthcare costs, while improving health outcomes.

- **Up with Direct Primary Care.** DPC eliminates the middleman, allowing individuals to deal directly with a doctor for a simple, affordable and manageable experience, rather than with complicated insurance forms and rules.
- **Down with Certificate of Need.** CON laws do not achieve their intended charitable outcomes, but rather decrease the supply and availability of healthcare services for everyone, especially the poor. By lifting these restrictions, we can allow new providers to begin operating and increase healthcare access for South Carolinians across our state.
- **Yes to a host of other cost-savings reforms.** Christian healthcare sharing, Right to Shop, charity care, and healthcare brokerage reform—all free market-based—also offer great promise in protecting the “smalls” (families and family businesses) from the “biggs,” (big government and big healthcare).

Inside these pages are keys to better health outcomes for all.

We invite you to join the conversation.

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INTRODUCTION

IT'S ABOUT ACCESS TO QUALITY CARE, NOT JUST COVERAGE

The discussion about healthcare reform in South Carolina has been dominated by a debate over whether the state should expand Medicaid under the Affordable Care Act to 170,000 able-bodied, working-age adults. Unfortunately, this has sidelined more substantive conversations about how to provide true *care*—not just insurance *coverage*—to South Carolinians who lack access, quality, and control over their healthcare decisions.

Regardless of income or socio-economic status, everyone deserves the opportunity to chart their own healthcare course.

We know that:

- A startling 55% of physicians across the country now claim they will not accept new Medicaid enrollees.¹
- Medicaid patients report more difficulty obtaining an appointment with a specialist than patients with private healthcare coverage.²

REFORMS THAT MAKE A DIFFERENCE

DIRECT PRIMARY CARE, REMOVING ANTIQUATED BARRIERS, AND INNOVATION

Palmetto Promise Institute understands the challenges lawmakers face in extending access to the poor, as well as those living in rural areas of our state. We believe this can be addressed by lifting antiquated **Certificate of Need** laws that limit access to care for low-income families and rural communities, and embracing **Direct Primary Care**, an exciting new reform that would deliver greater access, quality, and control to low-income earners currently being considered for a Medicaid expansion.

- The direct care system eliminates the middleman, allowing individuals to deal directly with their doctor, rather than with complicated insurance forms and rules, for a simple and manageable experience.
- Functioning much like a gym membership, individuals pay a monthly fee for access to expert physicians, averaging \$40 to \$80, which can be less than the cost of proposed premiums or copays for the same individuals under a Medicaid expansion.
- Because individuals get to know their doctors, they can trust that their healthcare concerns will be heard, and they will be *cared for*, not just *covered*.
- Direct care addresses rising healthcare costs by providing transparent, predictable costs patients can understand, afford, and rely on. Surgical procedures are often one-sixth to one-tenth the cost of a typical hospital charge under this system.

Similarly, the state's forty-year-old **Certificate of Need** law, while perhaps well-intentioned, has neither kept prices for medical treatment down nor provided support for those who cannot afford to pay.

Christian Healthcare Sharing, Right to Shop, Charity Care, and Healthcare Brokerage Reform—all free market-based—also offer great promise in protecting the “smalls” (families and family businesses) from the “big” (big government and big insurance).

These reforms will directly address the growing problems with our healthcare system, providing greater access to quality care for all South Carolinians, not just expensive insurance coverage for some.

In most cases, these innovations already exist to thrive in South Carolina, but must be shared and protected. Few seem to be aware of these opportunities except for government regulators and defenders of the status quo. It is time to get the word out about healthcare freedom initiatives and for legislators to protect the free market so that South Carolinians can be empowered to reclaim control over their healthcare decisions.

INTRODUCING DIRECT PRIMARY CARE

South Carolina families deserve the right to make their healthcare decisions around the kitchen table, free from the whims of Washington bureaucrats. In this vein, a movement has begun to sweep across other states to put patients back in the driver's seat and give access to high quality care to those living on fixed or low incomes.

Direct Primary Care (DPC) is an innovative model being embraced by patients, providers, employers, and policymakers across the United States. DPC offers a unique membership-based approach that enables patients to establish ongoing relationships with their physicians. Patients visit a "primary care home" for all routine and preventive services, including check-ups, urgent care, and chronic care management. Most notably, patients receive unrestricted access to *unhurried* primary care, essential for the patient's wellbeing and the ongoing maintenance of one's health.

THREE'S A CROWD: KEEPING BUREAUCRATS AND INSURANCE COMPANIES OUT OF DOCTORS' OFFICES

The Direct Primary Care Coalition puts it best: "The defining element of DPC is an enduring and trusting relationship between a patient and his or her primary care provider. Patients have extraordinary access to a physician of their choice, often for as little as \$70 per month, and physicians are accountable first and foremost their patients."³

