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

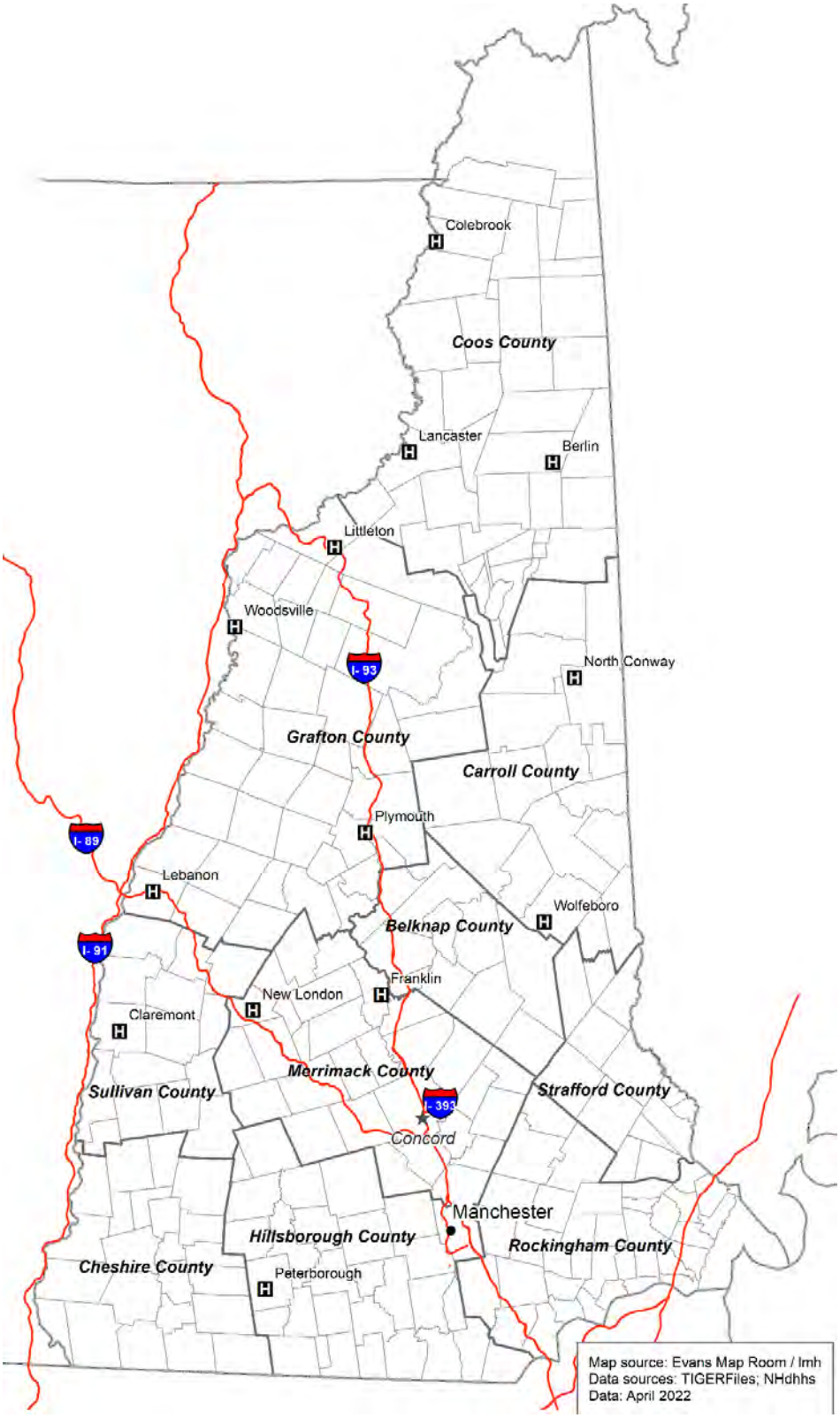


Figure 2. Population Density New Hampshire, By Town (People Per Square Mile)

