SPECIAL REPORT

HEALTHCARE

A HEALTHCARE FREEDOM AGENDA

NEW APPROACHES TO HEALTHCARE FOR THE PALMETTO STATE

JANUARY 21, 2020

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 more efficiently and more effectively 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 our citizens in poverty. 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 "bigs," (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 one-third 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 our citizens in poverty, 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 "bigs" (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 and are poised to thrive in South Carolina, but must be publisized 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."

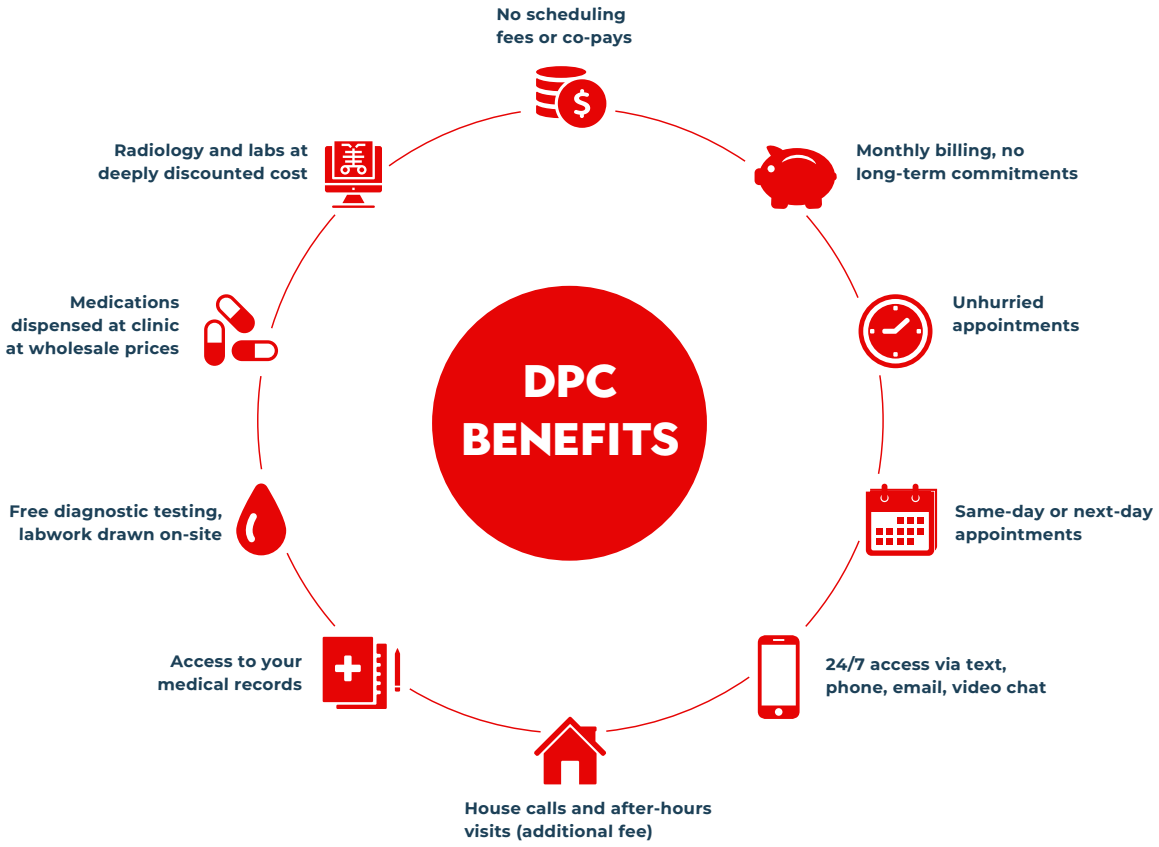
2. ***Patient Choice***: "Patients in DPC choose their own personal physician and are active partners in their healthcare. Empowered by accurate information at the point of care, patients are fully involved in making their own medical and financial choices. DPC patients have the right to transparent 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.