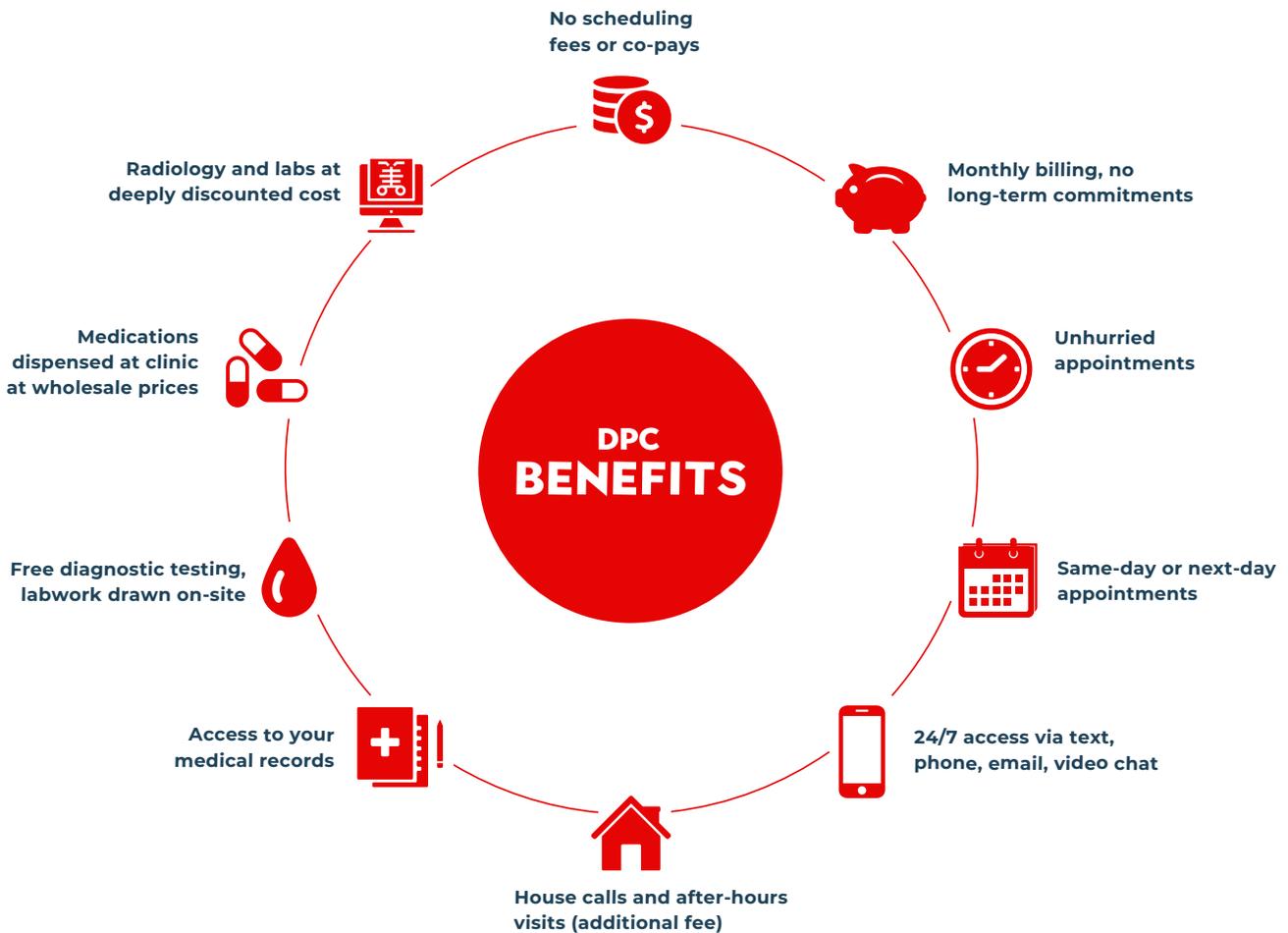
ANALYSIS

The Direct Primary Care model revolves around the following key pillars, as defined in the statement of the Direct Primary Care Coalition principles:

1. **Service:** "The hallmark of DPC is adequate time spent between patient and physician, creating an enduring doctor-patient relationship. Supported by unfettered access to care, DPC enables unhurried interactions and frequent discussions to assess lifestyle choices and treatment decisions aimed at long-term health and wellbeing. DPC practices have extended hours, ready access to urgent care, and patient panel sizes small enough to support this commitment to service."
2. **Patient Choice:** "Patients in DPC choose their own personal physician and are active partners in their healthcare. Empowered by accurate information at the point of care, patients are fully involved in making their own medical and financial choices. DPC patients have the right to transparent pricing, access, and availability of all services provided."
3. **Elimination of Fee-For-Service:** "DPC eliminates undesired fee-for-service (FFS) incentives in primary care. These incentives distort healthcare decision-making by rewarding *volume* over *value* [emphasis added]. This undermines the trust that supports the patient-provider relationship and rewards expensive and inappropriate testing, referral, and treatment. DPC replaces FFS with a simple flat monthly fee that covers comprehensive primary care services. Fees must be adequate to allow for appropriately sized patient panels to support this level of care so that DPC providers can resist the numerous other financial incentives that distort care decisions and endanger the doctor-patient relationship."

4. **Advocacy:** “DPC providers are committed advocates for patients within the healthcare system. They have time to make informed, appropriate referrals and support patient needs when they are outside of primary care. DPC providers accept the responsibility to be available to patients serving as patient guides. No matter where patients are in the system, physicians provide them with information about the quality, cost, and patient experience of care.”
5. **Stewardship:** “DPC providers believe that healthcare must provide more value to the patient and the system. Healthcare can, and must, be higher performing, more patient-responsive, less invasive, and less expensive than it is today. The ultimate goal is health and wellbeing, not simply the treatment of disease.”⁴

“The ultimate goal of Direct Primary Care is health and wellbeing, not simply the treatment of disease.”



AN ANSWER TO THE PLIGHT OF THE LOW-INCOME AND UNDERINSURED

Because Direct Primary Care fosters a personal relationship between physicians and patients, the DPC clinic becomes the facility through which a patient receives care for both chronic and urgent medical needs—rather than the emergency room. While a patient is advised to obtain a high-deductible, low-cost catastrophic insurance policy, their direct primary care clinic becomes the place they can go to address up to 90% of their healthcare needs.