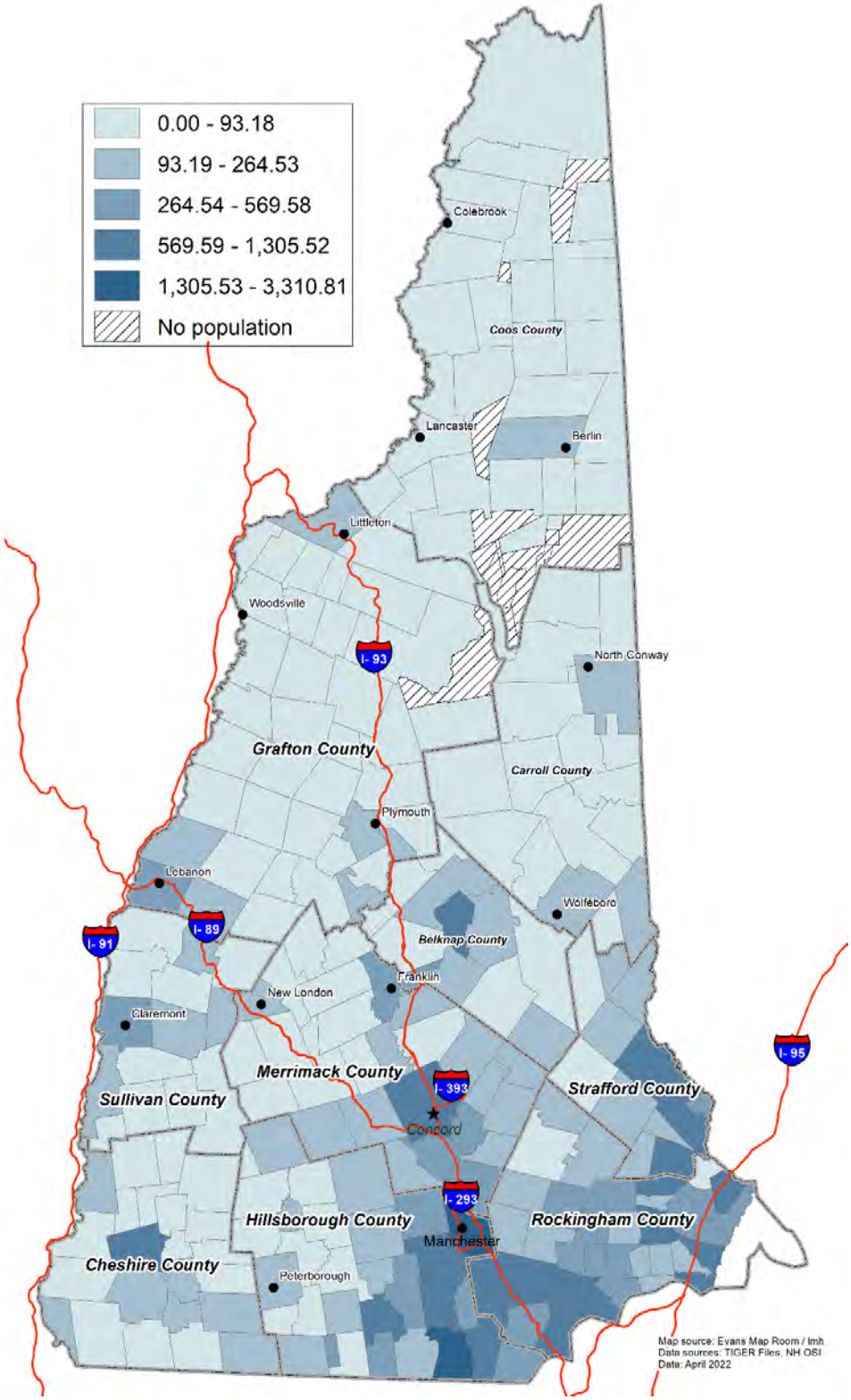
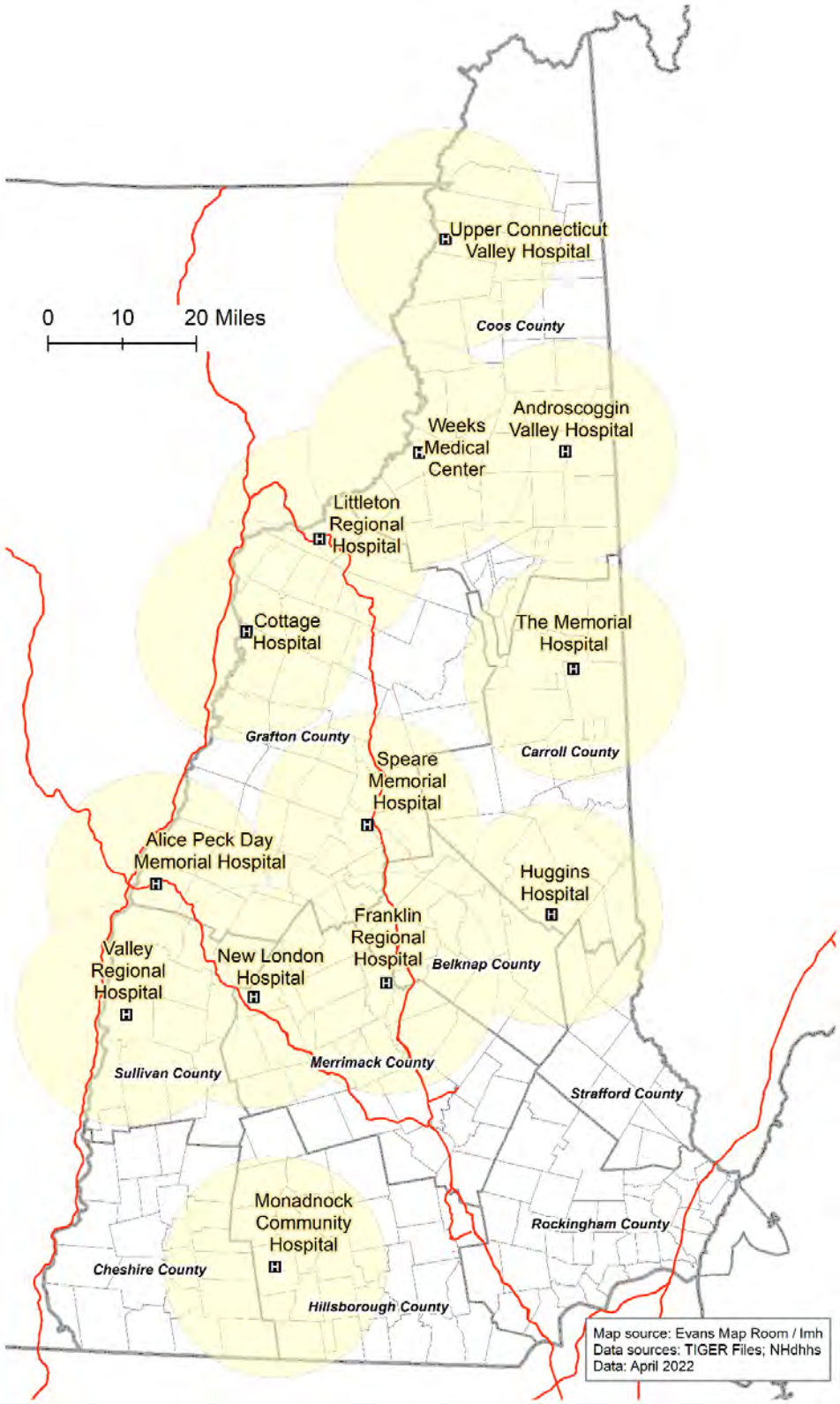


Figure 3. Coverage of 15-Mile Protection Zone Around Critical Access Hospitals in New Hampshire



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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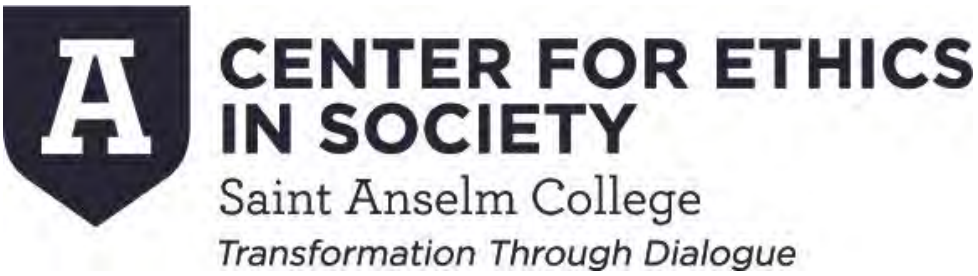

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