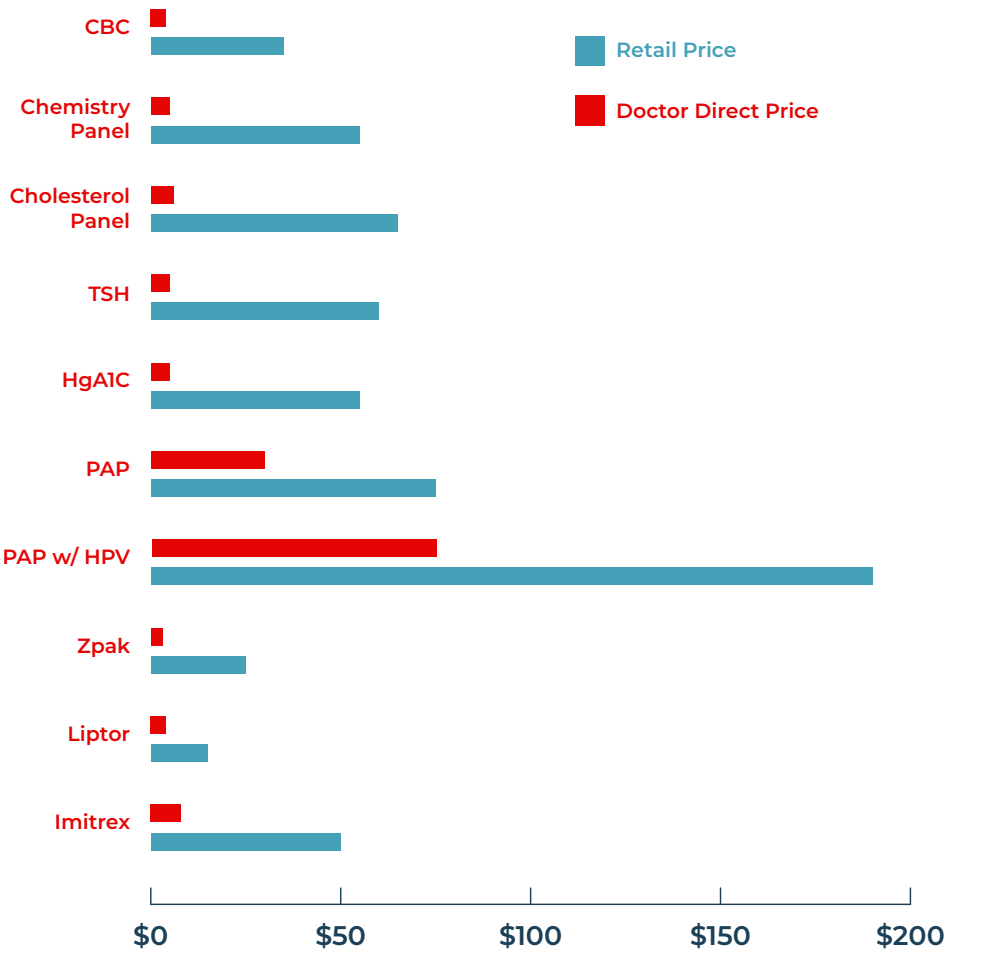
In fact, membership to DPC practices can provide access to the highest quality of care for those who are unable to afford traditional insurance. With costs ranging from as low as $40 to $80 per month, individuals can sometimes retain urgent and ongoing care for less than the costs of copays and premiums 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 CONDITIONS[6]

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. (As this report was being prepared, we learned that Anderson County (SC) will be offering a DPC option. Forthcoming data will provide more examples of the effects of widespread use of Direct Primary Care.)

THE ANTIDOTE TO DOCTOR BURNOUT[7]

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 that 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.