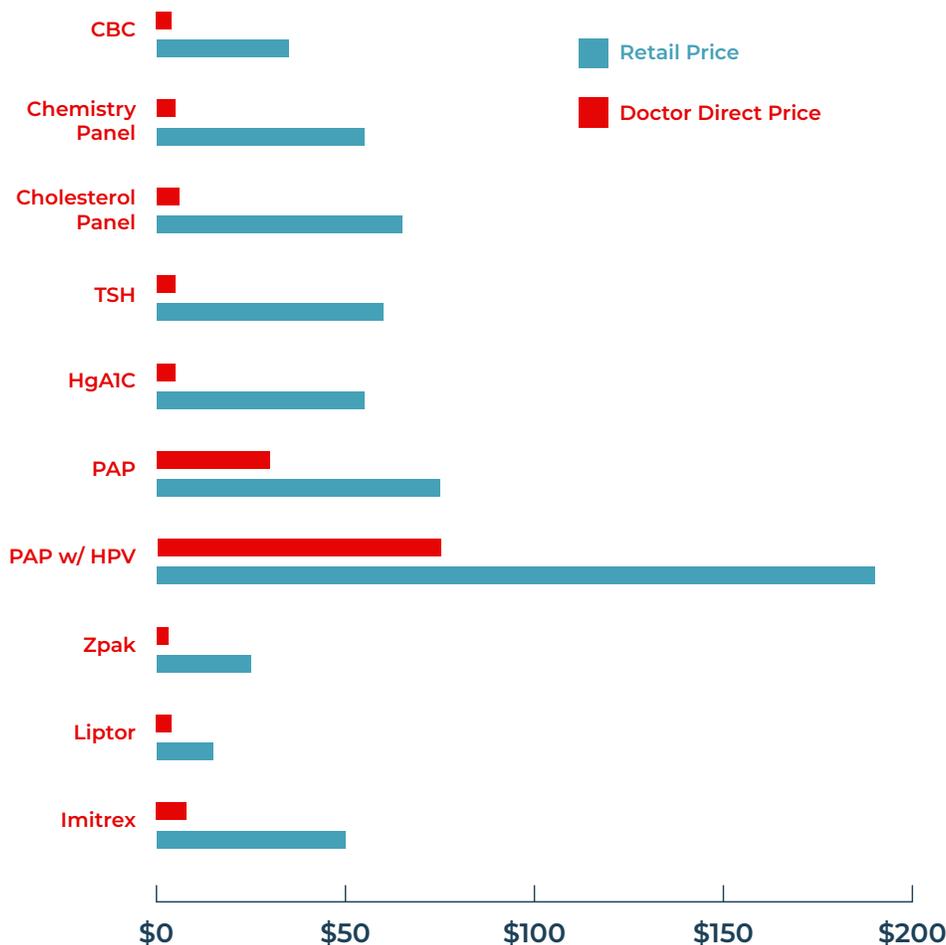
In fact, membership to DPC practices can provide access to the highest quality of care for those who are unable to afford traditional insurance. With costs ranging from as low as \$40 to \$80 per month, individuals can sometimes retain urgent and ongoing care for less than the costs of copays and premiums they would pay under a Medicaid expansion. Indeed, DPC membership can reduce a patient's dependence on more expensive parts of the system, such as surgeries, specialist care, urgent care, emergency rooms, advanced imaging, and hospitals.⁵

THE ANSWER FOR PATIENTS SUFFERING FROM CHRONIC HEALTH CONDITIONS⁶

Out of the thousands of Americans who have chosen to use Direct Primary Care, studies show around 59% of them suffer from at least one chronic health condition. So, how does the DPC model serve them?

Two of the several advantages of the DPC model are the costs associated with the administration and treatment of chronic conditions and the amount of time spent with a physician. Research from the University of North Carolina School of Medicine discovered that patients spent, on average, 27 more minutes with a DPC physician than through a non-direct care practice. They also spent 85% less money at a direct care physician's practice. A large part of the cost savings come from money saved on labs and medicine, where DPC doctors can charge closer to wholesale price. The table below shows the savings that are possible through a DPC plan.

LAB AND MEDICINE PRICING



Source: doctordirectmd.com

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Not only does this benefit patients, but also employers. In Union County, North Carolina, county administrators decided to enroll their employees into a DPC pilot program. The result? Of the 55% of employees who suffered from at least one chronic health condition, 90% became heavily engaged with their healthcare. Additionally, when compared to the employees enrolled in Union County's traditional program, those with at least one chronic condition who were enrolled in the DPC program cost 28% less, saving the county \$1.28 million.

THE ANTIDOTE TO DOCTOR BURNOUT⁷



In a survey conducted by the Physicians Foundation, doctors reported feeling profoundly dissatisfied, thinking their profession was in decline. Among the reasons were:

- Too much regulation and paperwork (79.2% of physicians)
- Loss of clinical autonomy (64.5%)
- Lack of compensation for quality (58.6%)
- Erosion of physician–patient relationship (54.4%)

It is well known that physicians are spending more of their time struggling to meet patient quotas and dealing with insurance companies, and less of their time with patients. This results in decreased quality of care, with patients feeling like their concerns haven't been heard or addressed. It has also led to higher levels of doctor burnout, as physicians leave the field of medicine, retire early, or are poached by larger medical corporations.

Direct Primary Care helps physicians avoid burnout by allowing them more time with patients. Instead of asking patients to book appointments months in advance due to patient overload, doctors can see patients immediately and build quality relationships. This results in improved quality of care and better patient reviews.

DPC IMPROVES QUALITY OF CARE⁸

The *British Medical Journal* did a study of one Direct Primary Care practice and found that its patients, when compared with similar populations, had:

- 35% fewer hospitalizations
- 65% fewer emergency department visits
- 66% fewer specialist visits
- 82% fewer surgeries

In the United States, a five-state study by the *American Journal of Managed Care* analyzed the effects of DPC on health outcomes. The study found that patients at MD-Value in Prevention (MDVIP), a DPC practice, saw avoidable, non-avoidable, and non-elective admissions decrease by 49%, 63%, and 56%, respectively.

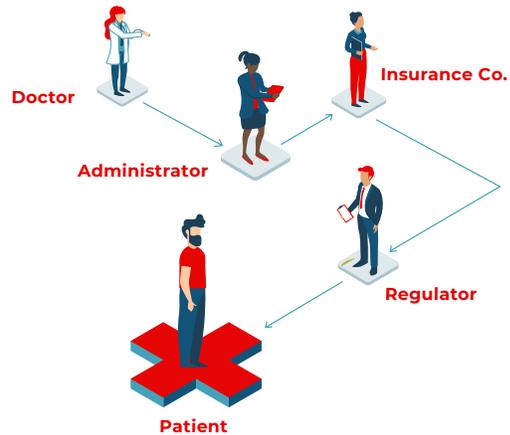
Quality healthcare is not only an obvious benefit to a patients' quality of life, but it also relieves the burden of costs associated with hospital visits. MDVIP patients saw savings of \$119.4 million dollars alone in 2010 from decreases in preventable hospital visits.

THE DIRECT PRIMARY CARE DIFFERENCE

DIRECT PRIMARY CARE

VS

CONVENTIONAL



How Can Direct Primary Care Become an Option for South Carolina Patients?

Currently, 13 states have passed legislation to define Direct Primary Care facilities as permissible *medical providers*, an important distinction from being classified as *insurers*. This has given DPC physicians the security of knowing they can establish their facilities within these states without fear of a state regulatory agency attempting to reclassify them as an insurance provider—and imposing the licensing and other regulatory requirements that such a classification entails.

