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Enhancing Healthcare Options in New Hampshire: The Direct-Pay Pathway

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November 15, 2022

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Executive Summary

When it comes to healthcare, New Hampshire is a state with strengths, challenges, and opportunities. On the positive side, New Hampshire is home to many high-quality medical facilities and talented medical professionals. In a composite scoring of clinical care taking into account measures such as preventive screening, immunizations, and hospital readmissions, New Hampshire ranks 11th best in the nation.[1] This helps to keep residents relatively healthy compared to residents of other states.[2]

At the same time, however, New Hampshire is comparatively thin on healthcare facility capacity and somewhat high in cost. New Hampshire ranks 37th in the nation in terms of available hospital beds, with barely more than 2 hospital beds per 1,000 population.[3] It is also not among the leading states in terms of either ICU beds per 10,000 population or ambulatory surgery center capacity.[4] Healthcare is also expensive for New Hampshire residents. New Hampshire workers purchasing employer-sponsored insurance pay an average annual premium for individual coverage of $7,255 (11th most expensive state in the country), and an average annual premium for family coverage of $20,078.[5] High healthcare costs raise the overall cost of living and can make New Hampshire less attractive a state to live in.

Exploring New Policy Opportunities

This report examines policy options that could help New Hampshire to address its healthcare challenges while preserving its strengths. The aim is to explore how the state can allow facilities to thrive and meet the demand for various healthcare services, as well as enable patients to be better positioned to seek out the care they need (whether primary care, secondary care, surgical care, or otherwise) *and* be empowered to shop and pay for that care more efficiently. We briefly survey a number of conventional policy ideas that are commonly employed by states, and then we intentionally look for newer, different strategies that are perhaps also deserving of a chance to succeed in New Hampshire.

Toward the goal of improving facility availability, this report examines options for expanding the number and financial accessibility of various types of healthcare facilities in New Hampshire, with a special focus on allowing new facilities to emerge that could accept direct payment from patients. Toward the goal of empowering individuals and offering an alternative to high health insurance costs, this report

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[1] "New Hampshire Summary 2021" America's Health Rankings. United Health Foundation. Accessed December 12, 2021.
[2] Ibid.
[3] "State Health Facts: Total Hospitals Beds" Kaiser Family Foundation. Accessed December 13, 2021.
[4] "State Health Facts: ICU Beds" Kaiser Family Foundation. Accessed December 13, 2021.
[5] "State-Level Trends: New Hampshire (2015-2019)" State Health Access Data Assistance Center. Accessed December 13, 2021.

examines the potential for fostering and expanding the options of Direct Primary Care (DPC) in New Hampshire. The resulting work extends the idea of patient empowerment and consumer control over healthcare spending, creating a new vision that could be called the “Direct-Pay Pathway.”

By taking advantage of new policy opportunities that allow for direct payment of care, New Hampshire can address some of its healthcare challenges while maintaining the features that make the state strong.

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Introduction

Healthcare is one of the most difficult and treacherous policy areas that governors and state legislators deal with regularly. Healthcare is complex and multifaceted. It involves everyone, seemingly reaching into all areas of business and the economy. It is simultaneously deals with population-level matters in the public space, and private matters that are deeply personal. No two states have exactly the same set of policies, programs, and laws. State health policy is the very embodiment of the Tenth Amendment-inspired idea of "laboratories of democracy."

Like all states, New Hampshire has strengths and weaknesses when it comes to healthcare. This report begins by touching briefly on those strengths and weaknesses. Then we review a sample of conventional policies that other states have experimented with in attempting to address similar challenges. Those policies include global budgeting, reference pricing, cost growth benchmarking, promotion of price transparency, discouraging low-value care, professional reform and educational incentives, and scope of practice expansion. That review of conventional policies guides us to explore how two alternative policies—deregulating health facilities and direct primary care—could work in combination to give New Hampshire residents a new option for seeking and paying for care directly via something that could be dubbed a "Direct-Pay Pathway." Removing policy barriers so as to allow this option to compete on a level regulatory playing field could supplement the many other approaches that are in place and ultimately help New Hampshire address some of its healthcare challenges.

Healthcare Challenges Facing New Hampshire

New Hampshire is home to many high-quality medical facilities and talented medical professionals. In a composite scoring of clinical care taking into account measures such as preventive screening, immunizations, and hospital readmissions, New Hampshire ranks 11th best in the nation.[1] New Hampshire hospitals are above average in terms of safety, ranking 23rd in the nation.[2] Furthermore, Granite Staters are relatively healthy compared to Americans in other states. Across a set of health outcomes variables including physical health, mental health, and percentage of individuals aged 65 years and older in high health status, New Hampshire residents ranks 6th healthiest in the nation.[3] New Hampshire has the 9th highest number of active physicians per 100,000 population.[4] In these areas, there is much to be pleased with.

Despite some strengths, however, there are areas of concern for healthcare in New Hampshire. Two things that people almost universally want from their healthcare system are for medical services to be *available* when they need them, and for those services to come at a reasonable *cost* or *price* (the difference in this case being one

of a system perspective or consumer perspective). New Hampshire has some challenges to face in both of those important areas.

Challenge I: Availability of Healthcare

New Hampshire is comparatively thin on healthcare facility capacity. With barely more than 2 hospital beds per 1,000 population, New Hampshire ranks 37th in the nation in terms of available hospital beds.[5] With 1.9 ICU beds per 10,000 population, New Hampshire ranks 45th in intensive care unit capacity.[6] Low bed supply has made the state especially vulnerable during the COVID-19 pandemic, leading to long waiting times in emergency departments, deferred surgeries and procedures in regular hospital floors, and backlogs for patients in rehabilitation and long-term care.[7,8,9] Availability of outpatient procedures is another area of risk for the state. New Hampshire is not in the top quintile for ambulatory surgery center capacity, either when measured by population or as a ratio of the number of hospitals in the state. Ambulatory surgery centers and other types of outpatient facilities provide important, cost-effective care. In a pandemic, these facilities help further by reducing the resource strain on hospitals and lessening the hazards of deferred care.

Challenge II: Cost and Price of Healthcare

The other continued challenge for New Hampshire is something that all states face—high healthcare costs. Although individuals purchasing health insurance on New Hampshire's federally-facilitated health insurance marketplace can do so relatively inexpensively (7th cheapest in the nation), that option is only open to about 3 percent of the state population (approximately 44,000 people out of 1.36 million).[10] Far more Granite Staters—more than 56 percent of the state population—purchase health insurance through their employers. Employer-sponsored insurance in New Hampshire is expensive, with an average annual premium for individual coverage of $7,255 (11th most expensive state in the country), and an average annual premium for family coverage of $20,078.[11] Expensive health insurance drives up the cost of living, making the state an overall less attractive place for people to live.

State Health Policy

According to official estimates, total health care spending in the United States reached $4.1 trillion or $12,530 per person in 2020, the latest year for which data are available.[12] Spending on health accounts for 19.7 percent of the nation's Gross Domestic Product, almost twice as much as the average OECD country.[13] National health expenditures are projected to reach $6 trillion within the next 10 years.[14]

While much of this spending is controlled at the federal level (e.g., Medicare at $829 billion, and the federal contribution toward Medicaid at $460 billion), substantial portions of the nation's healthcare system are also situated at the state level. For instance, private health insurance constitutes an annual expenditure of about $1.15 trillion, and is in part a state-regulated area of healthcare (federal influence from ERISA laws notwithstanding). States' contributions toward Medicaid total about $211 billion. Americans also spend roughly $388 billion per year out-of-pocket, which goes to their local physicians, clinics, hospitals, and other services.

Just as the federal government explores its policy options in pursuit of the "Triple Aim" of improving individual care, improving population health, and reducing costs, states also pursue these aims through the policy levers that are open to them.[15,16] Most states have some form of a Balanced Budget Requirement (BBR) that—along with pressure from constituents facing rising insurance premiums and diminishing choice and access—helps to motivate legislatures to cut costs and create incentives for delivering better value.[17] Common approaches include the use of legislative and regulatory functions to institute price controls, encourage or prevent mergers and acquisitions, mandate certain benefits as part of insurance, require governmental review of various business practices, create special new payment programs, and more.[18,19] As evidenced by continued challenges and the parade of new efforts and academic articles, states have yet to solve the puzzle.

Existing State Policy Options

States have made numerous attempts to address cost and access over the years. Some policy ideas have been recycled throughout the years, making a return under a different name and acronym, with modifications. Below we briefly review some of the familiar ideas, programs, and reforms that circulate on the state health policy scene today.

Reference-Based Pricing

Reference-Based Pricing is a method of paying healthcare providers a set price for each service based on an existing reference point, rather than negotiating a new schedule of prices. The payer, who might be a self-insured employer or a state government, pays the provider a set amount for each service, and if that amount is less than the provider is willing to accept, then the provider can attempt to bill the patient or some other entity for the remainder of the amount.[20] A common reference point to pick, because of its ubiquity and perceived neutrality, is the Medicare price schedule. Recognizing that Medicare reimbursements are low (sometimes lower than actual costs) and wanting to secure good service and good access for their insured members, payers might agree to pay a certain rate higher than Medicare reimbursement levels, e.g., 120 to 300 percent of Medicare reimbursement.

Montana provides an example of a state that has embraced Reference-Based Pricing. Since 2016, Montana's state employees' health plan has used reference-based pricing for hospital services. It pays 234 percent of Medicare rates for inpatient and outpatient services, and all major hospital facilities in the state participate.[21] Analysts say that the policy saved the state over $47 million in inpatient and outpatient expenditures in its first three years (FY2017-FY2019).[22,23]

Cost Growth Benchmarking

Cost Growth Benchmarking, sometimes called "inflation capping," is the placing of limits on the amount by which a service is allowed to increase in price from one year to the next. The allowable increase can be a fixed percentage (e.g., 3 percent), or a percentage that is arrived at through some pre-specified formula (e.g., Medicare price index plus 1 percentage point) or a linkage to another economic performance metric (such as the state's Gross State Product). Cost Growth Benchmarking can make it easier for payers to negotiate with providers, as it renders many decisions "already made" by external factors.[24] At the same time, however, Cost Growth Benchmarking can lock in existing distortions and unwarranted price differentials across providers.[25]

An example of a state with an annual healthcare cost growth cap is Massachusetts, which enacted in 2012 a system in which a state Board of Commissioners sets the goal for the following calendar year. The allowed cost increase for 2022 is 3.1 percent. The acting Commission has no actual enforcement power "except for the ability to place providers on performance improvement plans."[26] Rather, the main mechanism by which the benchmarking is intended to have an effect is by generating stakeholder consensus over what constitutes a reasonable price increase in a given year. Massachusetts has had mixed success in meeting the benchmark.[27]

All-Payer Accountable Care Organization (ACO)

Accountable Care Organizations (ACOs) are collections of hospitals, clinics, physicians, and other providers "who come together voluntarily to give coordinated care" to their patients.[28] A defining feature of ACOs is that their reimbursement is tied to their quality and financial performance. All else equal, an ACO that delivers high-quality care in an efficient and well-coordinated manner should generate savings for a given payer (such as Medicare), since healthy patients on average cost the healthcare system less than sick patients. The incentives for ACOs are similar to the incentives in effect under capitated managed care models. ACOs that succeed in these outcomes and cost metrics receive a positive reinforcement in the form of bonus payments, while ACOs that fail to reach their goal pay penalties. (Beneficiaries can still, however, seek low-value services outside the ACO, which can undercut the managed care aspect of the model.) Though ACOs to date have been implemented

most intently in Medicare, part of the vision for ACOs is that they might expand into the state policy scene via private payers and Medicaid.[29]

The state of Vermont is currently running a five-year (2018-2022) test of an All-Payer Accountable Care Organization program dubbed OneCare, which is a special arrangement between Vermont and the federal government that allows Medicare, Medicaid, and private insurers to pay for healthcare "based on value, high quality care and good health outcomes at a lower cost."[30] All private insurers in the state must participate, but self-funded plans are exempt. Under the agreement, primary care providers at participating hospitals and clinics receive $3.25 per patient per month, with higher payments for providers who see certain categories of sicker patients. A certain amount ($1.50) of the monthly capitated fee is "at risk." Based on whether the OneCare All-Payer ACO meets its performance metrics, participating providers will either share in a bonus or pay a penalty.[31] Vermont's experience with its All-Payer Accountable Care Organization has been mixed. Although participation by hospitals and providers is high (>50 percent), participants have been able to meet pre-defined quality goals, and the program may have saved the state as much as $97 million over three years, researchers have raised concerns about adverse selection that call into question the scalability of the policy initiative (i.e., the program might have differentially attracted providers who were already likely to do well).[32]

All-Payer Rate Setting & Global Budgeting

All-Payer Rate Setting is a system in which all payers—public and private—use the same fee schedule for a category of care, such as hospital care. Global Budgeting is a different but related type of system in which providers (e.g., hospitals) are given a fixed amount of funding with which to provide care of a specified population for a specified period of time (usually one year).