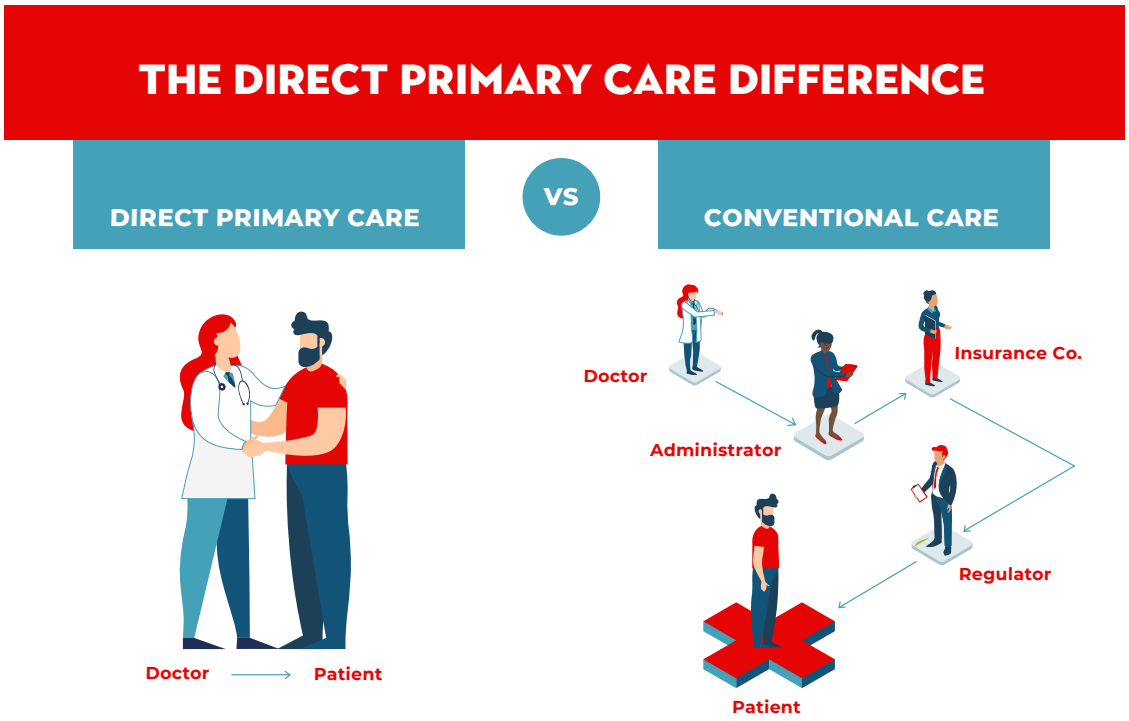
DPC IMPROVES QUALITY OF CARE[8]

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.



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

Currently, 26 states including most Southeastern 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 more, 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] As recently as the summer of 2019, the White House issued an executive order instructing the federal HHS to begin this process. South Carolina's own Dr. Jerome Aya-Ay was present at the signing. Dr. Aya-Ay had this to say about state legislation:

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. Most of the states with which we compete for doctors - those in the Southeast - already have a DPC protection law.

Source: palmettopromise.org

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 are 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 and my patients can get to know me.
—Dr. Jerome Aya-Ay, Palmetto Proactive Healthcare

THE UNFORTUNATE LAW: CERTIFICATE OF NEED (CON)

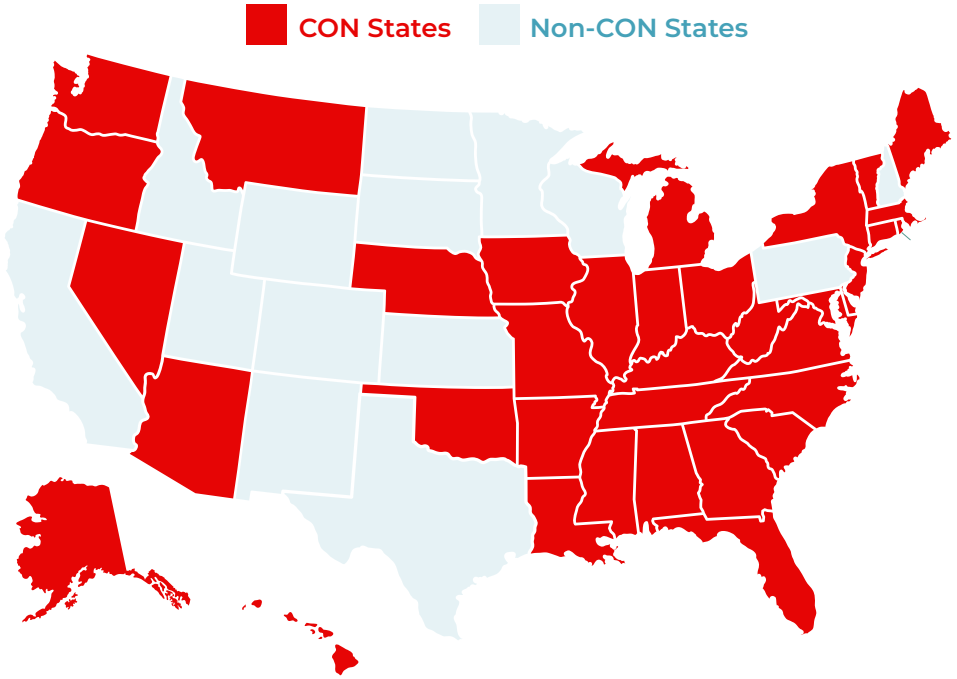
WHAT ARE CON LAWS AND WHERE DID THEY COME FROM?