Legislation authorizing DPC in South Carolina is necessary to attract new, high-quality providers to our state and give doctors freedom to provide a more direct level of service to their patients. Ideal language for legislative approval of DPC would include the following five components:

1. **Clearly defining providers and agreements.** A “primary care provider” would meet all the necessary licensure requirements to be an authorized medical provider in the state. Furthermore, a “direct primary care agreement” would describe the contract parameters between the providers and patients, including an outline of services, fees, and expectations.
2. **Direct primary care agreements as separate from insurance.** A direct primary care agreement would be clearly differentiated from insurance provider agreements and therefore exempted from insurance provider mandates.
3. **Exemption from licensure to sale requirements.** A primary care provider would not be required to obtain a certificate or license to sell services.
4. **Clearly defined agreement terms.** These would more precisely delineate the specific contractual obligations providers have to patients. Such obligations may include timelines, written notices of intentions, changes to policies, or adjustment of fees. Additionally, patients would be asked to affirm their understanding of a direct primary care provider’s distinction from an insurance provider.

5. **Allow patient control over the direct primary care arrangement.** Patients would be protected from arbitrary dismissal from services by a DPC provider, as well as protected from discrimination for eligibility based solely on their health status.

State Rep. Anne Thayer (R-Anderson) sponsored a bill (H.4643) protecting DPC that passed the S.C. House of Representatives in 2018 by a vote of 100-0. But it died in the Senate Banking & Insurance Committee when the 2017-2018 session ended. State Sen. Mike Gambrell (R-Anderson) has introduced a similar bill (S.445) in the Senate for the 2019-2020 session.

Other DPC reforms require federal action, such as allowing Health Savings Accounts (HSAs) to be used for DPC dues, as well as allowing Medicare to pay a beneficiary a fixed amount per month that could be placed into an HSA-type account to pay DPC dues.⁹

It would be nice if we could have some legislation that protects Direct Primary Care and says we are not an insurance agreement. If we get labeled an insurance agreement, we won't be able to perform our duties as physicians if there are many more regulations.

—Dr. Jerome Aya-Ay, Palmetto Proactive Healthcare, Columbia-Greenville-Spartanburg



Nationally, **1/3** of physicians now claim they will not accept new Medicaid patients.



Last year, **2/3** of Medicaid patients had difficulty obtaining an appointment.



Only **11%** of those with private coverage had trouble booking an appointment.¹⁰

THE SOLUTION: DIRECT PRIMARY CARE
Individuals pay a monthly fee for access to expert physicians.

BOTTOM LINE QUESTIONS TO ASK ESTABLISHING DIRECT PRIMARY CARE (DPC)



Isn't Direct Primary Care, which allows people to pay upfront for medical care, only for the wealthy?

No.

Direct Primary Care (DPC) provides all patients, especially those operating on limited income, with a medical team dedicated to providing unrestricted access to expert primary care. Patients, employers, or insurers pay a monthly fee—ranging from as low as \$40 to an economical \$80—directly to the DPC practice, which covers the majority of care needs. These monthly payments can sometimes cost low-income patients less than they would be paying in copays and premiums under an expanded Medicaid program.

Isn't Direct Primary Care only for basic check-ups?

No.

Patients go to their primary care doctor for all routine and preventive services, which include check-ups, along with expansive services like screenings, urgent care, and chronic care management. In fact, DPC can address up to 90% of a patient's healthcare needs.

Even though I'd be paying a monthly fee for these Direct Primary Care services, won't other costs like imaging or trips to the emergency room cause my costs to skyrocket?

No.

Because patients maintain a personal relationship with their primary care physician, the DPC clinic is where they would first seek treatment for their healthcare needs—not the ER. DPC can diminish dependence on more expensive parts of the system, such as surgeries, specialty care, urgent care, emergency rooms, advanced imaging, and hospitals. In fact, DPC practices have seen surgical costs at one-sixth traditional pricing and one-tenth the patient costs of traditional insurance.

Is a Direct Primary Care arrangement legal under Affordable Care Act requirements, and are there any actual providers in South Carolina?

Yes!

DPC can fill a void in healthcare access for those who cannot afford traditional insurance. By retaining a high-deductible, catastrophic plan, individuals may comply with the Affordable Care Act's insurance mandate and be free to enter into a DPC arrangement for all of their non-catastrophic care. Currently, there are DPC clinics in every major metropolitan area of South Carolina, but they need the reassurance of legislation that will enable them continue to safely practice, and new providers need assurances that they are welcome to begin practicing in the state and the rules aren't going to suddenly change.



INNOVATION PROFILE

DR. JEROME AYA-AY

PALMETTO PROACTIVE HEALTHCARE



*"If you go into medicine to be a family care doctor, it is what you signed up for. **Direct Primary Care is the old-school way of doing medicine.** The advantage to the physician is that you're a doctor again. You're not a hamster in the wheel trying to get through patients, getting paid according to doctor's contracts. You don't have to 'churn-n-burn' or 'treat-n-street' patients. As a physician, it gives me that satisfaction that I'm doing what's right for the patient."*

— Dr. Jerome Aya-Ay, Palmetto Proactive Healthcare

Dr. Jerome Aya-Ay was raised in the small rural town of Grantsville, West Virginia. He graduated from the University of Notre Dame with a bachelor's degree in biology. After studying for a master's degree in biomedical sciences at Marshall University in Huntington, West Virginia, he went on to graduate from the university's Joan C. Edwards School of Medicine with a medical degree. Dr. Aya-Ay completed his residency in family medicine at Spartanburg Regional Medical Center, where he was awarded the Family Medicine Resident of the Year in 2007. He is board-certified in family medicine and has a special interest in preventative care and lifestyle medicine. Aya-Ay learned the business side of medicine during his residency by spending time in the business office of the hospital. He started his Palmetto Proactive Healthcare practice, which now has offices in Columbia, Greenville and Spartanburg, from scratch. In his early career, Jerome worked as a traditional doctor from 7:00 p.m. to 7:00 a.m. in York, S.C., then drove to Spartanburg to run his DPC practice from 8:00 a.m. to 5:00 p.m.

Dr. Aya-Ay calls DPC both "an old school way doing medicine" and "an honest way of doing business."

Aya-Ay estimates the cost of paperwork and insurance in a typical non-DPC medical practice to be \$90,000 per year per physician in South Carolina, with a 30- to 90-day waiting period before receiving payment from the insurance company. But by eliminating the third party from the doctor-patient relationship, Aya-Ay says he is able to eliminate interference, overhead, and paperwork and focus on the patient. That means lower prices, and that those prices—both for members of his practice and one-time walk-in patients—can be transparent.

