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I. SPECIAL REPORT

Any-Willing-Provider And Freedom-Of-Choice Laws: An Economic Assessment

by Fred J. Hellinger

In recent years the prerogative of managed care plans to selectively contract with health care providers to establish networks of preferred providers has been circumscribed in many states through the enactment of any-willing-provider (AWP) and freedom-of-choice (FOC) laws.

AWP laws require managed care plans to accept any qualified provider who is willing to accept the terms and conditions of a managed care plan. These laws do not require managed care plans to contract with all providers. However, they do require managed care plans to explicitly state evaluation criteria and ensure “due process” for providers wishing to contract with the plan.

FOC laws permit an enrollee to obtain reimbursable health care services from any qualified provider even if the provider has not signed a contract with the managed care plan. These laws often compel managed care plans to pay the same amount to a non-network provider chosen by an enrollee as they pay to a network provider. Yet this does not guarantee that an enrollee will incur the same out-of-pocket costs. Enrollees who obtain all of their care from non-network providers pay the fixed copayment per service (or a fixed percentage of covered charges) their plan requires, plus any charges in excess of the plan’s covered charges.

Arguments pro and con. Proponents of AWP and FOC laws contend that health care providers who are willing to abide by the terms and conditions of a health plan should be permitted to sign a contract with that health plan. They also contend that their inclusion would not increase costs because they would be reimbursed at the same rate as other network providers. These laws improve quality, proponents say, because they increase continuity of care and enhance access to care by offering patients a broader choice of providers. In particular, mental health care providers maintain that a patient should be able to choose a mental health care provider because a patient’s feelings toward this provider can increase the likelihood of successful treatment.

Opponents of AWP and FOC laws assert that the ability of managed care plans to contract with some providers while refusing to contract with others (without specifying the reasons) enables plans to control use of resources and maintain quality of care. Without selective contracting, opponents insist, plans are unable to obtain volume discounts because they are powerless to channel patients to selected providers. In addition, they believe that AWP laws reduce quality of care because increases in the number of providers in a network make care more difficult to monitor and coordinate.

Evolution Of The Laws

AWP and FOC laws are pervasive. Yet they are a relatively new phenomenon, and there is little evidence on their impact. Existing studies apply only to AWP laws, and these studies base their conclusions on actuarial and descriptive models. AWP and FOC
laws do not apply to managed care plans that sign exclusive contracts with a network of providers. Thus, they do not apply to group/staff-model health maintenance organizations (HMOs).

**HMO Act of 1973.** The federal HMO Act of 1973 includes provisions to override state laws that hinder the growth and development of HMOs. In particular, the act prohibits state laws from requiring that “all physicians, or a specific percentage of physicians in the locale participate or be permitted to participate in the provision of services for the entity."² For this reason, most AWP and FOC laws that include physicians do not apply to federally qualified HMOs.

This act was amended in 1988 to include a “catch-all” provision that overrides all state laws otherwise not enumerated in the 1973 legislation that obstruct the creation or operation of federally qualified HMOs.³ The scope of these amendments has not been tested in court. Nonetheless, the act has no doubt deterred many states from applying their AWP and FOC laws to federally qualified HMOs.

**State laws.** The first state to enact an AWP law was Wisconsin in 1980, and it applied only to pharmacy services.⁴ Today, thirty-three states have passed either an AWP or FOC law. Eighteen states have AWP laws that apply to pharmacy services, and eight states have AWP laws that apply to hospitals and most other providers (including pharmacies). Fifteen states have FOC laws, and each of these laws applies to pharmacy services.

Independent pharmacists have been particularly successful in convincing state legislatures that their survival is dependent on legislative protection. State legislatures tend to be sympathetic to the needs of small business, and there is evidence that many independent pharmacies are in financial distress. Data from the American Pharmaceutical Association indicate that about 5 percent of the 30,000 independent pharmacists in the United States go out of business each year.⁵ Much of the pharmacy business in recent years has shifted to large chains that combine discount drug pricing with a broad range of other retail goods.