Maryland is the one state that has experimented with both systems in unison.[33] Since the 1970s, its Health Services Cost Review Commission (HSCRC) has served as the state's centralized hospital rate-setting authority. Unlike in other states, Maryland health insurers do not negotiate with hospitals and providers to arrive at a fee scheduled for various services. Instead, the HSCRC determines what health insurers pay for hospital care.[34] Since 2014, Maryland has also had a centrally-determined Global Budget that limits how much revenue hospitals can bring in. The idea is that under a Global Budget, hospitals—which are expected to take care of the needs of a given population—will cease to see high volume and high utilization as a good thing, and will instead be incentivized to invest in keeping people healthy, minimizing readmissions, and so on.[35,36] In recent years, physician practices and nursing homes have become eligible to participate in the program voluntarily. Some analysts claim that the arrangement is successful in saving money for the Medicare program.[37] Other analysts argue that Maryland's system has been captured by the hospitals, and that in fact it allows incumbent hospitals to charge *more* for Medicare services by keeping them insulated from price competition. [38]

Promotion of Price Transparency

Promotion of price transparency is a newly popular policy option in many states. These efforts are bolstered by the common sense economic reasoning that patients ought to have better information about the cost of the goods and services they are purchasing, such that they make wise consumer decisions. We should want patients to seek and accept care when its value to them is greater than or equal to the cost, and we should want them to *not* seek or accept care when its value is less than the cost. Especially in a healthcare system driven by third-party payment, the fact that most prices are undiscoverable creates an incentive for patients to engage in overutilization, "consuming healthcare until the last amount obtained has a value that approaches zero."[39] Price transparency potentially can help.[40] As the well-known quotation from Nobel Laureate economist Milton Friedman goes, "Nobody spends somebody else's money as carefully as he spends his own."[41] State policies that either incentivize or mandate various forms of price transparency are new, however, and the peer-reviewed literature analyzing their effectiveness is still emerging.[42] Three types of state-level price transparency policies are: 1) All-Payer Claims Databases, which use claims data to highlight unwarranted price variation, 2) Consumer-Facing Price Comparison Tools, which enable consumers to compare prices for common services and procedures in a geographic region, and 3) Right-to-Shop Programs, which provide financial incentives and rewards to patients who use price comparison tools and opt to receive care at lower-cost providers.[43]

New Hampshire is one of just a few states that have all three of these price transparency policies already in place. New Hampshire's Comprehensive Health Care Information System makes data available for all stakeholders, helping consumers and employers to make informed choices.[44] Furthermore, the state's consumer price website, NH Health Cost, posts prices of common services and procedures. Analysts believe the resource has resulted in modest savings and decreases in list prices.[45]

Medical Student Loan Forgiveness

One of the most common ways that states use policy to address issues with access to care is to attract physicians to come to their state and practice medicine by offering medical student loan forgiveness. State programs promote this because it gives them an added policy lever to address perceived shortages and disparities, by requiring that recipients practice in a designated health care shortage area, usually for a multi-year commitment period.[46]

Thirty-four states and Washington D.C. offer some form of medical student loan forgiveness for physicians.[47] Some states also offer student loan debt forgiveness to nurses and dentists. In exchange for their services, physicians receive partial loan forgiveness, with the amount varying dramatically from state to state, with some states offering $10,000 to $20,000 in forgiveness (e.g., New York, Rhode Island), and

other states offering up to $140,000, $160,000, and $200,000 (e.g., Virginia, Oklahoma, and Iowa/Michigan). All three states that border New Hampshire offer medical student loan forgiveness.

Expanding Occupational Scope-of-Practice

States can also expand their health system capacity by making it attractive for nonphysicians to locate and practice in their state. States can expand scope of practice for nurse practitioners (NPs), advanced practice registered nurses (APRNs), physician assistants (PAs), and other professionals, allowing them to work at the top of their license, increasing their employment options and allowing them to play a bigger role in augmenting the care that physicians and hospitals provide. Relaxing scope-of-practice restrictions may help to enable lower-cost alternatives to flourish, with little to no tradeoff in quality (at least in certain settings).[48,49,50]

About half of states and Washington, D.C., grant nurse practitioners—to pick one occupation—a broad scope of practice. About 12 states are considered restrictive. The remainder are mixed in terms of the stringency of the restrictions that they place upon the profession.[51] Many states (Pennsylvania, Tennessee, and Wisconsin, to name just three examples) experimented with temporarily waiving their nurse practitioner scope-of-practice limitations during the COVID-19 pandemic.[52] There were no major reports of problems stemming from this action.

Summary

Table 1 summarizes the state policy initiatives described above, and describes the implementation of each of these ideas in New Hampshire. As the summary shows, these conventional state policy ideas have varying amounts of applicability, of those not already implemented in the state, none appears to be particularly well suited to New Hampshire at present.

Table 1. Summary of Conventional State Policy Approaches to Addressing Cost and Access, and Their Suitability to New Hampshire

Policy Option	State Example	New Hampshire Experience
Reference-Based Pricing	State of Montana Benefit Plan	Not implemented in New Hampshire
Cost Growth Benchmarking	Massachusetts Health Policy Commission	Not implemented in New Hampshire
All-Payer Accountable Care Organization	Vermont's Green Mountain Care Board	Not implemented in New Hampshire, although independent ACOs have formed in New Hampshire
All-Payer Rate Setting & Global Budgeting	Maryland Health Services Cost Review Commission	Not implemented in New Hampshire
Promotion of Price Transparency	New Hampshire Comprehensive Health Care Information System; NH Health Cost	Implemented in New Hampshire
Medical Student Loan Forgiveness	34 different states and Washington, D.C.; programs range from $10K (New York) to $200K (Michigan, Iowa)	Implemented in New Hampshire, but limited to helping medically underserved areas
Expanding Occupational Scope of Practice	23 different states and Washington, D.C. have permissive scope-of-practice laws for nurse practitioners	Implemented in New Hampshire for NPs and behavioral health, but potentially needed for midwives, pharmacists, dental hygienists, others

Rethinking Approaches to Payment

If conventional state policy options for controlling costs and improving access have varying success in other states and varying suitability for New Hampshire, and if no single policy option is a "silver bullet," then the pertinent question is: are there new ideas or a new paradigm that could still help New Hampshire with cost and access, even if in a supplementary way? Toward that end, we identify in the remainder of this report a pair of ideas that could contribute to a new strategy—one that might be called the Direct-Pay Pathway.

Direct-Pay Component I: Direct Primary Care

The Direct Primary Care (DPC) model offers patients and physicians a way to connect with each other in a simplified, straightforward, and personalized way. By eliminating third-party inefficiencies and distractions, it restores and updates the traditional physician-patient relationship to meet modern needs.

Understanding Direct Primary Care

Direct Primary Care is a model in which a practice charges patients a fixed periodic fee (usually monthly) for a suite of primary care services, and does not bill any third parties (e.g., insurance companies or government programs).[53] A more technical definition used by some who study DPC closely is: a DPC practice is a primary care practice that 1) charges a periodic fee for services, 2) does not bill any third parties on a fee-for-service basis, and 3) any per visit charges are less than the monthly equivalent of the periodic fee.[54]

There is flexibility around some of the parameters of the definition. For instance, most DPC practices are run by primary care physicians, although other clinicians such as nurse practitioners can also practice this way. Also, DPC periodic fees are most often paid directly by the patient, but in cases where the "subscription" to the practice is part of a benefits package offered by an employer, the fee could be paid by the employer. (Approximately 157 million Americans nationwide receive healthcare coverage through their employer. Of those, 60 percent are enrolled in self-funded plans.[55]) Employers can offer the combination of a DPC subscription and high-deductible health plan instead of conventional insurance to their employees.

A defining characteristic of DPC practices is that they neither accept insurance as payment for the periodic fee, nor do they submit bills to insurers for any of the services they provide. Indeed, the point of DPC is to enable physicians to move away from fee-for-service insurance billing and in doing so, leave behind the overhead costs associated with those processes. By eliminating administrative staff resources associated with third-party billing, DPC practices can reduce administrative overhead by as much as 40 percent.[56,57]

Direct payment and reduced administrative overhead are what enable DPC practices to distinguish themselves further with smaller patient panels, longer office visits, expanded access, and other benefits.[58] It has been reported that DPC also uniquely allows physicians to "serve their patients in other more interpersonal roles, such as educator and trusted advisor, care coordinator, and a guide and advocate to help navigate our complex healthcare system."[59]

Many people of think of DPC practices as small, independent, and physician-owned. There are also larger practices that employ physicians and fill their panels by marketing themselves to large employers.[60] Some consider these practices a form of DPC, too. Examples include Iora Health, MedLion Clinic, and Paladina.[61] These

companies generally contract with large employers and unions to attract their patients, and some also operate in the Medicare Advantage space.[62]

Finally, it is important to distinguish DPC from other forms of retainer-based practices, such as "concierge medicine" and "boutique medicine." Concierge medicine (the more commonly-used term of the two) emerged in the 1990s and earned some press due to its connection to professional athletes, celebrities, politicians, and other wealthy individuals.[63] In a concierge medical practice, patients typically pay an annual fee of approximately $1,500 to $2,500 in exchange for greater access and more personalized service. The practice accepts the fee and also bills the patient's insurance for visits, lab tests, and other services.[64] Some observers describe this as "double dipping."[65] In contrast to DPC, in which practices are run almost entirely from the periodic fee, the expectation under concierge medicine is that patients keep and continue to use their insurance.[66,67]

Services

DPC practices typically offer a wide range of primary care services, including clinical, routine labs, x-rays, and consulting services.[68] They provide sick care, health maintenance services, chronic disease management, women's health (pap smear, pregnancy testing), and care coordination services as needed.[69] Minor procedures such as stitches, wart removal, foreign body removal, cerumen removal, rapid strep test, electrocardiograms, and wound care are commonly included either at no extra charge or at the cost of materials alone.[70] Some practices include immunizations and nutrition services.[71]

Other commonly offered services include access to clinicians via email, wholesale labs and tests, same-day appointments, and 24-hour access in the case emergencies and after-hours needs.[72] Phone consultations and home visits at no additional charge are not uncommon.[73] Some DPC practices also provide assistance with negotiating discounted "cash pay" prices.[74] To protect against unusual, unexpected, and catastrophic medical needs, most DPC patients usually purchase a high-deductible wraparound insurance policy.[75]

Some DPC practices dispense medications at discounted prices and consider it an important part of the savings and value that they can provide. A prescription expenditure that might run $40 per month for a patient in a traditional practice might be able to be reduced to $3 or less if purchased through the DPC practice.[76] Other practices do not dispense medications, either because the state in which they operate does not allow it, or because alternatives such as GoodRx already have a strong presence in their vicinity. A 2020 analysis of state policy surrounding DPC direct dispensing found that 21 states and Washington DC allowed DPC practices to dispense fully; 5 prohibited the practice; and the remaining 25 states allowed some limited amount of dispensing.[77]

Periodic Fees and Visit Fees

DPC practices charge patients a periodic fee, which is typically charged on a monthly basis but could be charged quarterly, annually or any other recurring timeframe. The fees are intended to be affordable, so as to make DPC a model that is accessible to the general public.[78,79] Monthly fees vary from practice to practice. Practices on the lower end of the distribution charge about $50 per month, whereas practices on the higher end charge $85 to $100 per month. A good point estimate is about $75 per month per individual patient. Many practices also offer a discounted family rate. A data brief published by the AAFP in 2018 reported that most DPC practices at the time charged $50 to $75 per month for individual adults, and $75 to $175 for families.[80]

Table 2. Published Estimates of Direct Primary Care Practice Periodic Fees

Source	Monthly Fee for Individual Patients	Notes
Cole (2018)[81]	$77	Scientific review of 116 DPC practices
Rubin (2018)[82]	$70	Direct Primary Care Coalition member estimate
AAFP (2018)[83]	$50 - $75	Also noted $75 to $175 for families
Rowe, et al (2017)[84]	$42 - $125	$500 to $1,499 annual fee, divided by 12
Weisbart (2016)[85]	$50 - $125	$600 to $1,500 annual fee, divided by 12
Huff (2015)[86]	$25 - $85	Estimate of most common monthly fees
Eskew and Klink (2015)[87]	$70 - $100	Estimate of most common monthly fees
Kamerow (2012)[88]	$50 - $150	Estimate of most common monthly fees

Most DPC practices do not charge a separate per-visit fee for office visits, in effect allowing unlimited free office visits as part of the membership fee. Some practices—about 13 percent, according to one 2018 analysis—do charge a per-visit fee, commonly $15 to $20, not unlike the standard visit copay that individuals with conventional insurance pay.[89,90,91] In the DPC model, per-visit fees are always less than the monthly equivalent of the periodic fee.[92] A small minority of practices charge a one-time enrollment fee in addition to the periodic fee—a holdover from the influence of concierge medicine that appears to be fading away in the DPC world.[93]

Some DPC practices get creative with their pricing options by offering various levels and tiers, with the idea of offering something that will appeal to everyone. One

physician set up a three-tiered plan with Silver, Gold, and Platinum, costing $100, $150, and $200 per month, respectively, for increasingly generous services that at the higher end includes radiology services and around-the-clock physician access. Explains the practice owner, "I wanted to set up a tiered pricing system with three different plans, so I'd have a better chance of attracting three different types of patients."[94]

Panel Size

One of the factors that drives physicians to leave their conventional volume-driven medical practices and set up a DPC practice is the pressure to see an unreasonably large number of patients each day.[95,96] Seeking ways to reduce their administrative work, eliminate overhead costs, and spend more time with their patients, DPC physicians tend to opt for smaller patient panels of about 600 to 800 patients per physician, compared to conventional panel sizes of 2,000 to 2,500 patients (or more).[97,98,99]

Some DPC practices reach their target panel size with relative ease. Having a large panel size to start with (if converting a traditional practice to DPC) provides some advantage. One article in *JAMA* describes a physician and physician assistant duo who previously in their insurance-based practice cared for a combined 6,000 patients, but who felt the long hours and burdens were unsustainable. Since switching to the DPC model, they have found success caring for 600 patients combined, allowing for longer visits, and consultations via email and telephone.[100] Referrals from existing patients are important and are what enable many DPC practices to grow.