Since 1971, South Carolina has been among the states that have restricted the supply of healthcare services through Certificate of Need, or CON, laws. Rather than the market demand determining the supply, under CON laws, clinicians and medical facilities must seek approval from the state before purchasing or expanding services they provide to patients. This is due to the mistaken belief that regulations requiring proof of the *need* for a medical service before its established would somehow reduce or control healthcare *costs*.

Instead, CON laws have resulted in reducing everything but costs. The supply of over 22 essential devices and services, ranging from hospital beds to magnetic resonance imaging (MRI) machines, is restricted by CON laws. The passage of the National Health Planning and Resources Development Act of 1974 provided a strong incentive for states to implement CON programs and made certain federal funds contingent on the implementation of CON laws. In the seven years that followed, nearly every state without a CON program moved towards adoption of CON statutes. By 1982, Louisiana was the only state without some form of CON regulation.[11]

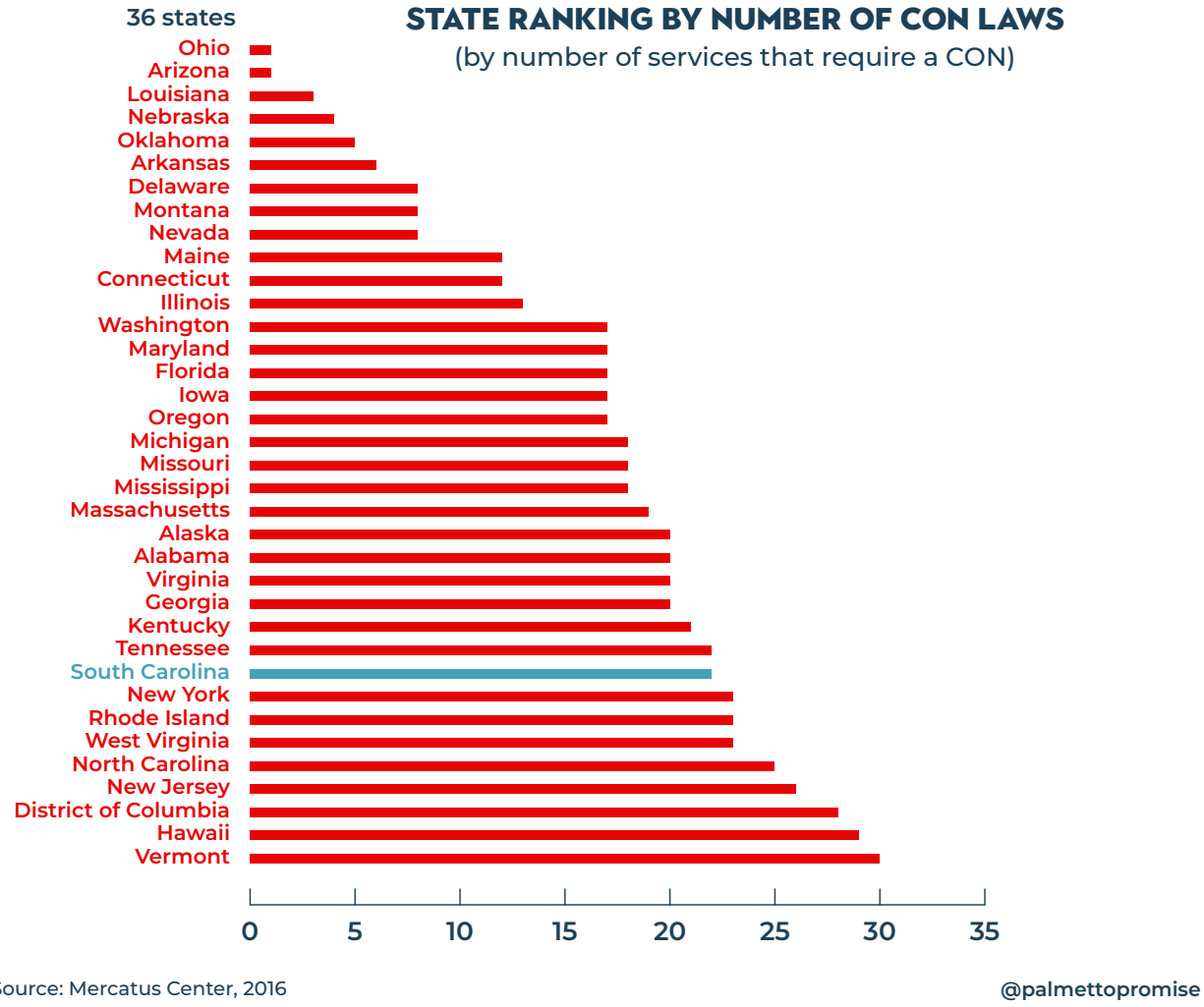
CON laws have failed to accomplish their intended mission of reducing costs and increasing indigent care.