One of the unique benefits of joining a Direct Primary Care practice is 24/7 access. Dr. Jerome Aya-Ay remembers the day he was attending a festival with his family in Spartanburg when his cellphone rang. One of his DPC members had cut himself severely and couldn't stop the bleeding. Aya-ay left the festival, met his patient at the office on John B. White Boulevard, stopped the bleeding, and sewed him up. No extra charge.

Dr. Aya-Ay and his medical practice partner Dr. Chris McCarthy also proficient in prescribing medicines that are less expensive or free. "I saw a patient recently with six medications," says Dr. Aya-Ay. "Two of them turned out to be free at BI-LO—diabetes and blood pressure medicine—and the rest were maybe \$4 elsewhere. They had been paying \$80 per month, we got it down to \$20. Guess what? We saved them the cost of their DPC membership right there—\$60 per month."

Direct Primary Care vs. Traditional Doctor's Visits

	Family Practice	Direct Primary Care
Medical Professionals Practicing	133,000	1,500
Patients Per Doctor	As many as 2,367, according to some estimates	500-1,000
Cost per Visit	Depends on insurance plan	Free with monthly membership, which is about \$50
Length of Visit	13-16 minutes	30-60 minutes
How Doctors get paid	Salary - about \$207,000	Paid with monthly membership fees
Can you use insurance?	Yes	No
Blood Test Cost	Depends on insurance plan, typically billed after the fact	Wholesale price, often included for free as part of exam
Prescription Drug Cost	Copay amount	Wholesale price plus 10%

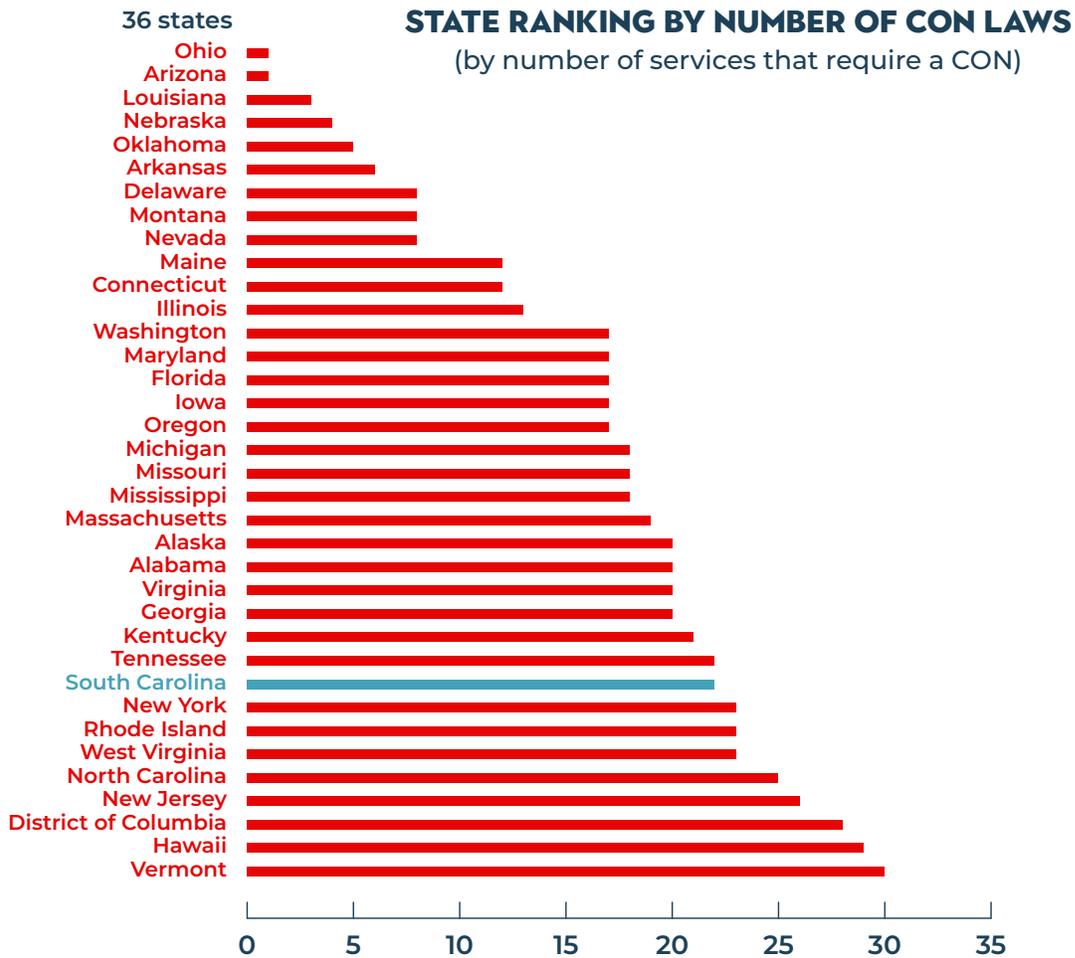
Source: Business Insider

Typically, a family doctor sees between 30 and 40 patients per day. We want our doctors here to see 15 patients per 8- to 9-hour day. That's very reasonable. We get less burned out and we can really enjoy what we do. I can get to know my patients my patients can get to know me.

—Dr. Jerome Aya-Ay, Palmetto Proactive Healthcare

Yet, South Carolina and 34 other states, along with the District of Columbia, have continued to impose and expand upon their CON law programs. In fact, South Carolina's CON program is tied for the ninth-most restrictive in the United States.

On average, states with CON programs regulate 14 different services, devices, and procedures. South Carolina's CON program currently regulates 22 different services, devices, and procedures, which is much higher than the national average.



Source: Mercatus Center, 2016

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TEAR DOWN THESE WALLS: REPEALING CERTIFICATE OF NEED

The Mercatus Center at George Mason University recently examined state-specific CON laws to explore their impact on patient costs and access to care. As researchers Christopher Koopman and Thomas Stratmann note, the theory that drove states to embrace CON laws is that “by restricting market entry and expansion, states might reduce overinvestment in facilities and equipment. In addition, many states justify CON programs as a way to cross-subsidize healthcare for the poor.”¹² Thus, CON laws were rationalized as a protection from runaway healthcare spending and a means of increasing hospitals' capacity to provide greater charity care.