Other practices face challenges in reaching their target panel size. Traditional marketing, such as in magazines, newspapers, and on television and radio, tend to be ineffective because DPC is a new concept and must be explained.[101] Upon switching from conventional practice to DPC, it is common for it to take one to two years for a DPC practice to reach its target panel size. A 2018 report by the American Academy of Family Physicians found that the average DPC panel size is 345 patients, while the average target (i.e., desired) panel size is 596 patients.[102] Case studies and other profile articles corroborate this.[103,104] Many physicians report that they lose most (80 to 90 percent) of their insurance-based patients when they make the switch from a conventional practice to DPC, making the process of switching to DPC and rebuilding their panel a risky and harrowing experience.[105] Only about 17 percent of DPC practices have achieved their target panel size.[106]

During this practice "restart" phase, many physicians will moonlight and take on additional work at hospitals, urgent care clinics, or Veterans Health Administration facilities.[107] DPC practices might go three to six months without making enough revenue to cover costs, and it may take more than a year for a practice to hit its target panel size, and one to three years to cover all the startup costs and be

operating profitably.[108] It has been said that some physicians must "hit rock bottom emotionally" before making the transition from convention practice to DPC.[109]

Benefits to Patients and Physicians

Although more extensive study of the DPC model would be welcome, particularly from academics publishing in the peer-reviewed literature, experience to date suggests that the DPC model provides an assortment of benefits to patients, physicians, and the healthcare system in general.[110] The American Academy of Family Physicians (AAFP) and DPC physicians themselves have vocally declared DPC to be a model consistent with the goals of increasing access, protecting the physician-patient relationship, improving health outcomes, and lowering healthcare costs.[111,112] Among the practice improvements identified specifically by DPC physicians are improved access; longer patient visit times; improved care quality; reduced administrative burdens; and lower overhead costs.[113,114] (Physician commentators have argued that unlike capitated insurance payments, which also pay the physician on a per-member-per-month basis, DPC makes the *patient* the payer and thus engenders a psychological shift in the relationship that capitation—in which the insurance company is the customer—cannot achieve.[115]) Reported patient satisfaction numbers are high; one analysis of a DPC practice in North Carolina reported 99 percent participant satisfaction with provider access and overall experience.[116]

Patient benefits can be numerous. The most obvious benefit is office visit length. As Busch, et al. write: "The typical length of an office visit for a traditional primary care practice is around 13 to 16 minutes, a significant portion of which is typically not 'face time' as coding and electronic health record documentation pressures keep physicians behind a computer screen. A Missouri physician in a traditional clinic reports seeing 45 to 55 patients a day in appointments that often were as short as 5 to 7 minutes.[117] By contrast, for DPC practices, office visits average around 40 minutes…."[118]

Likewise, there are many physician benefits. Among the major ones is the reduction in administrative burden. To the extent that administrative burden leads to career dissatisfaction and physician burnout in primary care, DPC can be the model that prevents physicians from leaving medicine. As one author writing in the *Annals of Family Medicine* journal put it, the DPC model "has piqued the interest of work-weary physicians who like the idea of taking back control of their practices and eliminating insurance hassles."[119] One South Carolina physician described in the literature turned to DPC "after becoming frustrated by the pressures and dictates of payers, including having to see 30 to 35 patients a day, feeling his care was compromised because of the rush, and not understanding the financial rules under which he worked."[120]

According to a 2018 national survey on physician lifestyle, New Hampshire tied with Kentucky for having the third highest rate of physician burnout, with 50 percent of physicians reporting experiencing "a feeling of physical, emotional, or mental exhaustion, as well as frustration and cynicism related to work."[121] (Idaho and

Delaware tied for having the greatest percentage of physicians experiencing burnout at 51 percent, while the state with the lowest percentage of physicians experiencing burnout was Montana at 25 percent of physicians.)

Table 3 shows advantages and disadvantages of the DPC model for physicians and patients, as found in the published literature.

Table 3. Advantages and Disadvantages of Direct Primary Care for Patients and Physicians

Possible Advantages for Physicians	Potential Drawbacks for Physicians
More time with patients	Possible lower income at start
Reduction in administrative work	Risk of feeling isolated
Improved professional satisfaction	Fewer patients
Decreased interaction with payers	May overburden other, non-retained-based practices
Improved work-life balance	Difficult to recruit and build patient base
Fewer patients	Insurers may not cover services
Lower overhead costs, fewer staff	May need to moonlight while building the practice*
Greater control over design of practice, services*	Opting out of Medicare may limit later options*
Possible Advantages for Patients	**Potential Drawbacks for Patients**
More time with physician during visits	Does not eliminate requirement to carry insurance
Increase access to physician after hours	Additional monthly payment
Improved quality, personalization of care	Potentially more difficult to get referred to specialists*
Possible lower out-of-pocket costs	Employer might not contribute or share in expense*
Ease of communication with physician via email, text, or telephone	Potential for misunderstandings about covered benefits*
Increased price transparency	

Source: Adapted from Lindsey E. Carlasare. *Wisconsin Medical Journal* (2018). Author's additions based on expanded literature review are marked by asterisk (*)

Popularity and Growth

Without a national directory or database of DPC practices, it is hard to offer a definitive count of DPC practices in the United States or analyze longitudinal trends.[122] However, by collecting counts and estimates from the literature and placing them in chronological order, it is possible to see the long-term growth trend of the DPC model nationwide and have some confidence in the latest estimate of 1,705 practices.

Some states have significantly more DPC practices than others. This is due to a variety of factors, including differing state regulatory environments, the presence of DPC "evangelists" who help other physicians set up practices, and expected factors such as population density.[123] According to DPC Frontier, an online resource founded to "facilitate the growth of the DPC movement among physicians" DPC practices currently can be found in 49 states, plus Washington, D.C.[124] States with the highest number of DPC practices include Washington, Colorado, Texas, North Carolina, Kansas, Florida, New Jersey, Wisconsin, Minnesota, and California.[125] The only state believed to be without a DPC practice is South Dakota.

Over the past few years, estimates of how many primary care physicians nationwide operate in DPC, cash-only, or retainer-based practices have varied from about 2 percent to 6 percent.[126] In 2018, Optimum Direct Care estimated that there about 20,000 (4.5 percent) of primary care physicians work in the DPC model.[127]

Table 4 shows the growth of DPC nationwide. An alternative that began as a low-cost offshoot of concierge care and numbered just over 100 in 2014 has grown to over 1,700 practices in 2022.

Table 4. Estimates of Direct Primary Care Practice Prevalence in the United States, 2014-2022

Source	Year	Practices	States	Notes
DPC Frontier Mapper	2022	1,705	49	Accessed April 26, 2022 by Rhoads
Brekke, et al.	2021	1,500	--	Accessed June 21, 2021 by Brekke
DPC Frontier Mapper	2020	1,265	48	Accessed May 1, 2020 by Kauffman
DPC Frontier Mapper	2018	850	--	Accessed July 3, 2018 by D4PC
Rubin, R.	2018	770	48	Citing Direct Primary Care Coalition
DPC Frontier Mapper	2017	723	48	Accessed November 7, 2017 by Cole
Hint Health DPC Trends Report	2017	620	--	Based in part on DPC Mapper
Hint Health DPC Trends Report	2016	445	--	Based in part on DPC Mapper
DPC Frontier Mapper	2016	429	47	Accessed March 31, 2016 by Eskew
Hint Health DPC Trends Report	2015	290	--	Based in part on DPC Mapper
Eskew, at al	2015	141	39	Identified through literature review, practice listings, and conference agendas
Hint Health DPC Trends Report	2014	125	--	Based in part on DPC Mapper

It bears noting that not all DPC practices are "pure" direct primary care. Some "split" practices have two separate patient panels—one using the DPC model and the other using a conventional third-party fee-for-service model. Physicians sometimes take this approach in order to remain working at full capacity while they grow their DPC membership. (Physicians often also choose to opt out of Medicare so as not to run afoul of Medicare rules that prohibit charging Medicare patients for covered services.[128] Medicare patients may sign up for DPC, but DPC monthly subscriptions cannot be submitted to Medicare for reimbursement.)

One 2015 survey of DPC and concierge practices found 141 practices with 273 locations across 39 states. 93.2 percent of the practices had four or fewer providers. Of the practices that provided enough information to determine their form, 83.9 percent were "pure" and 16.1 percent were "split." Of the practices that provided enough to determine whether they were accepting Medicare, 77.4 percent had opted out of Medicare, and 22.6 percent were accepting Medicare.[129]

Critiques

Some observers and policy commentators have criticized the DPC model on the grounds that it might worsen the physician shortage, since DPC panels are smaller than the panels of conventional practices.[130,131] This is an issue that has yet to be studied, but there is reason to believe DPC will not exacerbate physician shortages and might actually mitigate the problem. Many physicians who transition to DPC do so out of a feeling out burnout and moral injury, and do so as an alternative to leaving medicine entirely. It is therefore possible that the more accurate approach to accounting is not to look at the migration of a physician from, say, a 2,500 patient panel to a 500 patient panel as a *loss* of capacity to care for 2,000 patients—rather, it is the *retention* of 500 that otherwise might have gone to zero. (Furthermore, critics should re-examine the premise that panel size ought to be a public policy lever. While it is within the realm of analysis to ask what the effects would be of a given change, the number of patients one agrees to provide care for is surely a decision that belongs with the physician.)

Another critique exists over equity of access to DPC care. It has been argued that DPC practices "lack specific mechanisms to counteract adverse selection that threatens equity in access to care," and that practices could benefit from accepting healthier patients and rejecting sicker patients and patients with pre-existing conditions.[132,133,134] For this and related reasons, it is argued that DPC is not a scalable model.[135] Although one could argue that theoretically DPC practices have an incentive to choose healthier patients because they might schedule fewer visits and thus be cheaper to have on panel, there is no evidence to show that is happening to any significant extent. DPC practices are located in both urban and rural settings, and DPC practices are generally happy to accept all new patients, regardless of patients' socioeconomic status or where they are on the health spectrum.[136,137] There is as yet

no evidence that DPC practices have a strong incentive to prefer healthier or wealthier patients out of a belief that they will generate greater revenue through greater utilization. As a form of delivery that relies on a flat fee, for patients of a given age, DPC practices get the same top-line revenue per patient regardless of health level.[138] Unlike traditional fee-for-service practices, there is practically no incentive to upsell or order unnecessary tests and services. (These concerns could be alleviated by allowing Medicaid patients to join DPC practices and allow Medicaid to cover some or all of the periodic fee.) Which way the adverse selection issue "cuts" vis-à-vis DPC is an intriguing area for future research. One might hypothesize that DPC might attract relatively unhealthy patients, who would prefer the enhanced access. On the other hand, many healthy patients feel that they currently overpay for conventional insurance and would be better off with a small monthly DPC subscription, even if they use it sparingly and only schedule one or two visits per year.

Another critique challenges the applicability of DPC. Some commentators grant that the DPC model sounds reasonable in certain cases, such as for pediatrics, or telehealth, or for patients with very specific chronic conditions, but challenge whether it can successfully be put toward such a broad purpose as primary care for a general adult population. The relatively linear rate of growth of DPC practices in the United States (see Table 4) is one data point that could be marshalled in support of this critique. DPC proponents could respond that the rate of growth that has been observed is to be expected, given the barriers in place, and that those barriers are not a shortcoming of the model but rather an indication of the inertia exerted by the status quo toward new approaches.

Another critique that appears in the literature pertains to the relative lack of peer-reviewed studies and evidence to demonstrate improved quality and cost control. Adashi, et al write, "The DPC community would do well to establish that the quality of the care it espouses is indeed equivalent or superior to that of other primary care paradigms.[139] Some studies exist. For example, one study of employer costs found that enrollment in DPC was associated with statistically significant reductions in total healthcare utilization and emergency department visits.[140] More studies would be welcome, but since DPC prioritizes patient face-time over administrative paperwork, EHR documentation, and population-based quality metrics, researchers looking to study the DPC model have a heavier lift to obtain data. This critique is as much a critique of academia's research priorities and methods as it is of the DPC model.

A final critique comes from a consumer protection ethos. Some observers argue that there is little regulation to prevent exploitative business practices from emerging. For instance, DPCs could sell patient data to marketers or pharmaceutical companies.[141] However, there is nothing unique about DPC in this regard. Consumer protection in this realm can be achieved with the same consumer-driven processes (e.g., disclosure, informed consent, terms of use, etc.) as any other business with data to sell. Practices that sell data might be able to share some of that revenue in the form

of lower membership fees, and practices that do not sell data can boast that they offer greater privacy, but at the tradeoff of a slightly higher membership fee.

Direct Primary Care in New Hampshire

Relatively little has been published to date that specifically measures or describes the state of DPC in New Hampshire. To inform this project as well as provide information for future extensions of this work by others, a survey of all New Hampshire DPC practices was conducted in January 2022. Questions were developed based on themes and key issues identified in the DPC literature and garnered from interviews with two subject matter experts. The survey was built electronically using the Qualtrics XM software, tested for question clarity, and then again tested for compatibility across different technology platforms (i.e., mobile and web). The full survey instrument is available in Appendix A.

The sample frame consisted of all known DPC practices in New Hampshire. To construct this list, multiple resources and approaches were used, including the New England DPC Alliance Physician Directory; the DPC Frontier Mapper; referrals from subject matter experts, and web searches using Google and Bing using the intentionally broad terms "direct primary care," "concierge medicine," "cash-only practice," and "health sharing ministry" (as well as some grammatical variations). Only practices located in New Hampshire were included.

Thirteen practices met the broad search criteria. Each practice had a website, which provided the contact information necessary (i.e., email address) to introduce the practice and share the link to the electronic survey. Each of these 13 practices was asked to complete the survey. 10 practices completed the survey, and 3 did not. Further examination of the three non-respondents determined that they were not of core interest to this study (1 was a concierge practice; 1 was a group practice tied mainly to one large employer; 1 was a faith-based healing center). Thus 10 out of 10 of the core DPC practices in New Hampshire answered the survey.