Alabama passed a statute in 1988 prohibiting selective contracting with pharmacists that included both an FOC provision and an AWP provision. The wording in this statute is illustrative of many other AWP and FOC provisions:

No health insurance policy or employee benefit plan which is delivered, renewed, issued for delivery, or otherwise contracted for in this state shall: (1) Prevent any person who is a party to or beneficiary of any such health insurance policy or employee benefit plan from selecting the pharmacy or pharmacist of his choice to furnish pharmaceutical services, including without limitation, prescription drugs, offered by said policy or plan or interfere with said selection provided the pharmacy or pharmacist is licensed to furnish such pharmaceutical services in this state; or (2) Deny any pharmacy or pharmacist the right to participate as a contracting provider for such policy or plan provided the pharmacist is licensed to furnish pharmaceutical services, including without limitation, prescription drugs offered by said policy or plan.⁶

Of the twenty-six states with an AWP law, eight (Arkansas, Idaho, Indiana, Kentucky, Utah, Virginia, Washington, and Wyoming) apply the law to hospitals and most other providers, and the growth of managed health care in these states has been slow. Of these eight states, only Utah had more than 20 percent of its population enrolled in HMOs in 1993.⁷

**Recent developments.** Much of the legislative activity related to AWP and FOC laws in 1993 and 1994 emerged in response to concerns by health care providers about the possibility that federal health care legislation would preempt state laws in this area. It was hoped that even if federal health care reform legislation were to do that, existing AWP/FOC legislation might be exempted.

The demise of prospects for federal health care reform legislation has not reduced efforts to pass AWP and FOC laws. In 1994 AWP bills were introduced in twenty-five states and FOC bills in twelve states. In all, twenty-nine states had AWP or FOC bills submitted in 1994, and a recent survey of members of the Group Health Association of America revealed that AWP and FOC legislation was their main legislative concern in 1995.⁸

Kentucky’s AWP law was the only law
passed in 1994 that applies to all, or nearly all, providers. Although eleven states passed AWP laws and four states passed FOC laws in 1994, efforts to pass comprehensive AWP laws failed in Connecticut, Maryland, Florida, and Colorado. Efforts in Connecticut, Florida, and Colorado failed, in part, as a result of opposition from the governor, and in each of these four states a coalition of insurers, HMOs, small businesses, and large corporations worked to defeat the bills.

Organized opposition. The legislative efforts of those who support AWP legislation endured a setback in July 1994 when the National Governors’ Association (NGA) unanimously approved a policy to resist AWP legislation. Part of the reason for this action may be that thirty-five states now rely on some form of managed care to contain the cost of their Medicaid programs. Another setback to AWP supporters has been the position of the hospital community. The American Hospital Association (AHA) opposes such laws because it believes that selective contracting is necessary to restructure the delivery system. However, the AHA has not actively lobbied against AWP legislation and does support the right of providers denied access to a network to receive a written explanation for the decision.

Businesses have generally opposed AWP legislation because they are concerned about its effects on their health plan costs. More than sixty businesses have joined with the Association of Private Pension and Welfare Plans, the ERISA Industry Committee, and the National Business Coalition on Health to support the development of managed care plans and to oppose legislation that restricts their ability to selectively contract.

Physicians. Although state medical societies invariably have supported AWP and FOC laws, the support of organized medicine at the national level has been less apparent. The American College of Obstetrics and Gynecology and the American Academy of Pediatrics have refused to take a position on AWP legislation, while the American Academy of Family Physicians has taken a public stand against it.

The American Medical Association (AMA) supports the passage of a prototype for legislation in this arena referred to as the Patient Protection Act. Although this act does not guarantee a provider access to the network of a managed care plan, it would make it more difficult for a managed care plan to terminate a contract with an existing provider or to refuse to sign up a willing provider.” The AMA maintains that the Patient Protection Act is not an AMP law, although it is often characterized as such by opponents.

The Patient Protection Act establishes a process that managed care plans must follow before terminating a physician’s contract. This process requires that the physician be provided adequate notice of the impending action, that there be an opportunity for discussion about the reasons for termination, and that the applicant have the opportunity to enter into a “corrective action plan.”

