Any Willing Provider: An Unacceptable Risk for a Marginal Gain

Samuel Sutton

It is no secret that many Americans are less than happy with their health care coverage – either due to a total lack of coverage or simply a lack of choice and flexibility within their current plan. The latter objection is often a feature of the coverage afforded by Managed Care Organizations (MCOs), also commonly known as Health Maintenance Organizations (HMOs). These plans usually restrict a patient’s choice of doctors in exchange for lower monthly premiums. In response to frustrated patients and citizens, legislation titled Any Willing Provider has been introduced in several states, which aims to curb the ability of an HMO to control patient access to the healthcare market. While the goals of this type of legislation seem noble and logical on their face – allowing patients to have their choice of doctors and not allowing companies to restrict access to the market – the unintended consequences of these laws could easily outweigh their benefits. By undermining an HMO’s cost-saving techniques, America runs the risk of increasing the number of uninsured citizens. This report will outline the issues and debates surrounding the MCO/HMO industry in America as well as the Any Willing Provider movement. It will then argue that this kind of legislation, while desirable on its surface, demonstrates a potential for negative consequences, which may be too much of a risk to our healthcare system.

INTRODUCTION

The United States healthcare system is among the most envied in the world. People who can afford to go anywhere for care come to America first; even patients from Canada, where healthcare is free for citizens, often jump across the border to get specialized treatments in the U.S., despite the high extra cost. So how could the healthcare system in the U.S. rank 37th in the world in overall performance, according to the World Health Organization’s (WHO) 2000 Report (World Health Organization, 2000)?

The problem is not the healthcare itself, but rather the sheer lack of accessibility. Healthcare in the United States is also the most expensive in the world, both per capita and as a percentage of GDP, and while this translates into exceptional care for those who can afford it, those who cannot are often left with less than desirable coverage, if any at all. Roughly 16% of Americans now find themselves uninsured (about 45 million people as of 2003), and the cost for a business to provide health coverage for an individual employee has risen to almost $7,000 annually (By the numbers insurers/managed care, 2004, p. 38). This makes for a burdensome overhead which falls squarely on the shoulders of American companies – a feature that is rather unique among industrialized countries.

Addressing some of these issues has been the primary mission of the Managed Care Organization (MCO) movement in the United States; to offer adequate healthcare or health insurance for a more affordable price. Unfortunately, no system is perfect, and with the lower costs associated with MCOs come some inevitable trade-offs, most notably patients a lack of choice about which doctors they can see. Many patients, doctors, and politicians have therefore striven to mitigate this (and other) problems by pushing for the enactment of Any Willing Provider (AWP) legislation, which restricts MCOs from forming the highly exclusive networks that save money, but exclude doctors and restrict patient choice.

This report will first outline the history, impact and general structure of the American MCO industry, as well as their benefits and drawbacks. It will then describe how Any Willing Provider laws work, what they are designed to achieve, and the legal history and challenges they have faced. Arguments for both sides of the issue will then be presented, followed by a summary of available evidence and a discussion and analysis of the issue in order to determine what kind of effects these kind of laws can be expected to have, if any.

Much like the system, no solution is perfect, and this essay will contend that the unintended consequences of forcing patient choice on the MCO industry are likely to only make healthcare more expensive in the United States, forc-
ing more people into the uninsured category and further raising the overhead costs for American businesses. With so many Americans lacking coverage already and health costs constantly rising faster than median incomes, we simply cannot afford to risk undermining MCOs, which have proven themselves to be one of the few solutions to date that have been able to reliably curb rising prices. AWP may solve some minor healthcare problems, but unfortunately it runs an unacceptable risk of making the bigger ones even worse – something that America simply cannot afford.

**History and Impact of the MCO Industry**

The National Center for Health Statistics (NCHS) defines managed care as “…where care is provided under a fixed budget and costs [is] therein capable of being ‘managed’” (NCHS, 2004b). The managed care movement in the United States can trace its roots back more than 50 years, but it did not have much impact until the early-to-mid 1970s. Healthcare costs had begun to rise faster than the economy could keep up with, so Congress, with the help of the Nixon Administration, passed the Health Maintenance Organization Assistance Act in 1973. The Act provided a host of economic incentives and advantages to the MCO industry, thereby thrusting it to the forefront of the American healthcare system. Despite the fact that many of the economic advantages set forth in the Act have since expired, MCOs have had a visible impact on the market ever since. Today, it is estimated that roughly 80% of those Americans who get health coverage through their employer are covered by such a system (Carroll, 2002, p. 927). They have become especially popular among business owners because they usually offer lower premiums than most other health insurance providers. Overall, MCOs are now responsible for providing healthcare or health insurance to roughly half of the American population (By the numbers, 2004, p.1).

There is much evidence that these MCOs have been at least somewhat effective in holding down the cost of healthcare in America. During much of the 1990s, when MCOs became truly significant players in the market, the rate of healthcare cost increases slowed to the lowest levels in decades, increasing by only 4.8% in 1997 (American Association of Health Plans, 1999, p.1). Research has also indicated that a ten percent increase in the market share of HMOs is attributable to a 6.6% decrease in insurance premiums (AAHP, p.1). In addition, the Congressional Budget Office estimated, in a 1995 report, that if 70% of the population had been enrolled in “effective HMOs” in 1990, national health costs would have actually fallen by 8.3%. Several other studies have found that states which have a relatively higher percentage of their population enrolled in MCOs experience lower rates of increase in their overall healthcare costs than states that have relatively fewer enrolled in managed care (Sheils, Stapleton and Haught, 1995, p. vi). Table 1 illustrates the average annual rate of increase in personal health expenditures in the United States and Table 2 illustrates total national membership in MCOs.