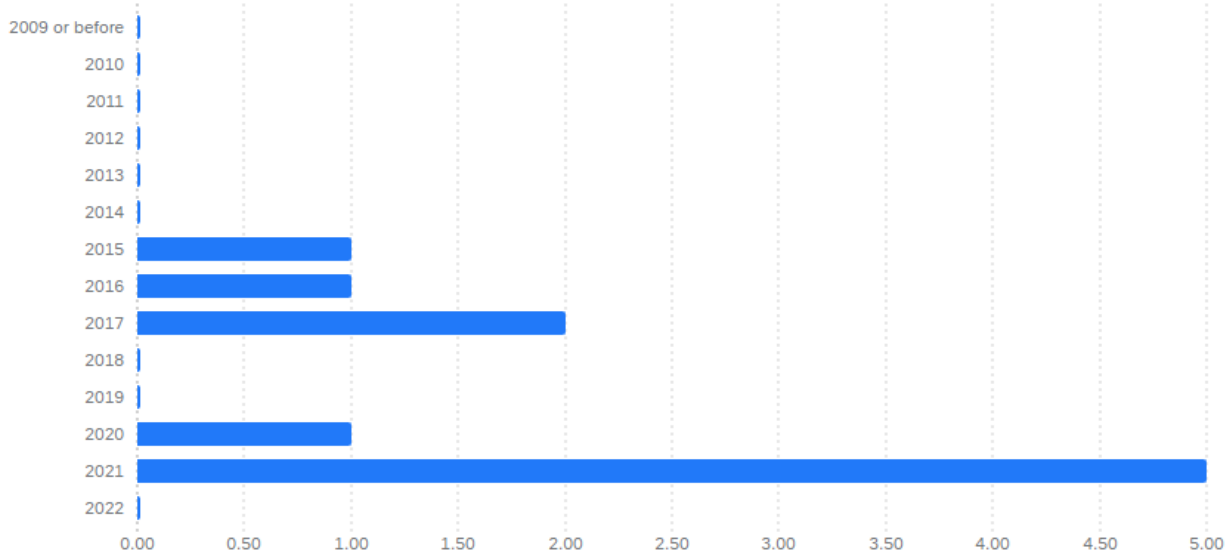
QUESTION #1 asked respondents for the name of their practice. The purpose of this question was primarily to avoid duplicate submissions, and to enable targeted follow-up in the event that there were any non-responses.

QUESTION #2 was a screening question that asked respondents whether they consider their practice to be a direct primary care practice. All 10 respondents confirmed that they think of their practice as DPC.

QUESTION #3 asked respondents whether their DPC practice was "pure" DPC or a "hybrid" practice, with some patients enrolled in a DPC membership and other patients using traditional insurance. 9 of the 10 respondents are pure DPC. 1 practice is a hybrid.

QUESTION #4 asked respondents when they started their DPC practice (or, if applicable, when they converted their existing practice to the direct primary care model). Half of respondents (5 of 10) started their practice in the past year (2021).

Q4. What year did you start your direct primary care practice?



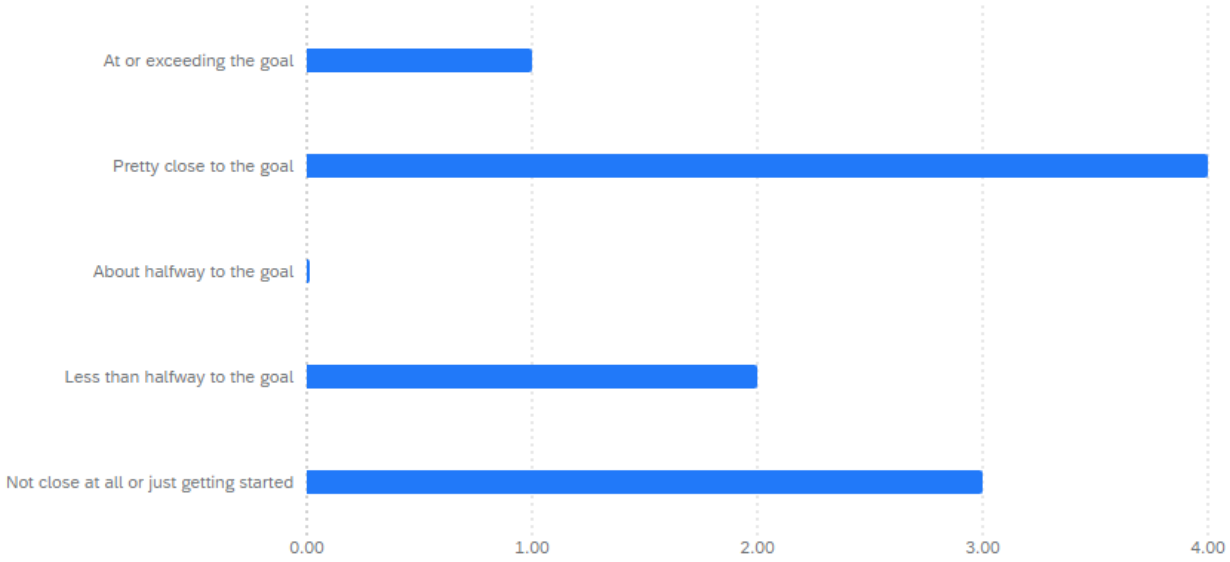
QUESTION #5 asked respondents how many clinicians provide clinical care at their DPC practice. As expected for a delivery model that is known to be predominantly independent practitioners, 8 of 10 respondents practice solo. 2 of 10 respondents have two practitioners. No DPC practices in New Hampshire have more than two practitioners.

QUESTION #6 asked respondents their goal for how many patients they would like to have enrolled in their practice. The table below summarizes the responses for this question:

Responses (Sorted from low to high; divided by two for the two practices with two practitioners, to protect anonymity)	200
	200-400
	250
	300+
	400
	400-600
	450
	450
	500
	600
Range	200-600
Mean	395
Median	450

QUESTION #7 asked respondents in approximate qualitative terms how close their practice is to reaching their enrollment goal. For privacy reasons, this question was posed in this form rather than in the more sensitive form of asking in quantitative terms how many patients are currently enrolled. Half of the respondents are at or close to their enrollment goal. The other half are less than halfway to their goal, or just getting started.

Q7. How close is your practice to reaching your aforementioned goal for patient enrollment?



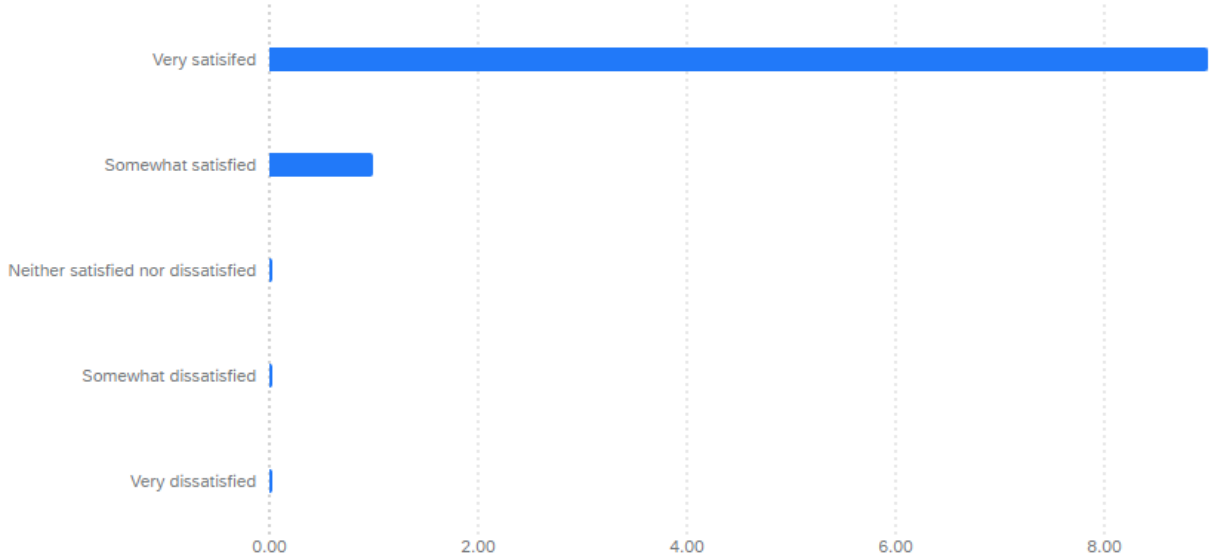
QUESTIONS #8, #9, and #10 asked what the monthly DPC membership fees are at their practice for a 5-year-old child, 40-year-old adult, and 75-year-old senior, respectively. Since special discounts are possible, such as family plans or veterans discounts, expressing an "average" fee can become complex. The table below simplifies and summarizes the responses for this question:

For a 5-year-old child	
See members of this age	7 out of 10 practices
Range	$25 to $150
Mean	$71 per month
For a 40-year-old adult	
See members of this age	8 out of 10 practices
Range	$50 to $125
Mean	$83 per month
For a 75-year-old senior	
See members of this age	7 out of 10 practices
Range	$60 to $250
Mean	$133 per month

Note: Services included in the monthly fee also vary from practice to practice.

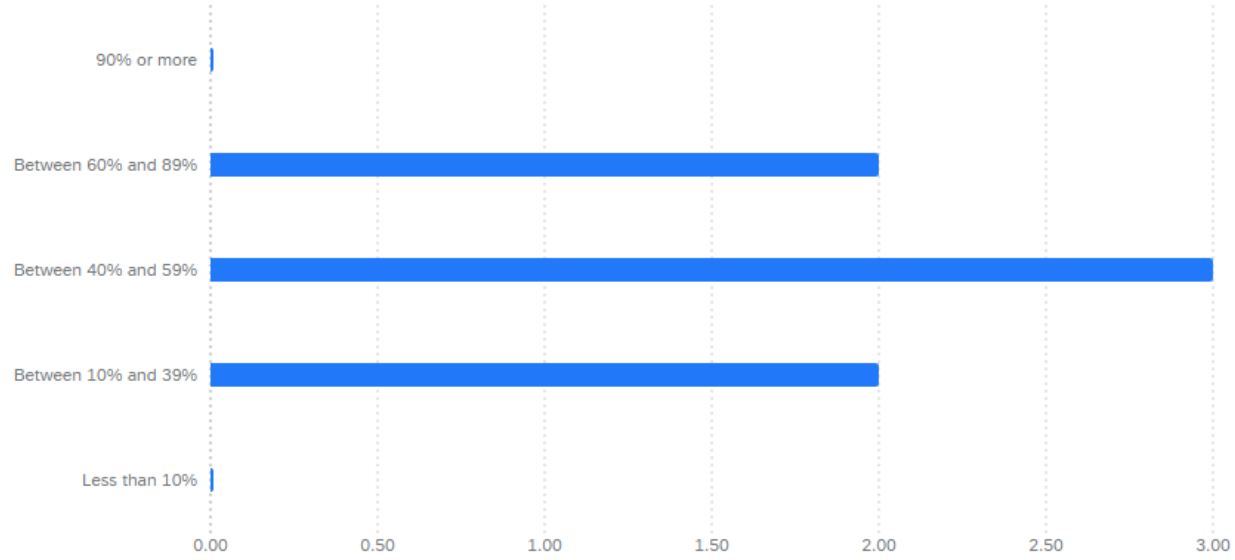
QUESTION #11 asked respondents how satisfied they are with practicing medicine under the direct primary care model. The high level of positivity (9 out of 10 reporting "very satisfied") reflects especially well on the DPC model considering that many respondents are still in the phase of growing their patient panel to their target size.

Q11. How close is your practice to reaching your aforementioned goal for patient enrollment?

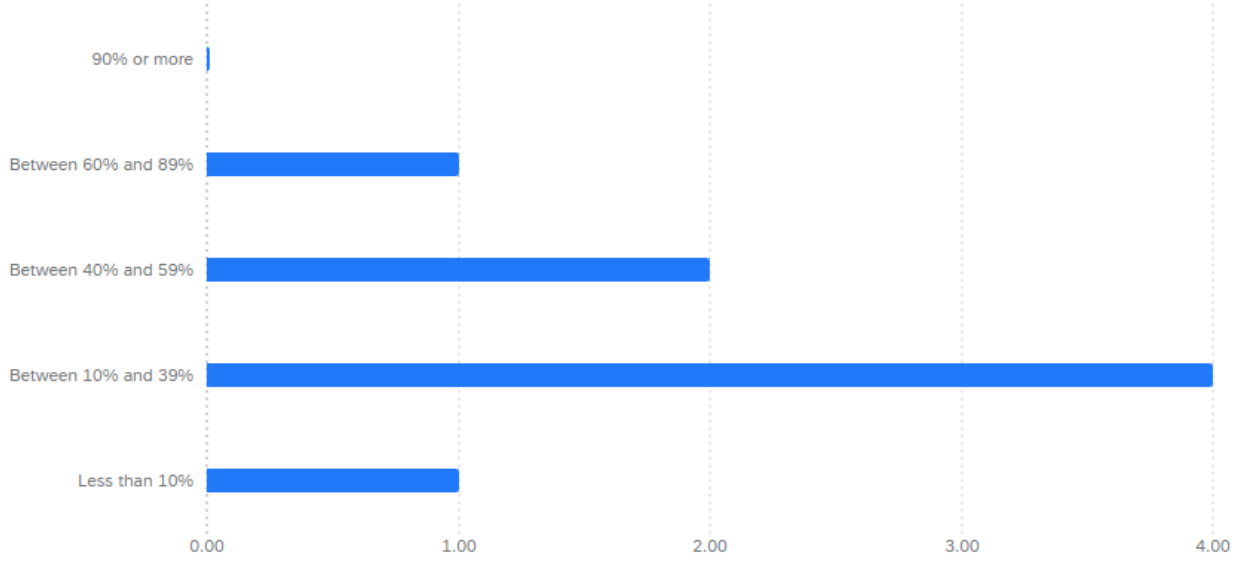


QUESTIONS #12 and #13 asked respondents to estimate the percentage of their patients who augment their direct primary care membership with a High-Deductible Health Plan (HDHP), and/or a Health Savings Account (HSA), respectively. High participation in a HDHP is appropriate for most patients and is expected. The estimate might have been higher if the question had also explicitly mentioned "wraparound" plans by name, which are a related type of coverage. Under IRS rules, tax-deferred HSA funds cannot be used to pay for DPC membership fees, but they still can be used to pay for other out-of-pocket expenses, so some DPC patients have them.

Q12. What percentage of your patients... High-Deductible Health Plan (HDHP)?