Let's first consider the well-intentioned goal of **reducing state spending** on non-essential healthcare services. Research to support this outcome has been mixed, with little to no substantial cost reductions detected, while others have found that costs may actually increase by 5% or more. As Koopman and Stratmann acknowledge, "By limiting the number of providers that can enter a particular practice, and by limiting the expansion of incumbent providers, CON regulations effectively give a limited monopoly privilege to providers that receive approval in the form of a certificate of need. Approved providers are therefore able to charge higher prices than would be possible under truly competitive conditions."¹³

The Mercatus Center calculates that per-capita healthcare spending in South Carolina is \$200 higher because of CON laws and spending on physicians is \$69 higher than necessary.¹⁴

So, if CON laws are incapable of lowering costs, are they at least successful at encouraging **higher provisions of charity care** due to their ability to inflate prices? No. In fact, the most comprehensive empirical study to date on South Carolina's CON laws found no relationship between CON laws and increased rates of charity care.¹⁵

There are other opportunity costs associated with CON:

Less Access

Compared to CON states, non-CON states have more hospitals, including more rural hospitals.¹⁶

Mercatus estimates South Carolina would see an increase of over 50 healthcare facilities, including rural facilities, without CON regulations. Access to hospital beds also suffers due to the state's CON regulations. Because South Carolina's CON program regulates acute hospital beds, the Mercatus Center found our state has 133 fewer beds per 100,000 people than the national average. Per South Carolina's population of 5.024 million, this could mean 6,581 fewer hospital beds in the state due to CON laws.

Lower Quality

Data from Mercatus¹⁷ also suggests there would be a decrease in mortality rates for heart attacks, heart failure, and pneumonia in South Carolina without CON laws. There is a similar decrease in re-admission rates and post-surgery complications when fewer CON laws are on the books. After the repeal of Pennsylvania's CON program, a study found that the market for heart surgery benefited by "directing more volume to better doctors and increasing access to treatment."¹⁸

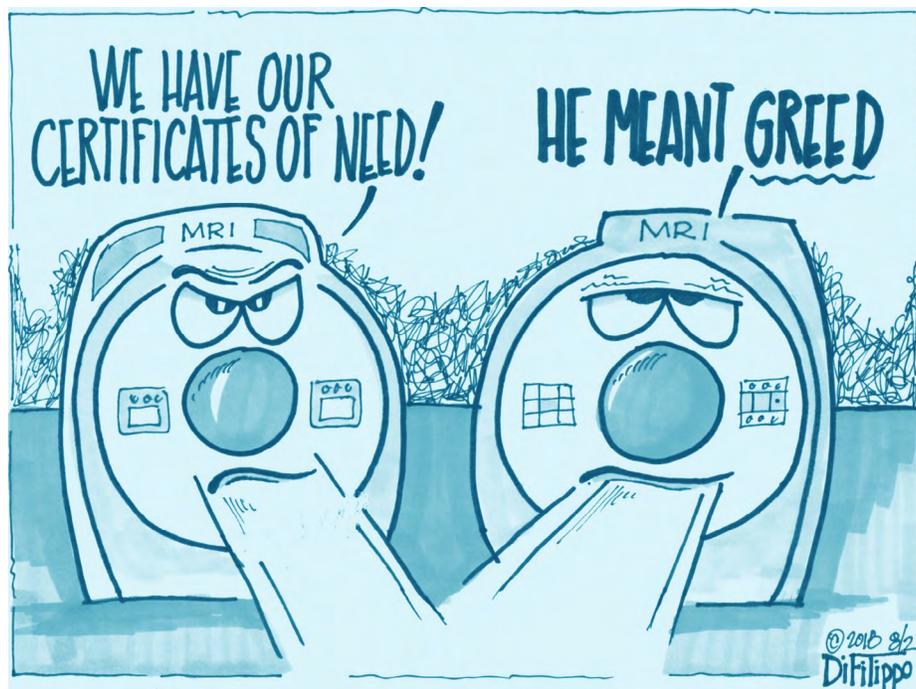


The Roper St. Francis Berkeley Hospital (shown here under construction) was delayed for nearly 10 years due to CON litigation. MUSC's planned Berkeley community hospital is now under fire.

(Photo/Roper St. Francis)

Lower Utilization Rates

CON laws have also influenced the utilization rates of imaging services. Without CON laws in place, Mercatus estimates that South Carolina would see a 36% increase in utilization of MRI scans by non-hospital providers. Positron Emission Tomography (PET) utilization rates by non-hospital providers would double without CON, according to Mercatus' estimates.¹⁹



Source: Dave DiFilippo, Wilson Times. Used with permission.

SOUTH CAROLINA AND CON

South Carolina has played a unique role in the battle over CON laws that has crossed jurisdictional and party lines. On Nov. 13, 2015, then-Gov. Nikki Haley petitioned the federal government to address CON laws' failure to help the needy in the Palmetto State.²⁰ The response from the **Obama** Administration, in the form of a joint memorandum from the U.S. Department of Justice's Antitrust Division and the Federal Trade Commission,²¹ provides one of the most powerful and succinct cases against CON. The DOJ and the FTC did not mince words:

“CON laws, when first enacted, had the laudable goals of reducing health care costs and improving access to care. However, after considerable experience, it is now apparent that CON laws can prevent the efficient functioning of health care markets in several ways that may undermine those goals ... For these reasons... the Agencies historically have suggested that states consider repeal or retrenchment of their CON laws, and in this case, respectfully suggest that South Carolina repeal its CON laws.”²²

FTC and DOJ explained their near-unprecedented willingness to weigh in on state legislation was because antitrust has remained a key priority of the agencies, and specifically, “the importance of health care competition to the economy and consumer welfare...”²³

The agencies determined that the process of receiving a Certificate of Need from the South Carolina Department of Health and Environmental Control, and the potential intervention of the state's Ad-

ministrative Law Court or other judicial bodies, to be “time-consuming and costly, potentially involving multiple layers of review and spanning many months or years ... even before any appeal to the judiciary, the CON process can delay entry or expansion by approximately two years.”²⁴ The agencies supported the goals of H.3250 (2015), including sunseting or repealing the CON program altogether within two years.