Fortunately, the federal government took a closer look at the impact of CON laws, and by 1987, seeing little evidence of their desired effects, decided to repeal its incentive program. In response, 12 states almost immediately repealed their CON laws. By 2000 three more—Indiana, North Dakota, and Pennsylvania—had followed suit. (Indiana restored CON for comprehensive care beds only in 2015 for three years.)



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

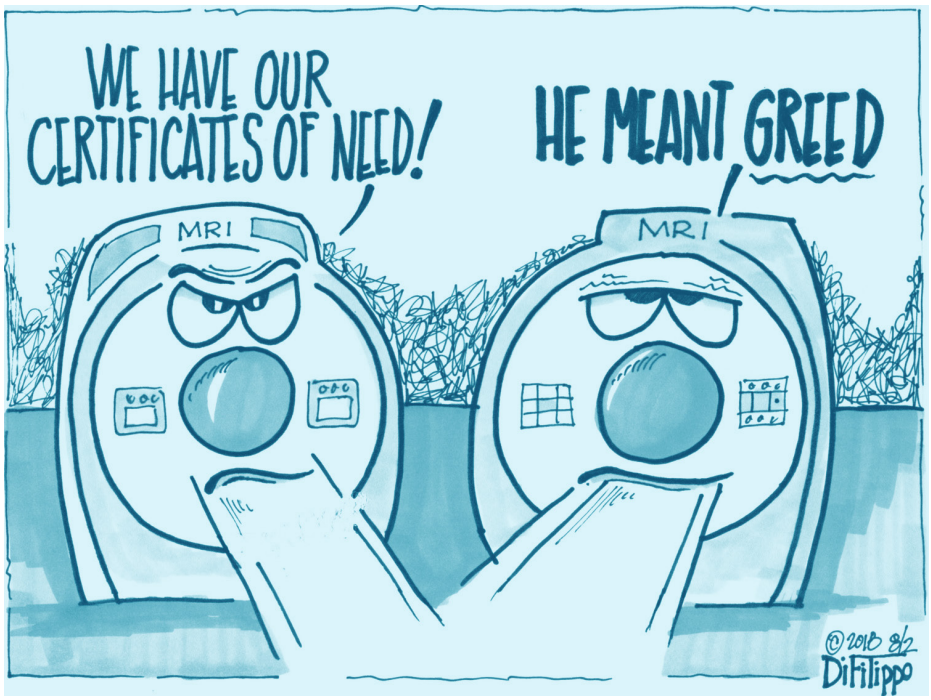
Data from Mercatus[17] also suggests there would be a decrease in mortality rates for heart attacks, heart failure, and pneumonia in South Carolina without CON laws. There is a similar decrease in re-admission rates and post-surgery complications when fewer CON laws are on the books. After the repeal 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 nearby 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 healthcare costs and improving access to care. However, after considerable experience, it is now apparent that CON laws can prevent the efficient functioning of healthcare 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 healthcare 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

Administrative Law Court or other judicial bodies in that process, 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 legislation sunsetting 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 healthcare 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 healthcare facilities… Writing in a sweeping, nearly 120-page report on healthcare 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 healthcare 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.

What is the current status of South Carolina's CON laws?

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. In 2020, Sen. Wes Climer introduced a companion bill (S.990) on the senate side.

Among the supporters of Rep. Mace and Sen. Climer'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, along with Sen. Climer, 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 SHARING[27]

A healthcare 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 pooling of risk.