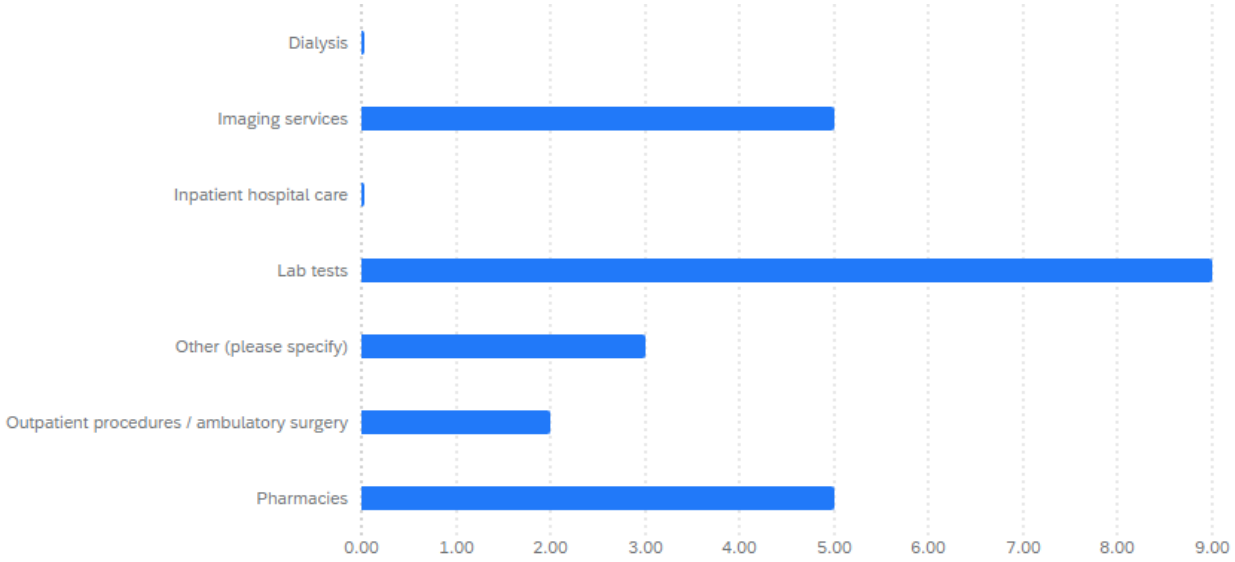


Q13. What percentage of your patients... Health Savings Account (HSA)?



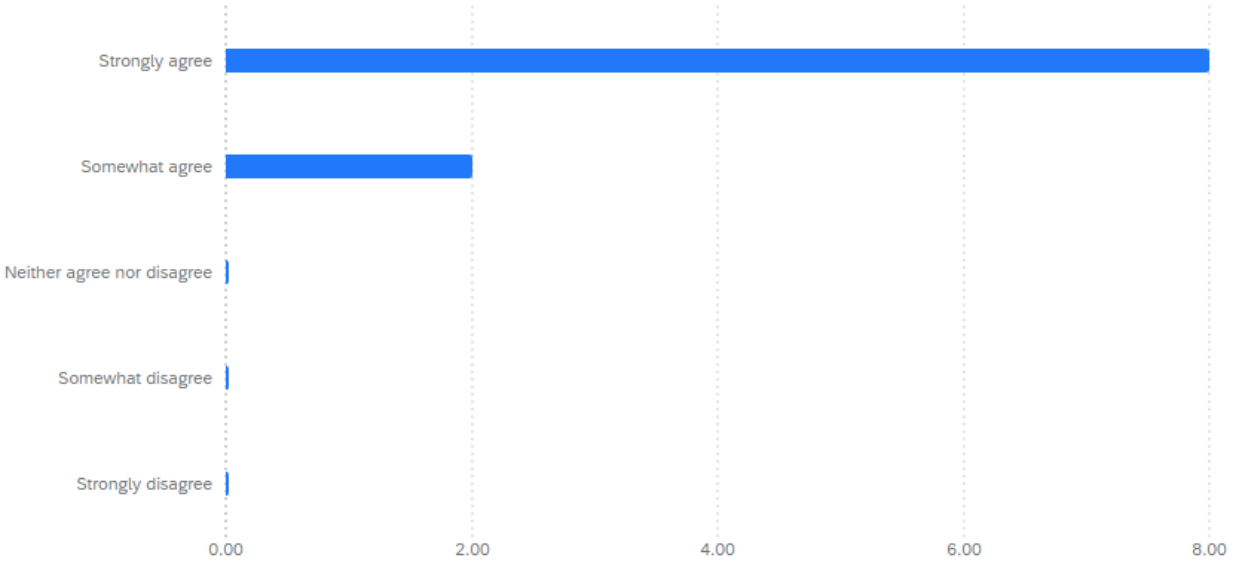
QUESTION #14 asked respondents about the healthcare service providers they collaborate with in order to extend a discount to their DPC members. Respondents could select all options that applied. Almost all (9 out of 10) practices get discounted labs for their patients, and the one practice that did not select that option indicated that it was currently working to bring about that arrangement. The next two most common types of discounts were for imaging services and pharmacies (both at 5 out of 10). Write-in answers identified vaccinations and supplements.

Q13. With which of the following service providers [can you] get your patients a discount?



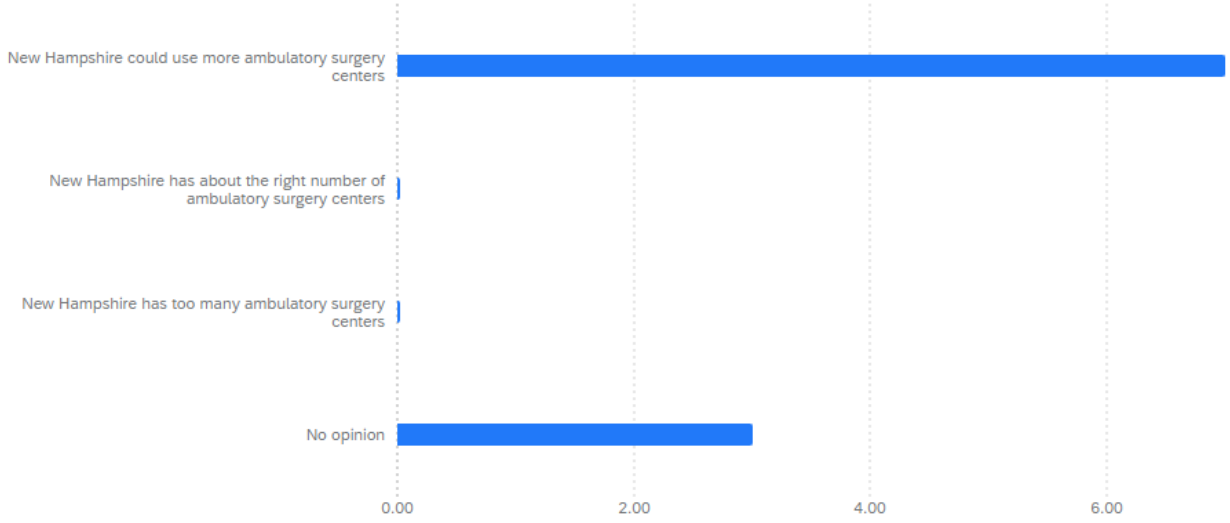
QUESTION #15 asked respondents to what extent they agree or disagree with a statement about the overall value of the DPC model to the healthcare system in terms of reducing hospital utilization and controlling costs.

Q15. Do you agree or disagree: "By providing the right care at the right time, the direct primary care model reduces hospital utilization and therefore helps to reduce costs."



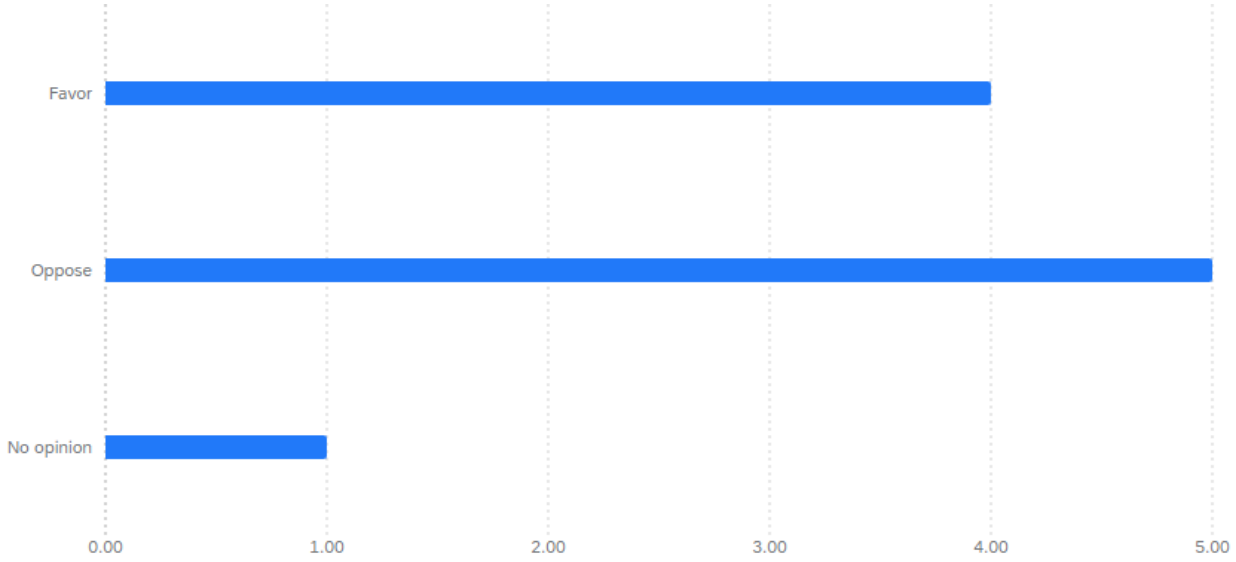
QUESTION #16 asked respondents their opinion of the availability of ambulatory surgery services in New Hampshire. The reason for asking this question was to give DPC physicians an opportunity to share whether, on balance, they believe that their patients have enough options for where to go in the event that they need ambulatory surgical care beyond what they can receive through their DPC practice. When asked, 7 of 10 respondents said that New Hampshire could use more ambulatory surgery centers. 3 of 10 did not have an opinion on the question. Zero respondents said that New Hampshire has "too many" or "about the right number" of places to receive ambulatory surgery services.

Q16. What is your impression of the availability of ambulatory surgery services in New Hampshire?



QUESTION #17 asked respondents their opinion of healthcare facility regulation in New Hampshire. Specifically, this question described the current law in New Hampshire that stipulates that anyone who wishes to build a new healthcare facility (e.g., a new hospital, ambulatory surgery center, skilled nursing facility, or other care facility) within 15 miles of a critical access hospital must undergo a review process. Respondents were asked whether they favor or oppose this law. Responses were split. The plurality (5 of 10) oppose the law. 4 respondents support the law. 1 respondent did not have an opinion.

Q17. In general, do you favor or oppose this law?



QUESTION #18 gave respondents an open-ended opportunity to provide ideas and suggestions on how policymakers can improve the conditions for DPC in New Hampshire. The survey specifically asked about what obstacles and roadblocks exist for DPC practices in the state. 8 of 10 respondents took the opportunity to provide comments. The table below summarizes the recurring themes and most common ideas that arose. Comments have been aggregated by theme, edited for conciseness, and anonymized:

Address restrictions on patients with HMOs that require orders (e.g., labs, imaging) and referrals to be made from an in-network provider.
Enable Medicaid patients to join DPC practices and pay for their membership either through their program benefit or make it reimbursable.
Clarify and possibly modify IRS rules regarding the use of flexible spending accounts (FSAs) and health savings accounts (HSAs) toward DPC membership.
Encourage or incentivize more private practice specialists and surgical centers to negotiate fair and transparent cash pricing for services and procedures.
Clarify and possibly modify restrictions around physician dispensing of non-controlled medications (a practice currently prohibited by the board of pharmacy).

States that seek to encourage and foster growth of the DPC model typically start by clarifying their statutory language around the applicability of insurance regulations to the DPC model. Without explicit clarification that DPC is not insurance and thus ought not be regulated as such, physicians are reluctant to redesign their practices under a new model. Eskew points out that direct primary care "is arguably legal in every state without this legislation," but concedes that legislation is often helpful to removing barriers because "it clears up legal gray areas."[142] Fortunately, New Hampshire has already taken this step. New Hampshire HB 508 was signed into law on August 16, 2019 giving appropriate clarity on the question of insurance applicability. DPC practices are required to put the agreement in writing, and that agreement must: a) specify fees and services covered in writing; b) describe the duration of the agreement and renewal terms; c) allow either party to terminate the agreement without penalty.[143] These provisions are relatively uncontroversial and are not experienced as restrictive.

Dispensing

One restriction on DPC practices that warrants review is a limitation on dispensing by New Hampshire Pharmacy Laws & Rules: "In the ambulatory patient treatment areas of an institution, a medical practitioner may dispense drugs for the immediate needs of the patient but not to exceed a 72-hour supply and only if permitted by the institution."[144] In other words, in outpatient offices and facilities, physicians may not dispense drugs beyond a 72-hour supply. Whatever the benefits of this policy in terms of patient safety, the policy adversely affects the value proposition that DPC providers can offer to their patients. At best, the rule creates vagueness that dissuades physicians from getting involved in DPC, as well as dispensing in general. At worst, it negatively affects the health of patients. The rule ought to be studied closely and potentially reconsidered.

Medicaid Compatibility

There is nothing in NH HB 508 that prevents DPC practices from privately contracting with Medicaid patients for covered services. The presumption under the Medicaid program is that a physician is not a Medicaid provider until he or she actively signs up to accept Medicaid.[145] Only then would the provider be unable to privately contract with a Medicaid patient for covered services. Given the low cost of DPC monthly memberships, a possible improvement upon this could be to modify state Medicaid laws to expressly allow DPC providers to contract with Medicaid, i.e., allow the Medicaid program to pay for the monthly DPC membership fee. Further analysis of this option is warranted. If a DPC membership for a Medicaid beneficiary would cost the same or less to the state (i.e., be truly budget-neutral), then this option would satisfy both the access interest of patients and the budgetary interest of taxpayers.