Action in 1995. AWP legislation was introduced in more than twenty states during the first six months of 1995; it was defeated in seven of those states, it passed in two states, and it is pending in the remaining states. Wyoming extended its AWP law to include HMOs (it previously applied only to preferred provider organizations), and Gov. Jim Guy Tucker (D) of Wyoming signed the Arkansas AWP legislation into law 1 March 1995. The Arkansas law is a broad-based law that applies to hospitals, physicians, and many other types of providers. Governor Tucker did not take a position on the AWP bill while it was being considered by the legislature and did not publicly indicate that he would sign the bill until several weeks after it was passed. The penetration of managed care in Arkansas is quite low, and only a few Arkansas managed care organizations lobbied actively against the AWP bill.

In early 1995 Gov. Parris N. Glendenning (D) of Maryland signed a law that requires HMOs to provide a point-of-service option. In June 1995 the Texas state legislature passed a version of the Patient Protection Act, which was vetoed by Gov. George Bush Jr. (R). And in August 1995 Gov. George E. Pataki (R) of New York signed a bill that enables enrollees in managed care plans to obtain care from physicians outside the plan’s provider network.
Impact Of Selective Contracting

Although there is limited evidence on the impact of AWP and FOC laws on managed care plans, I have examined their effect on administrative costs (process effects); the price health plans pay to health care providers (price effects); and the use of health services (practice effects).

**Process effects.** To the extent that AWP laws result in an increase in the number of providers in a network, the processing costs of plans increase. FOC laws do not affect the ability of managed care plans to select providers for their network, and thus it is assumed here that these laws do not increase the average size of provider networks.

For each provider who applies for membership, a managed care plan must conduct a background investigation to ensure that the provider is qualified to perform in the capacity indicated on the application. If an applicant is approved for membership, the new member and the managed care plan sign a contract, and the new member must learn the practices and procedures of the network. In addition, the plan must constantly review and evaluate the performance of each member to ensure that the network’s procedures and policies are being followed. These activities entail some cost to the plans.

In 1994 Atkinson and Company updated a 1991 report by the Wyatt Company on the cost of eliminating selective contracting. The updated report is based on information obtained from telephone interviews with staff from ten large managed care organizations whose membership exceeds eight million persons. Staffing and resource models that were developed indicated that implementation of an AWP law—which in effect eliminates selective contracting—would increase the administrative costs of the typical managed care organization by 43 percent. It also was estimated that administrative costs account for 3 percent of the total cost of managed care organizations. Thus, this study implies that elimination of selective contracting would increase the total costs of operating a managed care plan by 1.3 percent (3 percent X 0.43).

**Price effects.** To the extent that AWP and FOC laws limit managed care plans’ ability to funnel patients to specific providers, these laws lessen the plans’ power to obtain volume discounts. The precise amount of the volume discount received by a managed care plan for a particular product (for example, physician care, chiropractic services, hospital care, or drugs) is a function of many factors, including size of the plan’s network, supply of providers of the product in the relevant market area, and demand for the product in the relevant market area.

In health care markets characterized by a surplus of providers, it has been relatively easy for managed care organizations to obtain volume discounts. The Congressional Budget Office (CBO) found that staff- and group-model HMOs reduce enrollees’ health spending by 15 percent compared with traditional indemnity insurance, and that half of these savings are due to lower utilization and half to price discounts.16

A May 1994 study by Lewin-VHI found that individual practice association (IPA)-model HMOs operated by Aetna cost 28 percent less than Aetna’s traditional indemnity plans in 1992, and that 8 percent of these savings were attributable to reduced utilization and 20 percent to price discounts.17 The actuarial model used by Aetna to set prices for its IPAs and indemnity plans was used to derive this estimate.

The magnitude of volume discounts for drugs may be larger than that for other services. A recent study by Abt Associates that collected information from interviews in February 1994 with 100 pharmacists (eighty independent pharmacies and twenty chain pharmacies) and all Massachusetts HMOs revealed that the average charge for the ten most frequently dispensed prescription drugs was 66 percent lower at the HMOs than at independent and chain pharmacists.18

**Practice effects.** Inasmuch as it is clear that managed care plans enjoy price discounts because they are able to increase a provider’s volume of business, it is far more difficult to ascertain precisely what attributes of a managed care plan are responsible for lower utilization, and what the contribution of each attribute is to the overall reduction (for example, what are the roles of se-
lective contracting, financial and nonfinancial incentives facing physicians, enrollee characteristics, and physician characteristics in lowering utilization?).

