Beacon
CENTER OF TENNESSEE

A COMPREHENSIVE
PACKAGE TO REFORMING

HEALTHCARE

HEALTHCARE

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.

THE SOLUTION
DIRECT PRIMARY CARE

Individuals pay a monthly fee for access to expert physicians.

SUMMARY

IT'S ABOUT ACCESS TO QUALITY *CARE*, NOT MERE *COVERAGE*

The discussion about healthcare reform in Tennessee during the 2015 legislative session was monopolized by a debate over whether the state should expand Medicaid under Obamacare to at least 280,000 able-bodied, working-age adults. Unfortunately, this sidelined more substantive conversations about how we can provide true *care*—not just insurance coverage—to Tennesseans who lack access, quality, and control over their healthcare decisions.

Regardless of income or socio-economic status, everyone deserves the opportunity to chart his or her own healthcare maps. We know that:

- A startling one-third of physicians across the country now claim they will not accept new Medicaid enrollees.
- Last year, two-thirds of Medicaid patients reported difficulty obtaining an appointment with a specialist, while just 11 percent of those with private coverage faced the same obstacles.
- Medicaid expansion would have had several negative economic consequences in the Volunteer State. These include declining personal incomes for Tennesseans, as well as a shrinking of the state's private sector as a whole.

REFORMS THAT MAKE A DIFFERENCE

Direct Primary Care, Innovation, and Removing Antiquated Barriers

The Beacon Center understands the challenges lawmakers face of extending access to care for the impoverished as well as those living in rural areas of our state. We believe this can be addressed through lifting antiquated certificate of need laws limiting access to care for low-income families and rural communities, and embracing an exciting new reform aimed at providing care to the same population of low-income earners considered for a Medicaid expansion: *Direct Primary Care*, which gives individuals access, quality, and control.

- The direct care system eliminates the middleman from the process so that instead of dealing with complicated insurance forms and rules, individuals deal directly with the doctor for a simple and manageable experience.
- Functioning like a gym membership, individuals pay a monthly fee for access to expert physicians—averaging $40 to $80, which is sometimes 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 the rising costs of healthcare by providing clear and predictable costs you can understand, afford, and rely on. Often surgical procedures are one-sixth to one-tenth the cost of a typical hospital charge for surgical procedures.

These reforms will directly attack the growing problem with our healthcare system, providing greater access to quality care for all Tennesseans, not just expensive insurance coverage for some. It is time for legislators to empower Tennesseans to reclaim control over their healthcare decisions.

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.
Since 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 the requirements of Obamcare and are there any actual providers in Tennessee?

Yes!
Direct Primary Care 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 Obamacare's insurance mandate and be free to enter into a DPC arrangement for all of their non-catastrophic care. Currently, there are three DPC clinics in Tennessee, but they need the reassurance of enabling legislation that they can continue to safely practice, and new providers need assurances that they are welcome to begin practicing in the state.

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 anyways?

No.

Over 35 states, including Tennessee, currently use certificate of need (CON) laws to purportedly "slow the growth of healthcare prices, promote consolidation of healthcare providers, and limit duplication of services." 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 competitors during the vetting process. When a company seeks to enter a new market or expand in an existing market, competitors 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 1973, Tennessee has been among the states that restrict the supply of healthcare in this way, with 20 devices and services—ranging from acute hospital beds to magnetic resonance imaging (MRI) scanners 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 seventh most restrictive CON laws in the nation.

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 Tennessee has increased as a result of CON law implementation. In fact, more than 65 percent of Tennessee hospitals are providing less charity care than the national average.

Would CON law repeal have benefits for all patients regardless of insurance status, location, or current health?

Yes!