HMO Compatibility

Most patients with private health insurance will be under the control of either a Preferred Provider Organization (PPO) or a Health Maintenance Organization (HMO). Generally speaking, PPOs allow a patient to see any primary care physician, but require a physician referral to see a specialist. Because there is flexibility with the choice of primary care physician, PPOs and DPC are generally compatible. By contrast, HMOs make a patient choose an in-network primary care physician, and ancillary services ordered by specialists similarly need to be made by an in-network provider. Because there is inflexibility with the choice of provider, HMOs and DPC are generally incompatible. HMO patients have difficulty getting the HMO to pay for either the DPC fee or for any ancillary tests, procedures, or imaging. Additional research could explore whether there is a policy fix to this situation that does not itself impose force upon HMOs.

Direct-Pay Component II: Direct-Pay Healthcare Facilities

Just as primary care becomes affordable and more patient-centered when we become less reliant on third-party payers, so too might other outpatient procedures and services become more affordable and more patient-centered if we deregulate the healthcare facility space and allow for more direct payment.

Understanding Direct-Pay Healthcare Facilities

Currently, most outpatient healthcare facilities—surgical centers, imaging centers, outpatient rehabilitation facilities, and others—work squarely within the system of traditional insurance. They negotiate different prices for different buyers of their services (i.e., insurance companies), and unless forced to by law, try to keep those complex price schedules confidential. Physicians making inquiries for their patients need to know the details of their patient's insurance plan and current progress toward their deductible before even attempting to obtain an estimate of the price. Patients trying to shop around and obtain price information scheduling a service are often not given helpful information.[146] Facilities respond to inquiries by quoting "average prices" or by referring inquirers to lists of "chargemaster" (i.e., top-end) prices accompanied by difficult-to-understand clinical language.[147] As Bai et al. wrote in a 2019 *Health Affairs* article, "Even sophisticated patients will find it almost impossible to identify all the items they will need during a hospitalization and locate them on a hospital's chargemaster—let alone make meaningful price comparisons across hospitals."[148] Web-based healthcare cost resources that are intended to be helpful are often limited to providing estimates of prevailing prices by zip code, which vary greatly.[149] Few patients can obtain true price quotes in advance, and even they can obtain a price, they are left wondering how much insurance will cover and how much they will owe out-of-pocket.[150]

The lack of price transparency is perhaps to be expected, given the incentives at play in the traditional insurance model. Many patients treat insurance as a sunk cost, disassociated temporally and causally from any particular health event, and thus are not particularly motivated to exert the additional time and effort to choose a low-cost provider. As Tu and Lauer write, "Besides choosing the provider in the most convenient location, patients typically follow their physicians' guidance about where to go for medical procedures, according to many health plan and hospital executives."[151]

Direct-pay healthcare facilities (also called "cash-pay," cash-only," or "cash-based" facilities) conduct business differently. Direct-pay facilities do not accept third-party payment of any kind, whether from public payers or private payers. They only accept direct payment from the patient or someone offering to pay for the patient, such as an employer. A core tenet of running a direct-pay facilities is transparent pricing. Almost all such facilities post their prices online, in the form of "package prices" that include the facility fee, surgeon's fee, anesthesiologist's fee and so forth in one straightforward number.[152] Most direct-pay facilities include in their package price all services that are typical for that episode of care (including pre-operative and post-operative care), achieving the equivalent of what policy analysts call "bundled payments" in traditional insurance-based settings.

There are no estimates of the number of direct-pay healthcare facilities in the U.S. in the peer-reviewed literature. The Free Market Medical Association (FMMA) maintains a map-based directory of direct-pay service providers which it calls the ShopHealth Healthcare Marketplace tool, but additional analysis is needed to categorize and count the many different types of service providers (which include everything from surgery centers to spine centers, arthritis centers, sleep centers, sports therapy clinics, and more).[153] Anecdotal reports from physicians that work in this space claim that direct-pay facilities are on the rise and can be found in diverse locations including Texas, California, Pennsylvania, Nevada, Washington, Tennessee, Illinois, and North Carolina.[154,155]

The best-known example of a direct-pay health facility is the Surgery Center of Oklahoma (SCO). Cofounded in 1997 by board-certified anesthesiologists Dr. Keith Smith and Dr. Steven Lantier, and currently owned and operated by approximately 40 surgeons and anesthesiologists in central Oklahoma, SCO offers a wide variety of surgeries and procedures on a purely direct-pay model. SCO has clearly and transparently listed its package prices on its website since 2009.[156] Because it does not incur the administrative overhead from dealing with third-party payers, the prices it offers patients for paying in cash are anywhere from one-eighth to one-tenth the prices of traditional non-profit hospitals who are paid through insurance.[157] There are no negotiated rates, no surprise bills due to out-of-network irregularities, and very little paperwork.[158] Their service is popular with self-insured employers and individuals who choose to go without insurance and pay out-of-pocket. It also appeals to individuals who participate in healthcare shopper programs that share the savings from low-cost procedures with patients. SCO also is a main driver of

incoming medical travel (sometimes called medical tourism) to Oklahoma, which enhances the reputation of the state and provides economic boost. Local newspapers have reported on the trend, citing patient examples such as "an uninsured Florida woman who paid $10,800 for a hysterectomy at the Oklahoma Surgery Center versus $33,000 quoted by hospitals in Florida."[159] A sample of SCO's price list is available in Appendix B.

Another, less-well-known but relevant example is Arkansas Valley Surgery Center (AVSC) in Colorado. Like SCO, AVSC practices full price transparency, posting all of its prices for outpatient procedures online. Its price list applies to self-pay patients only, and does not apply to patients who wish to pay via "Medicare, Medicaid, other government insurance programs, or an insurance company." One contrast to SCO package pricing is that at AVSC the posted prices do not include professional fees. Patients are encouraged to follow up with the individual offices of those other professionals (e.g., surgeon, anesthesiologist) for that information.[160] A sample of AVSC's price list is available in Appendix C.

Healthcare Facility Regulation in New Hampshire

Past Regulation of Supply

For the past several decades, the most significant health facility regulation in New Hampshire were the Certificate-of-Need (CON) laws. CON laws are a regulatory mechanism that require state approval for "major capital expenditures and projects for certain health care facilities"(typically hospitals, outpatient facilities, and long-term care facilities).[161] Under CON laws, existing healthcare facilities that, for instance, wish to acquire an expensive new MRI machine or CT scanner, or add a new wing with additional inpatient or outpatient beds, are required by law to request for approval from a state review board. Similarly, under CON laws, organizations and entrepreneurs looking to start new healthcare facilities are required to seek approval before opening to the public. Each state's CON board is empowered to decide on behalf of all healthcare consumers in the state whether the newly proposed service is "needed." CON law supporters argue that because excess capacity tends to get used up, the laws help to limit healthcare utilization by limiting a state's health system capacity, and that this controls spending. CON laws, they argue, slow expansion, promote consolidation of healthcare providers, and limit the duplication of services.[162] Opponents argue that CON laws hinder health system capacity artificially, protect incumbents at the cost of those wish to bring new services to patients, and are less effective at controlling costs than allowing market-based competition to drive down costs.

CON laws were first implemented by New York in 1964 to enable the state's Health Department to engage in healthcare infrastructure planning.[163] Other states followed suit in the ensuing years, and New Hampshire eventually formed a CON board in 1979, partly in an effort to manage health care costs and partly in response to federal

incentives.[164,165] One of the features of the New Hampshire law was thresholds for investment that would trigger a mandatory board hearing ($3 million for hospitals, $2 million for other facilities, and $400,000 for equipment).[166] Nationally, the adoption trend continued. By the early 1980s, all states except for Louisiana had adopted some form of CON law.

In 1987, Congress removed federal funding support for CON laws. In the years that followed, lacking evidence that CON laws were achieving their stated goals, some states started repealing their CON laws. The authors of one study of 1,957 acute care hospitals across the country found that costs were higher in CON states, suggesting that CON laws "may actually increase [costs] by reducing competition."[167] In 2016, New Hampshire repealed its CON law.[168] To date, 11 other states have also fully repealed their CON laws or allowed their CON program to expire, leaving 35 states plus the District of Columbia with CON laws still in effect.[169]

What had the effects been of New Hampshire's CON law? In 2015, just before New Hampshire's CON laws were repealed, the laws were studied by researchers at George Mason University.[170] They estimated that as a result of New Hampshire's CON laws, New Hampshire at that time had:

- About 1,300 fewer hospital beds than it otherwise would have had;
- About 9 fewer hospitals offering CT scans than it otherwise would have had;
- An MRI availability of 2.5 hospitals with MRIs per 500,000 population, compared to a nationwide average of 6 hospitals with MRIs per 500,000 population.

The New Hampshire CON laws were retired soon thereafter. The final day of the CON era for New Hampshire was June 30, 2016.

Present Regulation of Supply

Replacing New Hampshire's CON laws and taking effect on July 1, 2016, is Senate Bill 481, which is titled "*Relative to a special health care service license and making an appropriation therefor.*" As a bill, it had received bipartisan sponsorship and was passed 195-134 (with 37 no votes and 32 abstentions).[171] This new law abolished the CON review board but replaced it with a different set of restrictions on the construction of new medical facilities and took steps specifically to protect critical access hospitals (CAHs).[172] ("Critical Access Hospital" is a designation given by the Centers for Medicare & Medicaid Services to certain hospitals to ensure that rural beneficiaries can access hospital services such as emergency care. They are reimbursed at a rate of 101 percent of their "reasonable costs," rather than at typical Medicare rates or at market prices. About two-thirds of rural hospitals have this designation.) Under the new law:

- All new healthcare facilities seeking a license to operate must accept all payers.
- All new inpatient healthcare facilities seeking a license to operate must have a 24/7 emergency department.
- Any new healthcare facility that wishes to open within a 15-mile radius of a critical access hospital must receive clearance from the New Hampshire Department of Health and Human Services (DHHS) Commissioner.
- Cardiac catheterization laboratory services, coronary artery bypass graft surgery, and megavoltage radiation therapy are specifically added to the list of healthcare facility types that are subject to these new location, payment, and service-related regulations.

The types of facilities affected are those licensed under RSA 151:2,I(a) and (d). They are: Hospitals; Educational Health Centers (infirmaries located on the grounds of a school); Ambulatory Surgical Centers; Hospice Providers; Non-Emergency Walk-in Care Centers; Dialysis Centers; and Birthing Centers.

According to sponsors of the bill, the purpose of the emergency department and all-payer requirements are to "level the playing field" between new healthcare facilities and existing facilities.[173] The purpose of the geographic restriction on new healthcare facilities is to protect critical access hospitals from new competition. Not allowing new health facilities to open might keep aggregate healthcare *expenditures* from rising in a collective sense, but it does so by sacrificing the opportunity to use competition to lower actual *costs*.

To examine the reach of the 15-mile protection zone around New Hampshire critical access hospitals, three maps of New Hampshire were generated. Figure 1 shows the locations of the 13 "critical access" hospitals in the state (denoted by the "H" symbol and labeled by town and county). Of New Hampshire's 10 counties, 6 counties have at least one critical access hospital. The four counties that do not have at least one critical access hospital are Belknap County, Strafford County, Rockingham County, and Cheshire County.

Figure 2 shows population density for New Hampshire, by town (people per square mile). The state's most densely populated areas are Manchester and Concord and the immediately surrounding towns, as well as a short stretch of the seacoast region along Interstate 95, although several other population centers exist and are distributed around the state, including Keene, Claremont, Lebanon, Franklin, and Laconia.

Figure 3 shows the geographic reach of the 15-mile protection zone (depicted in yellow shading) around each critical access hospital. In terms of land mass, most of the state (about 75 percent, upon a rough visual inspection) is closed to new facility creation and expansion, barring DHHS approval. In terms of population, the state is closed in areas where approximately half of the state's residents reside.[174] The extent to which these overlapping protection zones blanket the state should be concerning

to New Hampshire residents who would prefer there to be fewer obstacles in the way of opening new facilities.

It is difficult to know what effect the bill has had on the construction of new health facilities in New Hampshire. According to information obtained from the New Hampshire Department of Health and Human Services Office of Legal and Regulatory Services, since SB 481 became effective, there have been nine initial applications that have triggered the 15-mile radius rule. In each of the nine cases, "[I]t was determined that the establishment of the facility would not have an adverse effect on the Critical Access Hospital implicated."[175] It is not knowable how many health facilities were deterred from applying, or that rule out expanding into New Hampshire because of this law. The immediate status quo ante was a Certificate of Need regime, so there is also no recent unregulated period against which to compare.

An additional analysis of the status quo in New Hampshire is possible through prices. Returning to the aforementioned Surgery Center of Oklahoma—the direct-pay healthcare facility that posts its all-inclusive prices online—it is possible to compile a comparison of SCO prices to the prices quoted on the New Hampshire price transparency website NH HealthCost for an uninsured individual. (In an online directory of direct-pay ambulatory surgery centers that post prices online, there are currently no direct-pay facilities listed in New Hampshire.[176]) Shown in Table 5 are prices at SCO and in New Hampshire for a set of common procedures.

Table 5. Price Comparison on Common Surgical Procedures

Procedure	Surgery Center of Oklahoma Package Price	New Hampshire		
		Number of Providers	Estimate of Procedure Price (Range)	Statewide Median Price
Tonsillectomy / Adenoidectomy	$3,100	5	$7,655 - $15,755	$11,944
Arthroscopic Knee Surgery	$3,740	13	$8,130 - $18,114	$15,094
Arthroscopic Shoulder Surgery	$5,720	13	$23,871 - $92,320	$56,296
Breast Biopsy	$3,365	8	$2708 - $9548	$4,559
Hernia Repair, Laparoscopic, Unilateral	$5,750	11	$15,180 - $47,129	$29,615
Gall Bladder Surgery with Liver Biopsy	$6,465	9	$7,037 - $22,129	$23,699

Sources: Surgery Center of Oklahoma; NH Health Cost.