The three largest healthcare 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 recommendation letters from the clergy. (There are also healthcare sharing communities such as Sedera that are not faith-based.)

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

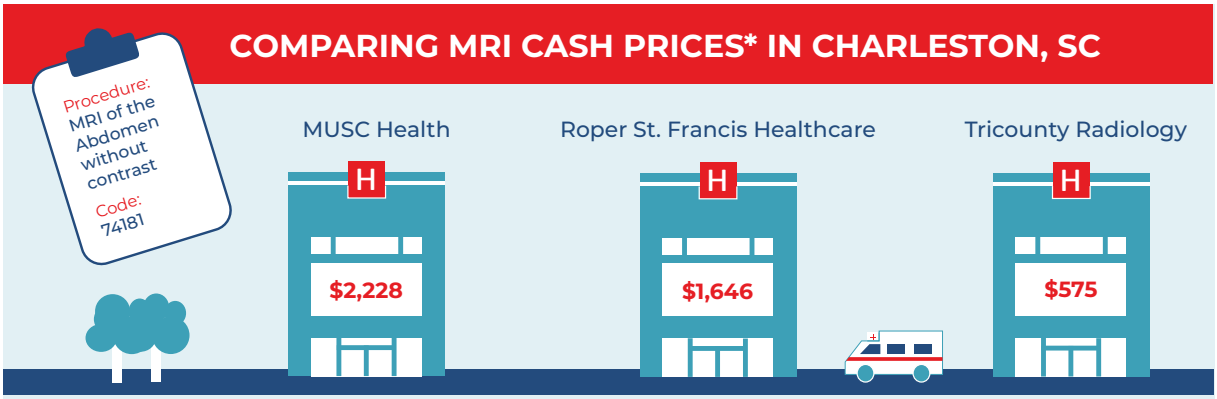
- Some insurance agents representing health insurance companies are now representing one or more HCSM.
- Most HCSM members do not carry traditional insurance or they maintain catastrophic insurance coverage only.
- It is common for families who use HCSM to subscribe to a Direct Primary Care practice 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.

Thankfully, we now have legislation that would protect HCSMs as Sen. Chip Campsen has filed S.1004 (2020) to clarify HCSMs as seperate from insurance.

PRICE TRANSPARENCY & THE 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. For example, Palmetto Promise has done some digging and found[29] that the exact same MRI in the Charleston, SC area could cost anywhere from under $600 to over $2,200—only difference being the provider.

COMPARING MRI CASH PRICES* IN CHARLESTON, SC



Source: Palmetto Promise Institute
*Prices listed include any discount for self-pay patients and came directly from the provider.

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[30], 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.

To show how this works in real life, Palmetto Promise also examined the "chargemaster" data (see graphic below[32]) from hospitals across four major cities in South Carolina to determine if there was a disparity in sticker prices. Using the example of a "hospitalization due to a blood infection," there were wide variations in "suggested retail price" within every market.

Again, because the cost to individuals is determined by their policy coverage and the contract between the hospital and the insurer, this information does not tell us what the insurance company will cover or what the patient will ultimately pay. But it does provide insight into the inconsistency across the board in hospital pricing.

AVERAGE CHARGES* VARY WIDELY ACROSS SOUTH CAROLINA HOSPITALS

Illness: Blood Infection
Insurer: Average charge across all payer types

COLUMBIA HOSPITALS

Prisma Health Baptist	$91,209
Providence Health	$35,464

GREENVILLE HOSPITALS

Bon Secours St. Francis	$66,234
Prisma Health	$39,549

CHARLESTON HOSPITALS

MUSC Medical Center	$63,128
Roper Hospital	$40,066

MYRTLE BEACH HOSPITALS

Conway Medical Center	$54,413
McLeod Health Seacoast	$47,554

*"Charge" = List price for services as reported by hospitals to SCHA, NOT an accurate reflection of a patient's eventual out-of-pocket costs
Source: scpricepoint.org/South Carolina Hospital Association (SCHA) accessed June 26, 2019

But providing only these chargemasters is of little practical value. They reveal only what amounts to their "suggested retail price." That doesn't tell the patient how much he or she can actually expect to be billed by a particular hospital.