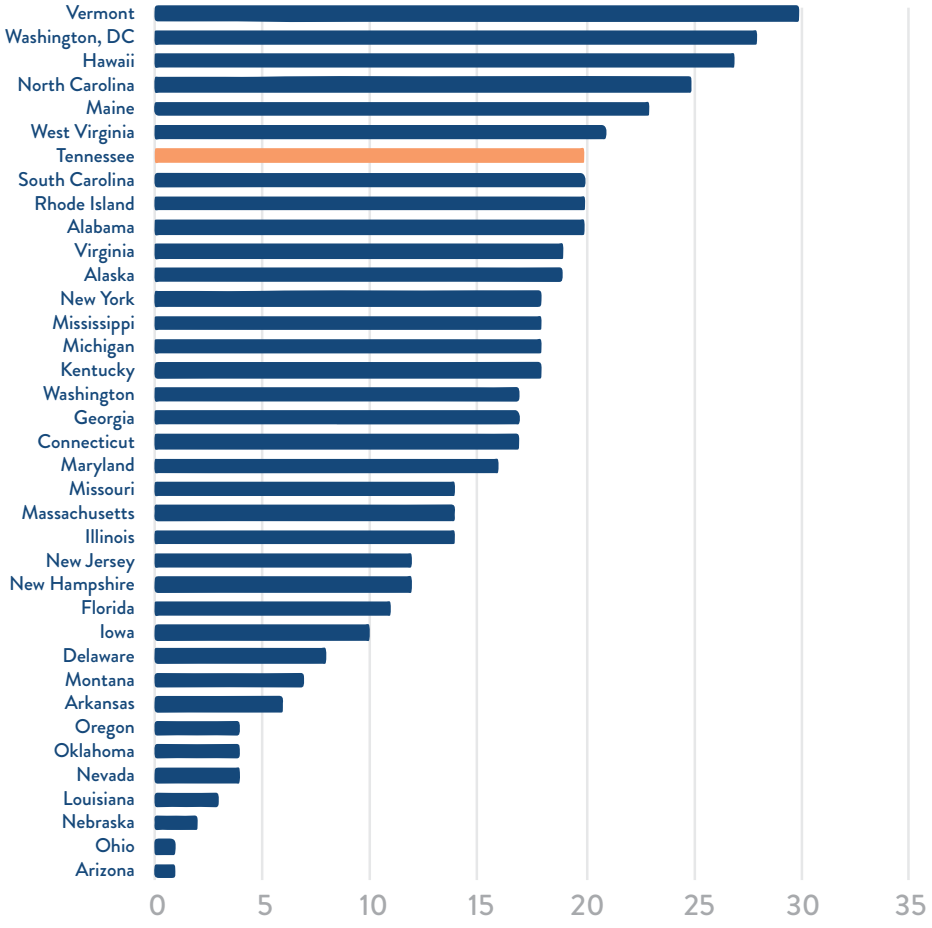
Evidence demonstrates that CON laws do not achieve their intended outcomes, but rather decrease the supply and availability of healthcare services for everyone, especially the poor. By lifting these restrictions, we can allow new providers to begin operating and increase access for Tennesseans across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

STORIES

CERTIFICATE OF NEED

On average, states with CON programs regulate 14 different services, devices, and procedures. Tennessee's CON program currently regulates 20 different services, devices, and procedures, which is much higher than the national average. As this graphic shows, Tennessee's certificate of need program ranks seventh most restrictive in the United States.

RANKING OF STATES BY NUMBER OF CERTIFICATE OF NEED LAWS



Note: Fourteen states either have no certificate-of-need laws or they are not in effect. In addition, Arizona is typically not counted as acertificate-of-need state, though it is included in this chart because it is the only state to regulate ground ambulance services.

Source: Mercatus Center at George Mason University

DIRECT PRIMARY CARE

DANIELLE MITCHELL

Dr. Danielle Mitchell is determined to change the way her Chattanooga-based patients experience healthcare. "It's usually, on average, a five-minute experience," Mitchell said when describing a typical doctor's visit these days. "There is no way you can talk about true preventative health care in five minutes." Instead, she hopes that by adopting the Direct Primary Care model, her patients can experience a more robust form of care that's driven by patient needs instead of physician compensation or dictated by third-party insurance companies.

At Mitchell's Chattanooga Sports Institute and Center for Health, patients can opt for a fee structure that functions like a monthly gym membership. For $50 per month, or $600 annually, members are provided with four, 30-minute office visits, as well as discounts for labs, imaging, and urgent care services. Beyond this option are others that give patients the choice of paying per office visit or tapping into their insurance for a slightly adjusted period of time with the physician. In all, the DPC model allows for greater customization and patient-centric experiences—all at a much lower cost to the individual.