Concerns over the actual impact of CON discussed in the report mirror several of our arguments here. The agencies had their own unique concerns as well:

- *CON laws create barriers to entry and expansion, which may suppress more cost-effective innovative, and higher quality health care options.* (“interfering with market forces”)
- *The CON process may be exploited by competitors seeking to protect their revenues and may facilitate anticompetitive agreements.*²⁵
- *The CON process can impede effective antitrust remedies.* The example cited is an Albany, Georgia case where CON laws in essence made it difficult to require divestiture (as the FTC recommended in *FTC v. Phoebe Putney Health System, Inc.*) as a means of preserving choices for hospital services in that city.

In short, the status quo is using CON laws to protect its bottom line.

*The **Trump** Administration agreed with the **Obama** assessment: “Three prominent members of the Trump administration called on individual states to eliminate Certificate of Need (CON) laws regarding the development of new health care facilities... Writing in a sweeping, nearly 120-page report on health care reform, the secretaries of the Health and Human Services, Treasury, and Labor departments.” — Alex Azar, Steven Mnuchin, and Alexander Acosta, respectively — accused states of holding back innovation in health care with the laws.*

Shifting from federal to local concerns, another problem voiced by many South Carolinians is the damage CON laws do to **home rule**. With CON on the books, local hospitals are not allowed to make decisions based on the needs of their community, but must turn to Columbia for approval. We would argue that no government agency should be involved in deciding which healthcare services may be offered to a community, but if a government is involved, consistent with the principles of the South Carolina Local Government Act of 1975, it should be the government closest to that community.

TOP 10 MOST RESTRICTIVE CERTIFICATE OF NEEDS STATES (2016) (By number of services that require a CON)

1. Vermont
2. Hawaii
3. District of Columbia
4. New Jersey
5. North Carolina
6. New York
7. Rhode Island
8. West Virginia
9. South Carolina
10. Tennessee

Source: Mercatus Center, 2016

BOTTOM LINE QUESTIONS TO ASK: REFORMING CERTIFICATE OF NEED (CON) LAWS



What are these laws and why do you think they need reform—aren't they meant to protect patients and providers anyway?

No.

Thirty-five states, including South Carolina, currently use CON laws to purportedly “slow the growth of healthcare prices, promote consolidation of healthcare providers, and limit duplication of services.” These states require agency approval for a wide range of expenditures, including the construction of new hospital bed space, purchase of additional medical technology, or expanding services of medical procedures. CON laws give inappropriate influence to established providers during the vetting process. When a company seeks to enter a new market or expand in an existing market, industry incumbents often use the CON process to block the potential competition. Recent studies have shown CON laws fail to achieve many of their stated goals and have instead reduced the availability of healthcare services. Since 1971, South Carolina has been among the states that restrict the supply of healthcare in this way. Of the 34 devices and services subject to CON throughout America, South Carolina restricts 22—ranging from ambulatory service centers to hospice to psychiatric services—requiring a CON from the state before the device may be purchased or the service offered. In fact, our state has the ninth-most restrictive CON laws in the nation. (Fifteen states either have no CON laws or their CON laws are not in effect. In addition, Arizona is typically not counted as a CON state, but is included because it is the only state to regulate ground ambulance services.)²⁶

If we repeal or reduce certificate of need law requirements, won't we inhibit the ability for hospitals to provide indigent care?

No.

While CON laws significantly reduce available healthcare services for everyone, they do not lead to an increase in care for the needy. Furthermore, there is no evidence to suggest that indigent care in the U.S. has increased as a result of implementing CON laws.

Would repealing CON laws benefit all patients regardless of insurance status, location, or current health?

Yes!

Evidence demonstrates CON laws do not achieve their intended outcomes, but rather decrease the supply and availability of healthcare services for everyone, especially the poor. By lifting these restrictions, we can allow new providers to begin operating and increase access for South Carolinians across the state.

RETURNING HEALTHCARE DECISION-MAKING TO SOUTH CAROLINA FAMILIES

As healthcare costs continue to rise, the plight of the uninsured remains a dilemma, and businesses across South Carolina are forced to make difficult decisions about the ongoing availability of health benefits.

Access to quality healthcare is quickly diminishing as well.

So, in the face of these challenges, why would a state continue to impose regulations as flawed as Certificates of Need?

By repealing state CON laws— that prevent local healthcare providers from responding to medical needs— and market demands, South Carolina would restore the ability of individuals, regardless of socio-economic status or region, to seek high-quality care at prices they can afford—without government interference or unsustainable costs to taxpayers.

Thankfully, Rep. Nancy Mace (R-Daniel Island) and House Ways and Means Committee Chairman Rep. Murrell Smith (R-Sumter) have renewed the effort to bring an end to CON laws in South Carolina, in line with the recommendations in this report. Mace's H.3823 (2019), which has earned 30 co-sponsors, takes an aggressive approach, removing CON from the state code entirely.

Among the supporters of Rep. Mace's legislation is the Charleston County Medical Society, which sent a letter signed by 100 state physicians to Gov. Henry McMaster, urging him to support the repeal of South Carolina's CON program. As they noted in their letter, **"Our CON law facilitates a cartel of ever-expanding hospital systems which block competitors from entering the market."**

Evidence clearly demonstrates that CON laws do not achieve their intended economic and charitable outcomes, but rather decrease the supply and availability of healthcare services for everyone, especially the poor. By lifting CON restrictions, South Carolina can encourage new providers to enter state healthcare markets, which will lower costs and increase access.

Reps. Mace and Smith have chosen to address the CON issue in the face of significant opposition from existing providers. We salute their courage and their belief that the free market, not the government, should determine who provides which healthcare services in South Carolina.

OTHER RECOMMENDED REFORMS

HEALTHCARE SHARING²⁷

A health care sharing ministry (HCSM) is a faith-based approach to healthcare in which members of the organization voluntarily share each other's health expenses.²⁸ Healthcare sharing is not insurance, because there is no contractual sharing of risk.

The three largest health care sharing ministries are Samaritan Ministries, Christian Care Ministry (Medi-Share), and Christian Healthcare Ministries. Policies differ between the associations, but in most cases, members pay a monthly "share" (based on family size and level of desired out-of-pocket expenses). That share is distributed to fellow members who have incurred health expenses. Members submit their medical bills to the ministry for "sharing." Most services and procedures beyond check-ups and minor expenses will qualify to be shared with other members. The family submitting an expense for sharing receives funds to cover their expenses from other members directly or through a clearinghouse system operated by the ministry. Membership in a HCSM often requires adherence to certain theological, lifestyle, and health guidelines and recommendations from the clergy.