Figure 1. Locations of Critical Access Hospitals in New Hampshire

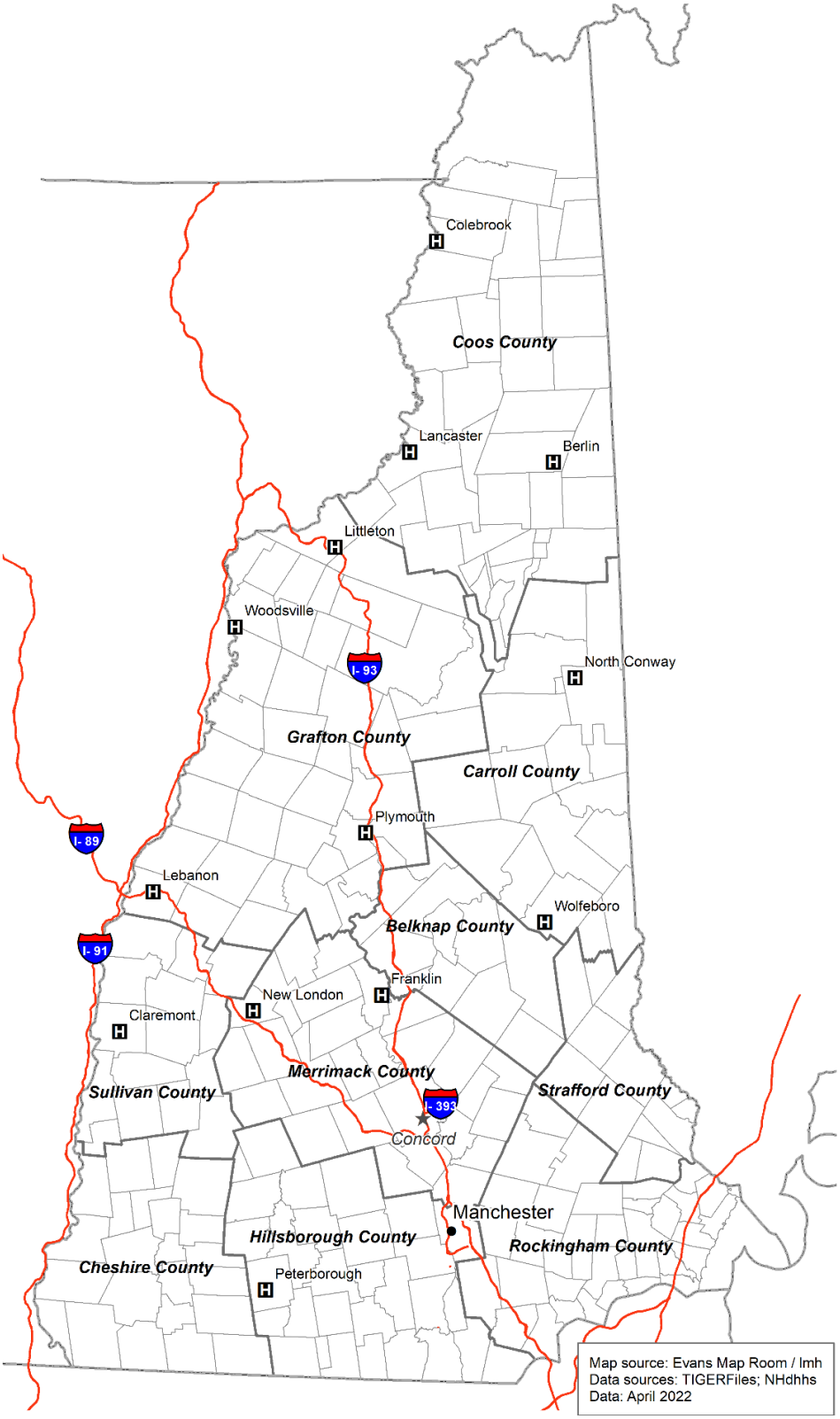


Figure 2. Population Density New Hampshire, By Town (People Per Square Mile)

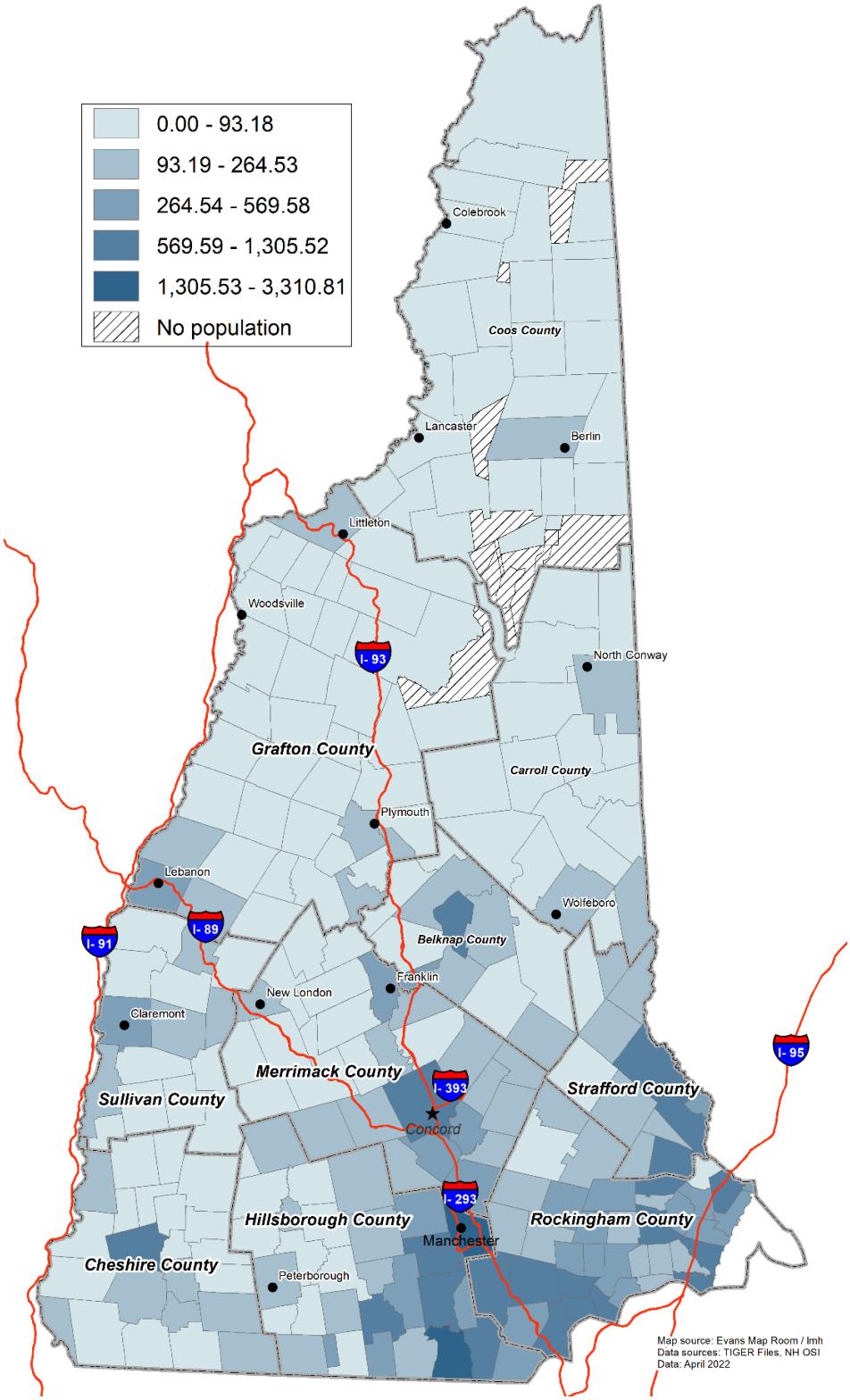
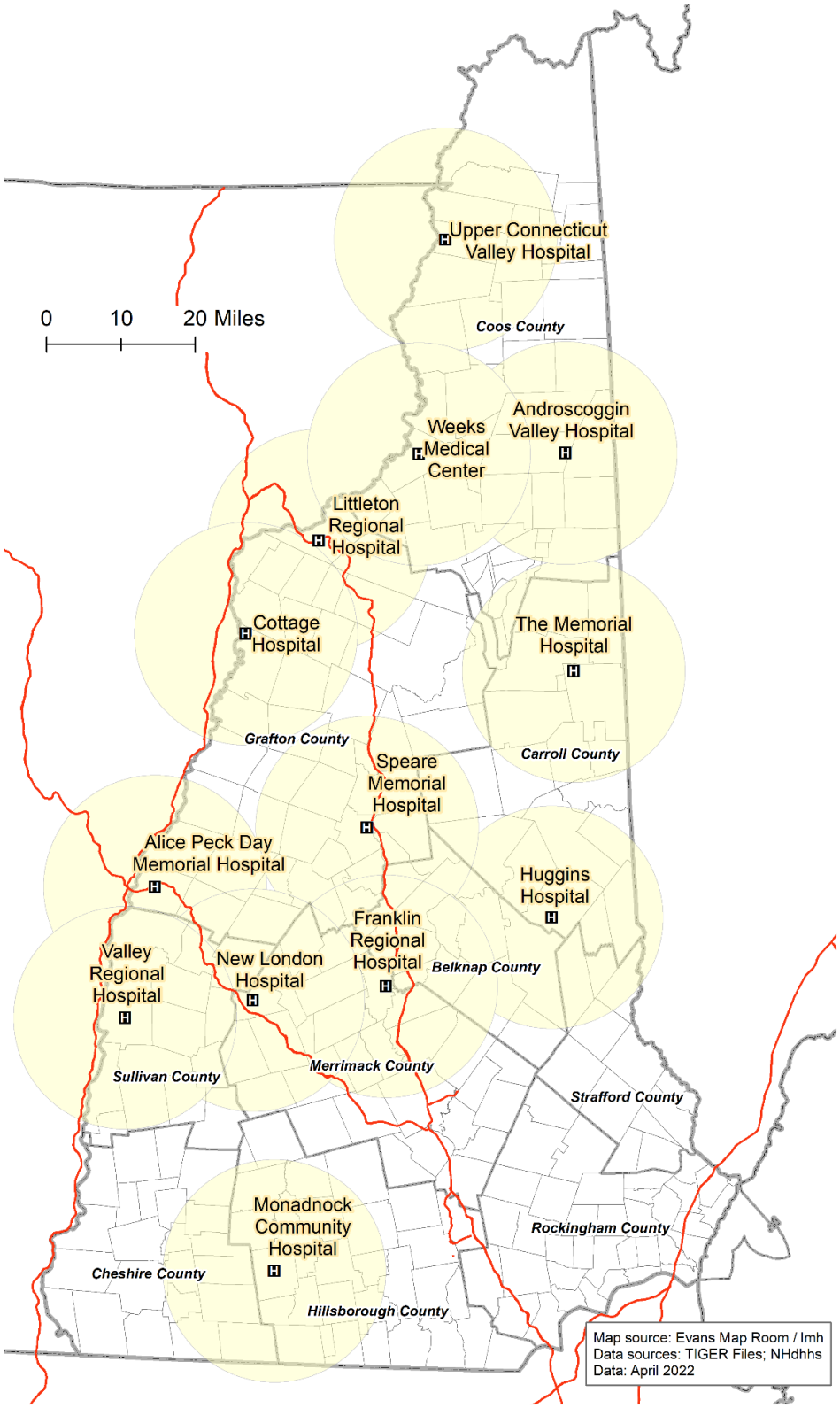


Figure 3. Coverage of 15-Mile Protection Zone Around Critical Access Hospitals in New Hampshire



Fostering Direct-Pay for Healthcare Facilities in New Hampshire

If allowed, direct-pay healthcare facilities potentially could become part of healthcare in New Hampshire. Their presence in the market would help to increase access to services, and it would help to impose cost discipline through increased transparency and competition. Direct-pay facilities help a wide variety of people, including uninsured individuals; self-insured individuals; and self-insured employers.[177] Like other healthcare organizations, direct-pay facilities provide charity care for patients who need it.[178] Direct-pay facilities potentially could even help insurance companies in the sense that instances could arise in which a member discovers that independently paying the full amount of a low sticker price on a service at a direct-pay facility could actually cost the member *less* out of pocket than paying a 20%-30% coinsurance on a high sticker price surgery within the conventional insurance-hospital system. In such a case, the insurance company is saved the amount that it would have contributed.

Encouraging direct-pay health facilities by way of a large, centralized program with taxpayer-funded incentives or special treatment would be anathema to the ethos of the direct-pay world. Instead, policymakers should consider ways to remove regulatory barriers such as those contained in the NH SB 481 legislation that replaced the previous NH CON law. The all-payer mandate and the licensing requirement triggered by the 15-mile CAH protection are particularly restrictive to direct-pay alternatives. (These provisions also limit the options that insurers have, and thus weaken their negotiating power with hospitals.) New Hampshire has an opportunity to open itself up to new investments in direct-pay healthcare facilities. Reopening discussion around the NH SB legislation would be welcome.

Completing the Direct-Pay Pathway

This report has explored at length the opportunities to improve healthcare cost and access through the lens of two models: direct primary care for primary care, and direct-pay healthcare facilities for outpatient surgeries, procedures, and other related services. However, these two models in fact form the basis for a new unifying idea, which can be called the "Direct-Pay Pathway."