Nonetheless, managed care plans use information about the utilization patterns of physicians to help them determine who should be permitted to join their network, and it is evident that some portion of the savings enjoyed by managed care plans results from their selection of physicians who are low users of health services. It also is possible that the enactment of AWP legislation could have an adverse effect on the provision of care outside of the preferred provider networks. If physicians adjust their practice styles to improve their likelihood of being permitted to join managed care plans, then the enactment of AWP legislation could increase the cost of care provided for both managed care and traditional indemnity plans.

Although it is not possible to ascertain how much impact the passage of AWP legislation would have on the cost of operating a managed care plan, the Federal Trade Commission opposes the passage of AWP provisions because it maintains that selective contracting enhances competition among providers and reduces cost.

Need For Further Study

The obvious limitations of the available information about the impact of AWP and FOC laws are a testament to the need for more research in this area. Indeed, there are no studies of the impact of FOC laws, and the few existing studies of AWP laws do not compare the experiences of health plans in states with and without an AWP law.

The eight states with comprehensive AWP laws are ideal sites in which to collect information. However, only Utah and Virginia implemented their comprehensive AWP law before October 1993. Thus, it has become feasible only recently to obtain data on the experiences of health plans in states with comprehensive AWP laws.

Without information from states with AWP laws, analysts have compared managed care plans to fee-for-service plans in states without AWP laws. Yet managed care plans differ from fee-for-service plans in many other respects than in their use of selective contracting. Thus, analysts have attempted to adjust for differences that influence costs and then have assumed that the residual is attributable to managed care plans’ ability to contract selectively with providers.

No studies have the necessary information to adjust for each of the differences between managed care plans and fee-for-service plans that affect costs (for example, no studies have data on the health status of enrollees, the propensity of enrollees to use services, and whether enrollees are covered under the health insurance policy of a family member). Furthermore, it is unclear how AWP laws affect the ability of managed care plans to specify networks of providers.

Studies of the impact of AWP laws assume that they eliminate entirely the ability of managed care plans to contract selectively, and that the cost of AWP laws may be measured by the difference in costs between managed care plans and fee-for-service plans after adjusting for other factors that affect costs. However, this assumption is not bolstered by empirical evidence.

With information from states with AWP laws, analysts could compare managed care plans in states with these laws to managed care plans in states without them. The conclusions of such studies would not be based on the assumption that AWP laws entirely eliminate the ability of managed care plans to contract selectively. Such studies, however, would need to adjust for characteristics of managed care plans that affect costs (such as deductibles, copayments, breadth of coverage, health status of enrollees, propensity of enrollees to use health services, and whether or not enrollees were covered under the policy of a family member).

With information from states with AWP laws, analysts also could compare the costs of specific managed care plans before and after the implementation of an AWP law. The advantage of this approach is that it obviates the need to collect information about all of the characteristics of different
managed care plans that affect the cost of care. Its disadvantage is that the impact of the AWP law may be confounded by changes in the market area or in the managed care plans that occurred during the time period the AWP law was enacted.

Although little information exists about the impact of AWP and FOC laws on the cost and quality of health care, the number of states with AWP and FOC laws is increasing each year. Managed care plans contend that these laws limit their ability to funnel patients to specific providers and to obtain price discounts from these providers. In addition, they maintain that these laws reduce quality and inhibit competition among providers. Providers maintain that these laws are necessary to ensure that managed care plans deal fairly with physicians, and that they enhance quality because they ensure that patients are able to maintain relationships with their physicians. Until such time as convincing evidence about the impact of AWP and FOC laws on the cost and quality of care is available, public policymakers must rely on their own good judgment when balancing the advantages and disadvantages of this legislation.

NOTES

2. 42 U.S.C., Section 300e-10. See especially Section 300e-10(a)(1)(c).
17. D.C. Stapleton, New Evidence on Savings from Network Models of Managed Care, submitted to the Healthcare Leadership Council (Fairfax, Va.: Lewin-VHI, 5 May 1994).
18. “Contracting HMOs Save 66 Percent on Drug Prices” (Press Release, Massachusetts Association of HMOs, Boston, Massachusetts, 12 May 1994).