Since 1994, 30 states have passed legislation clarifying that HCSM are not insurance and not to be regulated by insurance commissioners or Departments of Insurance. HCSM are nonprofit charities overseen and regulated by the IRS, states' attorneys general, and/or secretaries of state. If HCSM were regulated like insurance, the faith-based model couldn't exist.

- Some insurance agents representing health insurance companies are now representing one or more HCSM.
- Most HCSM members do not carry traditional insurance or they maintain catastrophic insurance coverage only.
- It is common for families who use HCSM to subscribe to a Direct Primary Care practice as well.
- Efforts to pass legislation protecting HCSM in South Carolina have been unsuccessful.
- Federal law references HCSM as meeting Affordable Care Act mandates, and as deductible as a business expense for employers who pay HCSM monthly sharing amounts on behalf of their employees.

RIGHT TO SHOP

It has been said that that price you pay for healthcare depends on where you park. Prices for exactly the same procedure vary widely in the same town, with the same surgeon, with the same equipment, and even in the same hospital. A recent study in California showed the difference in cost for a procedure known as an "MRI with Contrast" between two nearby Oakland hospitals to be *double*.²⁹ Prices released several years ago by the South Carolina Department of Health & Human Services revealed similarly stark price differences: A knee replacement at a Myrtle Beach hospital was twice the cost of a Murrells Inlet medical center only a few miles away.³⁰

Until very recently, patients had no way to shop for the best price. Fortunately, price transparency is on the rise in healthcare. For example, as of Jan. 1, 2019, the U.S. Centers for Medicare and Medicaid Services began to require hospitals to publish a master list (“chargemaster”³¹) of their charges on the internet.

But will patients shop? They will with a concept known as “Right to Shop.” Right to Shop is an incentive-based program that rewards the patient for comparing prices for medical procedures.

In New Hampshire, a pioneer state in Right to Shop, 90% of enrollees in the program shopped at least once. Savings there have averaged \$670 for each procedure, saving the state over \$12 million so far. Other states implementing similar programs include Maine, Kansas, Kentucky, and Massachusetts. Some companies that provide health insurance to their employees encourage shopping, and some insurers have offered programs as well.

The process of Right to Shop is simple: The patient receives codes for a procedure ordered by his or her doctor, shops for the best price, receives the procedure, and is given credit by the insurance company for a portion of the savings. (A bill filed recently in the South Carolina Senate would have required the patient to receive a credit for 50% of the insurance company’s savings as compensation for shopping.) The patient and the insurance company both win.

Right to Shop means lower prices, more choices, and direct patient engagement in the cost of the service, a crucial component that has been lost since patients were essentially cut out of the process by various gatekeepers and rigid networks of providers.

BROKERAGE REFORM

In the predominant system, an insurance brokerage firm shops for health insurance carriers on behalf of a business, gathering competing quotes, ostensibly so the business can weigh price, quality, and other options to see what best suits its employees. But in this system, there is often the question of “who is the client?” That is, if brokers are not paid directly by the business, but by insurance companies, there may not be a strong incentive to look out for the best interests of the business.

One of the most promising innovations of what might be called “free market healthcare,” however, is the rise of a new type of more independent and transparent health insurance broker.

Some of these new health insurance brokers work with their clients to conduct a form of Right to Shop and Direct Primary Care combined, where the broker advises the employer and employee on where to access the very best quality and price for a given procedure. This often involves innovative providers such as the Surgery Center of Oklahoma. Their slogan says it all: “free market-loving, price-displaying, state-of-the-art, AAAHC accredited, doctor owned, multispecialty surgical facility in central Oklahoma.”

Using this system, these new paradigm brokers are saving their business clients an average of 47%.³² South Carolina will be an important test case for this concept as a large county government recently began operating on this model.

VOLUNTEER (CHARITY) CARE

Thanks to legislation passed in South Carolina in 2015, physicians donating their services to a free medical clinic will receive continuing medical education (CME) credit, and a waiver of reasonable liability for services they perform for free. Palmetto Promise Institute has developed an interactive map that shows the location of all charity care clinics in South Carolina. That map can be accessed at PalmettoPromise.org.

AFTERWORD...

Most of the reforms described in the publication have made it to the starting point in South Carolina, but have not crossed the finish line. Please visit our website to learn more about Direct Primary Care, Certificates of Need, Christian healthcare sharing, Right to Shop, brokerage reform, charity care, and other reforms not mentioned here.

Together, with the tools of free enterprise, the marketplace of ideas, and individual freedom, we can make healthcare more affordable for all South Carolinians—*without* more government spending or red tape.

ABOUT PALMETTO PROMISE INSTITUTE

THE PALMETTO PROMISE

We promote policy solutions to support a free and flourishing South Carolina, where every individual has the opportunity to reach their full, God-given potential.

OUR VALUES

Finding Common Ground: Building trust and establishing relationships with South Carolinians of all backgrounds.

Best Practices: Performing rigorous research and thorough analysis to explain what's working in public policy, both here and around the country, and why.

Policy Entrepreneurship: Promoting innovative policy solutions that are grounded in the principles of freedom and equal opportunity and communicated with respect and kindness.

PPI encourages rigorous critique of its research. If an error ever exists in the accuracy of any material fact or reference to an independent source, please bring the mistake to PPI's attention with supporting evidence. If in its sole discretion PPI determines that an error has occurred, Palmetto Promise will correct the mistake in an errata sheet accompanying all subsequent distribution of the publication.

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Palmetto Promise Institute wishes to thank Justin Owen, President of The Beacon Center of Tennessee and Naomi Lopez Bauman, Director of Healthcare Policy at The Goldwater Institute for permission to quote extensively from their publication *A Comprehensive Package to Reform Healthcare* (2015).

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²⁵ The FTC/DOJ report cites the example of two West Virginia hospitals colluding in seeking CONs—one hospital agreed to seek a CON for open heart surgery while the other would apply for a CON for a cancer treatment center. The hospital seeking a heart center would not oppose the cancer hospital and vice-versa (p.8).

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³¹ The “chargemaster” is a reporting of hospital charges for a particular procedure or service. Real reform would involve requiring hospitals (most of which are nonprofit) to post their actual costs and “profits” for each procedure and service.

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