> **"There is no way you can talk about true preventative health care in five minutes."**
> **-Danielle Mitchell**

Indeed, Mitchell is operating an innovative method of delivering care that's sweeping across the nation. Currently, 13 states have laws that empower physicians to practice under the DPC model without worrying about state interference. When telling Dr. Mitchell's story, the *Chattanooga Times Free Press* also noted other physicians from neighboring states that have embraced the DPC approach. For example, Dr. Brian Forrest has been operating a primary care clinic in Apex, North Carolina for more than 15 years with tremendous success and without adverse affects from Obamacare. "Is Obamacare going to kill the model? Absolutely the opposite," Forrest told the *Times Free Press*. "Employers who contract with direct primary care physicians can save about 30 percent on their premiums and employees who've seen their deductibles soar under the Affordable Care Act can benefit, too."[1]

Doctors Mitchell and Forrest are just two examples of the groundswell of physicians hoping to see this model of care more widely available to patients in the 50 states.

ANALYSIS

As the costs of healthcare continue to rise, the plight of the uninsured remains a dilemma, and businesses across Tennessee are forced to make difficult decisions about the ongoing availability of health benefits. Lawmakers must take action that migrates *away* from an expansion of government entitlements and *towards* solutions that make healthcare more affordable, accessible, and responsive to a free market.

CERTIFICATE OF NEED LAWS:
What Are They and Where Did They Come From?

Since 1973, Tennessee has been among the 36 states that have chosen to restrict the supply of healthcare services through the addition of certificate of need (CON) laws, under the guise that these antiquated regulations would somehow reduce and control healthcare costs. Instead, CON laws have resulted in reducing everything but costs. The supply of essential medical provisions, ranging from hospital beds to magnetic resonance imaging (MRI) machines, and over 20 devices and services are 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 CON law implementation. 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.[2]

Fortunately, the federal government took a closer look at the impact of CON laws and by 1987, and seeing little evidence that it was having the desired effects, decided to repeal its incentive program. In response, 12 states almost immediately repealed their CON laws. By 2000, Indiana, North Dakota, and Pennsylvania had followed suit.

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

Yet, Tennessee and 36 other states, along with the District of Columbia, have continued to impose and expand upon their CON law programs. In fact, Tennessee's CON program is ranked the seventh most restrictive in the United States.

TEAR DOWN THESE WALLS:
Repealing Certificate of Need

As the federal government conceded in the mid-1980s, CON laws have failed to accomplish their intended mission of reducing costs and increasing indigent care. Rather than market demand determining the supply, clinicians and medical facilities must seek approval from the state before purchasing or expanding services they provide to patients. In a world where access to quality healthcare is quickly diminishing, why would a state body continue to impose such draconian policies?

The Mercatus Center at George Mason University recently examined state-specific CON laws to explore their impact upon 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 health care for the poor."[3] Thus, CON laws were rationalized as a protection from runaway healthcare spending and a means of increasing a hospital's capacity to provide greater charity care.

Let's first consider the first seemingly admirable goal of reducing state spending on non-essential healthcare services. Research to support this has been mixed, with little to no substantial cost reductions detected, while others have found that costs may actually increase by five percent 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."[4]

Sixty-seven percent of Tennessee hospitals provide less than the national average of charity care.

So if CON laws are incapable of providing measurable costs savings, are they at least successful at encouraging higher provisions of charity care due to their ability to inflate prices? The Mercatus findings are dismal. In fact, the most comprehensive empirical study to date—referenced by Koopman and Stratmann—found no relationship between CON laws and increased rates of charity care.[5]

Unfortunately, these reports are not surprising, nor are they inconsistent with the charity care rates exhibited by many Tennessee hospitals. The Beacon Center has found that 67 percent of Tennessee hospitals provide less than the national average of charity care—that is, less than three percent of their overall services.[6]

If state and federal regulatory schemes like CON laws are failing to adequately address the needs of our most vulnerable patients, while driving up costs for everyone else in the process, then what can be done to ensure that Tennesseans receive access to affordable, quality care?