TRUMP ADMINISTRATION EXECUTIVE ORDER

To help address this issue, the Trump Administration has released a new HHS rule[33] to force providers to reveal the confidential prices points they have negotiated with insurers.

The Trump HHS proposal, as it stands, would reveal the "payer-specific" negotiated charge for the first time, giving the patient an idea of what they would *actually* pay.

The reasoning behind the rule rests on the idea that empowering patients through pricing transparency allows market forces (also known as "shopping") to work, lowering prices and increasing access. This was summed up well in the HHS proposal[34]:

> ***Many empirical studies have investigated the impact of price transparency on markets, with most research showing that price transparency leads to lower and more uniform prices, consistent with predictions of standard economic theory. Traditional economic analysis suggests that if consumers have better pricing information for healthcare services, providers would face pressure to lower prices and provide better quality care. Falling prices may, in turn, expand access to healthcare for consumers.***

CMS Administrator Seema Verma further explained[35]: "Unlocking cost information is critical to enabling patients to become active consumers so that they can lead the drive towards value."

In the healthcare industry, we need "active consumers" to unlock the free market potential of a heretofore opaque industry: one that impacts all of us.

THE RIGHT TO SHOP

All the conversation surrounding price transparency begs an important question: Will patients actually 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.

Right to Shop's goal is to provide patients with access to information on out-of-pocket costs they will face after a nonemergency medical procedure. But in order for that vision to come to fruition, Right to Shop legislation must be passed that stipulates:

Transparency

At the request of a patient or prospective patient, healthcare providers across different networks will be required to estimate the total costs associated with a medical procedure within two business days of the request.

Healthcare providers and insurance carriers must work together to provide an out-of-pocket cost estimate for the patient for as many hospitals and carriers as the patient chooses.

Incentives

Insurance companies must create an incentive program which rewards patients who find procedures at a cost less than the average price paid by the insurance company for the same healthcare service. If you can get a colonoscopy at a lower than average cost, you take home some of the savings!

The procedures for which the carrier offers the shared incentive program are called "shoppable healthcare services," providing some reasonable boundaries to the law. A "shoppable healthcare service" may include a mammogram or colonoscopy but may not include cardiovascular surgery for example.

The Foundation for Government Accountability (FGA) reports[36] that 98% of insurers say that they have some sort of transparency tool, but only 2% of the insured actually access the tool. That is why Right to Shop legislation not only provides much needed transparency, but combines it with an incentive-based program. When consumers shop around for services in a Right to Shop state, they can cash in on their savings.

And patients want it too.

HOW "RIGHT TO SHOP" WORKS:

Once a medical procedure has been recommended to you, call or go online to request information about the cost of your procedure

↓

Choose the best location that offers the procedure at the most affordable cost for you

↓

Have your procedure at the location of your choice

↓

Cash in on shared savings

PATIENTS WANT THE RIGHT TO SHOP[37]

82% of voters want the right to know the cost of non-emergency procedures ahead of time.

72% of voters support the right to pick lower cost out-of-network providers.

68% support rewarding patients directly when they choose to shop and save

RIGHT TO SHOP SUCCESS STORY: NEW HAMPSHIRE

"Right to Shop" is fairly new legislation, but the results from the program in New Hampshire show that consumers have more access at less cost than they ever had before the law was passed. In New Hampshire:[38]

- **Average savings have been around $670 each time a service or procedure is shopped.**
- **88% of enrollees have shopped at least once, with 2 out of 3 shopping every year and receiving an incentive payment.**
- **Shoppers have been rewarded over $1.2 million for finding more affordable care**
- **Procedure cost savings have reached over $12 million**

Aside from New Hampshire, 7 other states have passed incentive-based programs including Florida and Tennessee[39].

Right to Shop legislation has also been introduced in more than 15 other states[40]. Sen. Wes Climer introduced Right to Shop legislation (S.991) at the beginning of the 2020 session.

If right to Shop is adopted in South Carolina, patients and insurance companies will save money, healthcare providers will have an incentive to lower healthcare costs and South Carolinians will have greater knowledge of the type and quality of care available to them in their communities.

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 30% in their first year.[41] South Carolina will be an important test case for this concept as a large county government recently began offering options based 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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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 opposed the cancer hospital and vice-versa (p.8).

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[29] Prices obtained directly from the providers: MUSC Health, Roper St. Francis Healthcare, and Tricounty Radiology.

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