A key idea of the Direct-Pay Pathway is that it is fundamentally cost-inefficient to use insurance to pay for relatively low-cost, predictable, office-based care. By definition, primary care mainly entails frequent, routine, low-cost care that many or most people need (e.g., annual exams, lab tests), not unusual, high-cost care needed by a relatively small number of people.[179] It could be more efficient to pay not just for primary care but also simple outpatient procedures directly, without insurance. To pay for more complex outpatient procedures or for inpatient care, other more insurance-like options could be used such as:

- HIGH-DEDUCTIBLE HEALTH PLANS (HDHPs), which provide coverage for the high-cost but unpredictable events, at a low cost to individuals and their families. (The IRS currently defines an HDHP as any plan with a deductible of at least $1,400 for an individual or $2,800 for a family.[180]) Currently, pairing of HDHPs with a DPC membership is legally allowed, and not only is it fairly common but it is highly recommended for most patients who enroll in a DPC membership. Pairing a DPC plan with a HDHP saves on average 20 percent to 30 percent.[181]
- HEALTH SAVINGS ACCOUNTS (HSAs), which enable individuals who are enrolled in a high-deductible health plan to save for their future medical expenses in a tax-advantaged account. Unfortunately, current IRS rules prohibit individuals with HSAs from using their HSA to pay for a DPC monthly fee (because it interprets payments for DPC membership as payments for health insurance).[182,183] This could be changed, but it would require action at the federal level. Senate Bill 128, titled the Primary Care Enhancement Act of 2021, seeks to amend IRS rules to allow DPC periodic fees to be compatible with HSAs.[184]

The more services and types of care that can be delivered via direct-pay, the more feasible the Direct-Pay Pathway is likely to be as a fully independent alternative. Under the status quo, it is not easy to convince a patient of the benefits of forgoing traditional insurance in favor of a DPC subscription because the natural question that arises is, "*Won't I need insurance if I need a procedure, imaging, or hospital care?*" However, from the experience of facilities such as Surgery Center of Oklahoma, we know that the direct-pay model that works in primary care can work for surgical care, too. As one physician commentator put it, "Policymakers need to understand that the key to 'affordable health care' is not to increase the role of health insurance in peoples' lives, but to diminish it."[185]

To be a compelling alternative, the Direct-Pay Pathway needs to cover a range of service *in a given geographical region*. People will be more likely to decline their current insurance-based arrangement and enroll in a DPC practice (supplemented by a HDHP) if they have access to nearby direct-pay health facilities that are transparent, navigable, and rationally priced for common services such as imaging, labs, and outpatient procedures. This availability of services would in turn attract more DPC practices, and the growing concentration of direct-pay patients in this hypothetical region might eventually be able to support that addition of a direct-pay surgical facility in the area.[186]

The idea of extending the direct-pay model to span the full continuum of care is relatively new, even if some of the constituent parts (e.g., direct primary care practices, direct-pay surgery centers, high-deductible health plans, health savings accounts) have been around for many years. This approach might not appeal to everyone; however, even in a world with a robust Direct-Pay Pathway, patients and providers who like using various insurance-based payment models still would be able

to do so. As this report has discussed, many models and arrangements have been tried, and none has yet solved any state's healthcare conundrums fully.

Allowing a Direct-Pay Pathway to compete on a level regulatory playing field would supplement the options that New Hampshire residents have in pursuing care for themselves and their loved ones. For some subset of patients and providers in the state, this could be the arrangement that serves their health the best.

Conclusion

New Hampshire has room to improve in terms of addressing healthcare cost and access concerns. Most conventional health policy ideas employed by other states either are either of questionable efficacy, have already been implemented in New Hampshire, or have no shortage of existing advocates. The current healthcare ecosystem characterized by third-party payment and overuse of insurance has become confusing for patients and providers alike, and has lost the cost-discipline that clear pricing and vibrant competition normally provide. If given a chance to succeed or fail on a level regulatory playing field, newer options such as direct primary care and direct-pay healthcare facilities could supplement other options, and help individuals in New Hampshire who seek a different approach to medical care.

Appendix A: Survey of New Hampshire Direct Primary Care Practices

Below is the survey instrument that was fielded to direct primary care practices in New Hampshire in January 2022. Practices were invited to take the survey via email. The platform used was Qualtrics.

Thank you for participating in this survey of direct primary care practices in New Hampshire. This is part of an important research effort, and if you provide your email address at the end of the survey, we would be happy to share with you the results of this work.

All of the responses that you provide will remain confidential. Only aggregated and non-identifiable results will appear in the published report that we are creating.

Q1 What is the name of your practice? (This is only to avoid duplicate submissions.)

_____

Q2 For the purposes of this survey, the term "direct primary care" (DPC) refers to a model of primary care in which patients pay a membership fee on a monthly or annual basis that covers a wide range of basic services at the primary care provider's office. Benefits might include discounted lab tests, dispensing drugs, and other services.

Do you consider your practice to be a direct primary care practice?

- ○ Yes. We think of ourselves as direct primary care.
- ○ Somewhat. We resemble direct primary care in some ways, but we think of ourselves as something different.
- ○ No. We are not direct primary care at all.

Q3 Which of the following best describes your practice model?

- ○ "Pure" Direct Primary Care (all patients pay a monthly or annual fee)

○ "Hybrid" Direct Primary Care (some patients pay a monthly or annual fee, and some patients pay with traditional insurance)

○ Other (please describe)
_____

Q4 What year did you start your direct primary care practice (or convert your existing practice to direct primary care model)?

○ 2022

○ 2021

○ 2020

○ 2019

○ 2018

○ 2017

○ 2016

○ 2015

○ 2014

○ 2013

○ 2012

○ 2011

○ 2010

○ 2009 or before

Q5 How many people provide clinical care at your practice? (Please include all MDs, DOs, APRNs, PNPs, and other caregivers who are employed by your practice)

- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ More than 5

Q6 For your practice as a whole, what is your goal for **how many patients** you would like to have enrolled as direct primary care members? (Please type the number below.)

_____

Q7 How close is your practice to reaching your aforementioned goal for patient enrollment?

- ○ At or exceeding the goal
- ○ Pretty close to the goal
- ○ About halfway to the goal
- ○ Less than halfway to the goal
- ○ Not close at all or just getting started

Q8 At your practice, what is the monthly membership fee for **a healthy 5 year-old child**? (Leave blank if you do not see patients this age.)

_____

Q9 At your practice, what is the monthly membership fee for **a healthy 40 year-old adult**? (Leave blank if you do not see patients this age.)

_____

Q10 At your practice, what is the monthly membership fee for **a healthy 75 year-old senior citizen**? (Leave blank if you do not see patients this age.)

_____

Q11 Overall, **how satisfied** are you with practicing medicine under the direct primary care model?

- ○ Very satisfied
- ○ Somewhat satisfied
- ○ Neither satisfied nor dissatisfied
- ○ Somewhat dissatisfied
- ○ Very dissatisfied

Q12 To the best of your knowledge, what percentage of your patients augment their direct primary care membership with a **High-Deductible Health Plan** (HDHP)?

- ○ 90% or more
- ○ Between 60% and 89%
- ○ Between 40% and 59%
- ○ Between 10% and 39%

- ○ Less than 10%
- ○ I don't know

Q13 To the best of your knowledge, what percentage of your patients augment their direct primary care membership with a **Health Savings Account** (HSA)?

- ○ 90% or more
- ○ Between 60% and 89%
- ○ Between 40% and 59%
- ○ Between 10% and 39%
- ○ Less than 10%
- ○ I don't know

Q14 With which of the following types of healthcare service providers do you have collaborations that enable you to get your patients a discount?

Please check all that apply:

- ☐ Imaging services
- ☐ Lab tests
- ☐ Pharmacies
- ☐ Outpatient procedures / ambulatory surgery
- ☐ Inpatient hospital care

- [ ] Dialysis
- [ ] Other (please specify)

_____

Q15 In general, do you agree or disagree with the following statement:

"By providing the right care at the right time, the direct primary care model reduces hospital utilization and therefore helps to reduce costs."

- ○ Strongly agree
- ○ Somewhat agree
- ○ Neither agree nor disagree
- ○ Somewhat disagree
- ○ Strongly disagree

Q16 What is your impression of the availability of **ambulatory surgery services** in New Hampshire?

- ○ New Hampshire could use more ambulatory surgery centers
- ○ New Hampshire has about the right number of ambulatory surgery centers
- ○ New Hampshire has too many ambulatory surgery centers
- ○ No opinion

Q17 Currently in New Hampshire, anyone who wishes to build a new healthcare facility (e.g., a new hospital, ambulatory surgery center, skilled nursing facility, or

other care facility) within 15 miles of a critical access hospital must undergo a review process.

In general, do you favor or oppose this law?

- ○ Favor
- ○ Oppose
- ○ No opinion

Q18 Are there any New Hampshire state laws or policies that prevent you from running your direct primary care practice the way that you would like to run it? We want to know what obstacles and roadblocks exist for direct primary care in New Hampshire.

_____

_____

_____

_____

_____

Q19 As part of this research project, we plan to hold some events where we discuss direct primary care and other health policy issues in New Hampshire.

If you would like to stay informed and potentially participate, please share your email address so we can contact you.

_____

Appendix B: Direct-Pay Surgery Center Sample Price Sheet #1

Arkansas Valley Surgery Center (AVSC) is a freestanding ambulatory surgery center in central Colorado, accredited by the Accreditation Association for Ambulatory Health Care (AAAHC). AVSC posts its prices for common outpatient procedures. The prices are for the specific service listed and do not include professional fees for services such as those provided by a physician, surgeon, or anesthesiologist.

CPT Code	CPT Description	Current Cash Price	Comment/Notes
15822	BLEPHORAPLASTY, UPPER LID	$1,233.00 PER LID	
28285	HAMMERTOE CORRECTION	$1,932.00	
28296	HAMMERTOE CORR/OSTEOTOMY	$1,932.00	
29881	ARTHROSCOPY, MENISCECTOMY	$1,932.00	
43239	EGD/BIOPSY	$585.00	
43450	ESOPHAGEAL DILATION	$585.00	
45378	DIAGNOSTIC COLONOSCOPY	$558.00	
45380	COLONOSCOPY WITH BIOPSY	$736.00	
45385	COLONOSCOPY W/LESION REMOVAL	$736.00	
45398	TC W/BAND LIGATION HEMORRH	$736.00	
46221	HEMORRHOIDECTOMY/INTERNAL	$272.00	
47562	LAP CHOLE	$3,165.00	
49505	INGUINAL HERNIA REPAIR	$2,011.00	PLUS COST OF MESH
49585	UMBILICAL HERNIA	$2,011.00	PLUS COST OF MESH
49587	UMBILICAL HERNIA INCARCERATED	$2,011.00	PLUS COST OF MESH
50590	ESWL	$4200.00/NON MCR	
52235	CYSTO/MEDIUM BLADDER TUMOR	$1,820.00	
52332	CYSTO W/STENT PLACEMENT	$1,820.00	
55040	EXCISION OF HYDROCELE	$2,011.00	
62321	CERVICAL EPIDURAL SPINE INJECTION	$428.00	
62323	LUMBAR EPIDURAL SPINE INJECTION	$428.00	
64483	TRANSFORAMINAL	$528.00	
64493	FACET	$528.00	
64721	CARPAL TUNNEL	$1,186.00	
66821	YAG	$384.00	
66984	CATARACT IOL	$1,497.00	
67900	BROW PTOSIS	$1,220.00 PER EYE	

Source: Arkansas Valley Surgery Center, Cash Pricing Program. Accessed March 19, 2022.

Appendix C: Direct-Pay Surgery Center Sample Price Sheet #2

The Surgery Center of Oklahoma multispecialty facility in Oklahoma City, owned and operated by surgeons and anesthesiologists in central Oklahoma. The facility posts its package prices, which include the fees for the surgeon, anesthesiologist, and facility, along with an initial consultation and uncomplicated follow-up care. As an example, the prices below are for procedures in the knee surgery category (there are many other categories, including neck, shoulder, cardiovascular, hip, ankle, nose, ear). The prices they post are available only to those who pay the entire amount in advance, and they are not available to patients paying with health insurance.

Prices for the Knee Surgery Category

Procedure/Surgery	Cost
Anterior Cruciate Ligament Repair	$6,790
Anterior Cruciate Ligament Repair with Allograft	$9,790
Bilateral Knee Arthroscopy	$5,300
Chondroplasty	$3,740
Complete Synovectomy	$3,740
Continuous Infusion, Regional Block (Pain Control Catheter)	$725
Excision Prepatellar Bursa	$2,700
Hamstring Repair (implants not included)	$5,730
Knee	$3,740
Knee with Lateral Release or Microfracture	$4,510
Manipulation, Knee	$1,400
Med & Lateral Meniscectomy	$3,740
Medial Collateral Ligament	$6,160
Platelet Rich Plasma Injection	$725
Posterior Cruciate Ligament Repair	$6,990
Quadricep Repair (implants not included)	$5,730
Reconstruction, Dislocating Patella	$6,270
Repair “Leg” Hernia	$3,450
Repair Gluteus Medius Tendon (implants not included)	$5,300
Repair Patellar Tendon	$5,400
Subchondroplasty (undersurface cementing)	$7,010
Tibial Tubercle Osteotomy	$6,270
Total Knee Arthroplasty (Knee Replacement)	$15,499

Source: Surgery Center of Oklahoma, Surgery Pricing (Knee). Accessed March 21, 2022.

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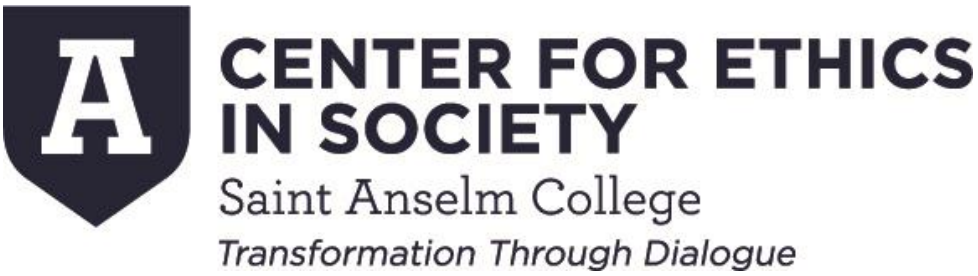

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