INTRODUCING DIRECT PRIMARY CARE

Tennessee families deserve the right to make their healthcare decisions at their kitchen tables, free from the whims of Washington bureaucrats. In this vein, a movement has begun to sweep across other states that aims to put patients back in the driver's seat and return accessibility to high quality care for those living on fixed or low-incomes.

Direct Primary Care, or DPC, is an innovative model being embraced by patients, providers, employers, payers, 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 this "primary care home" for all routine and preventive services, including checkups, 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 Doctor's Offices

As acknowledged by the Direct Primary Care Coalition, "the defining element of DPC is an enduring and trusting relationship between a patient and his or her primary care provider. Empowering this relationship is the key to achieving superior health outcomes, lower costs and an enhanced patient experience."[7]

ANALYSIS

DPC's 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 reactive 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."

The ultimate goal is health and wellbeing, not simply the treatment of disease.

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. 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."[8]

DIRECT PRIMARY CARE:
An Answer to the Plight of the Low-Income and Underinsured

Since 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 would 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 percent of their healthcare needs.

In fact, membership to Direct Primary Care 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 as part of an expanded Medicaid beneficiary population. Indeed, membership to a DPC practices 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.[9]

How Can Direct Primary Care Become an Option for Tennessee Patients?

Currently, 13 states have passed legislation to define Direct Primary Care facilities as permissible medical providers, an important differentiation from being classified as an insurer. Doing so has empowered direct primary care physicians with the security of knowing they can establish their facilities within these states without fear that a state regulatory body will attempt to reclassify them as an insurance provider—and attempt to impose the licensing and other regulatory requirements that such a classification entails.

Legislation authorizing Direct Primary Care in Tennessee is necessary to attract additional, high-quality providers to our state and provide freedom to doctors who want to provide a more direct level of service to their patients. Adequate model language for legislative approval 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 the 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 obligations the providers have to patients upon signing a contract for services. 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.

RESTORING HEALTHCARE DECISIONS TO TENNESSEE FAMILIES

By repealing certificate of need laws that hamper healthcare providers from responding to the medical needs and market demands of people across our state—and creating opportunities for families, regardless of socio-economic backgrounds, to seek high-quality care at prices they an afford—Tennessee can restore the ability for individuals across our state to chart their own healthcare maps without government interference or the consequences of unsustainable costs to taxpayers.

ENDNOTES

1 Tim Omarzu, "Doctor plans to cut ties with insurance companies, have subscriber-funded practice in Chattanooga." *Chattanooga Times Free Press*. August 30th, 2015. http://www.timesfreepress.com/news/business/aroundregion/story/2015/aug/30/chattanoogdoctor-plans-cut-ties-insurance-com/322178/.

2 Christopher Koopman and Thomas Stratmann, "Certificate-of-Need Laws: Implications for Tennessee." Mercatus on Policy. Mercatus Center at George Mason University. March 24, 2015. http://mercatus.org/publication/certificate-need-laws-implications-tennessee.

3 Ibid.

4 Ibid.

5 Ibid.

6 Lindsay Boyd, "Two More Reasons to Leave Insure Tennessee in the Dust." The Beacon Center of Tennessee. July 8, 2015. http://www.beacontn.org/2-more-reasons-to-leave-insure-tennessee-behind.

7 Direct Primary Care Coalition. "Policy". http://www.dpcare.org/.

8 "Our Principles." Direct Primary Care Coalition. http://www.dpcare.org/#!about1/ccz5.

9 Ibid.

ABOUT THE BEACON CENTER OF TENNESSEE

The Beacon Center empowers Tennesseans to reclaim control of their lives, so that they can freely pursue their version of the American Dream. The Center is an independent, nonprofit, and nonpartisan research organization dedicated to providing expert empirical research and timely free market solutions to public policy issues in Tennessee.

GUARANTEE OF QUALITY SCHOLARSHIP

The Beacon Center of Tennessee is committed to delivering the highest quality and most reliable research on Tennessee policy issues. The Center guarantees that all original factual data are true and correct and that information attributed to other sources is accurately represented. The Center 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 the Center's attention with supporting evidence. The Center will respond in writing and correct the mistake in an errata sheet accompanying all subsequent distribution of the publication, which constitutes the complete and final remedy under this guarantee.

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