**Table 1**

*Growth in personal healthcare expenditures – average annual percent increase*

<table>
<thead>
<tr>
<th>Year</th>
<th>Percent Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>1960-65</td>
<td>8.2</td>
</tr>
<tr>
<td>1965-70</td>
<td>12.7</td>
</tr>
<tr>
<td>1970-75</td>
<td>12.3</td>
</tr>
<tr>
<td>1975-80</td>
<td>13.7</td>
</tr>
<tr>
<td>1980-85</td>
<td>11.7</td>
</tr>
<tr>
<td>1985-86</td>
<td>8.7</td>
</tr>
<tr>
<td>1986-87</td>
<td>9.6</td>
</tr>
<tr>
<td>1987-88</td>
<td>11.3</td>
</tr>
<tr>
<td>1988-89</td>
<td>10.6</td>
</tr>
<tr>
<td>1989-90</td>
<td>11.7</td>
</tr>
<tr>
<td>1990-91</td>
<td>10.3</td>
</tr>
<tr>
<td>1991-92</td>
<td>8.5</td>
</tr>
<tr>
<td>1992-93</td>
<td>6.4</td>
</tr>
<tr>
<td>1993-94</td>
<td>5.2</td>
</tr>
<tr>
<td>1994-95</td>
<td>6</td>
</tr>
<tr>
<td>1995-96</td>
<td>5.2</td>
</tr>
<tr>
<td>1996-97</td>
<td>5.3</td>
</tr>
<tr>
<td>1997-98</td>
<td>5.3</td>
</tr>
<tr>
<td>1998-99</td>
<td>5.5</td>
</tr>
<tr>
<td>1999-2000</td>
<td>6.6</td>
</tr>
<tr>
<td>2000-01</td>
<td>8.7</td>
</tr>
<tr>
<td>2001-02</td>
<td>8.7</td>
</tr>
<tr>
<td>2002-03</td>
<td>7.3</td>
</tr>
</tbody>
</table>

Source: National Center for Health Statistics (NCHS, 2004a).

Note: these figures are for personal health expenditures, not insurance premiums. However, national trends on health insurance premiums follow a similar pattern, with the lowest rates of increase occurring during the mid-to-late 1990s, followed by an increase after 2000. The data on personal expenditures was used because they were more expansive and more readily available from a reliable governmental agency.
The two tables above illustrate the connection between MCO market penetration and the rate of personal healthcare costs. From 1990 – 2000, the rate of growth of personal health expenditures was, on average, the lowest among all available data. Simultaneously, those years saw the largest rate of growth in MCO market share and the largest total percentage of the population enrolled. Furthermore, a recent, general movement away from MCOs after the year 2000 has seen a new resurgence in personal healthcare costs. This impact has been especially significant given that few other options have been effective—or even available, for that matter—to help curb the steady increase of healthcare costs in America, which have consistently out-paced economic inflation.

### How MCOs Work

There are basically two general types of MCOs: Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). (While every organization differs in exactly how they are administered and managed, for the purposes of this paper they will all be generally referred to as MCOs, since they usually share a common set of general, basic traits, unless otherwise specified. However, the actual terms and definitions used to define different programs differ depending on each particular source, with many simply using the blanket term HMO to refer to most organizations that manage patient care.)

HMOs form the bulk of MCOs. They saw a steady rise in enrollment throughout part of the 1980s and all of the 1990s, topping out with 30.1% of the population enlisted in 1999 – roughly 81 million Americans (Enrollment in health maintenance organizations, 2004). Enrollment has since started to decline slightly, but it is estimated that HMOs still provide health coverage for at least a quarter of the American population.

In addition to providing insurance services, HMOs commonly own (or employ exclusively) specific doctors, clinics, and even entire hospitals. Therefore, patients insured by an HMO are usually covered only when they attend providers that are part of this “network”. This network of doctors, specialists and hospitals is usually tightly controlled and regulated by the HMO. All members of the network are subject to the terms of the contract they hold with the HMO, which often spells out which procedures will be covered and how much the company will pay for them. Members of the network are also required to meet and maintain certain standards of quality — thus allowing the HMO to guarantee quality care regardless of which doctor the patient sees.

Since the HMO gets to decide which procedures will be covered and when, they can cut what they believe is unnecessary or ineffective care out of their coverage. If the HMO decides that a patient does not, in fact, need a procedure that they—or even their primary physician—want done, the HMO will usually refuse to pay. HMOs can also dictate which kind of treatment a patient receives; if several different types are available, the HMO can choose to offer or cover only one or some of them, allowing them to choose the one that costs the least or offers the highest medical benefits and/or financial rewards. (In the classic model, these decisions were made by a panel of doctors at the top of the organization, but recently these executive boards have become increasingly dominated by administrators, not actual care providers.)

PPOs operate in much the same way as HMOs, but do not usually own (or even necessarily contract with) the doctors or hospitals in their network. The providers who wish to be members of this network must simply agree to the terms of the contract set forth by the PPO, rather than being directly employed. These plans often include many financial and quality stipulations that are similar to HMO agreements, as members on a PPO’s panel must agree to certain reimbursement rates for their services and uphold certain standards of quality. Also, since they are not directly employed by the PPO, panel members are somewhat more autonomous than their HMO counterparts, and are thus often granted more leniency in referring patients to specialists. However, PPOs are often slightly less involved in the care of their patients, doing less than HMOs in terms of keeping up on their patients’ medical treatments and history. This is largely due to the more autonomous nature of the plan’s providers and

### Table 2

<table>
<thead>
<tr>
<th>Year</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1976</td>
<td>2.8</td>
</tr>
<tr>
<td>1980</td>
<td>4</td>
</tr>
<tr>
<td>1985</td>
<td>8.9</td>
</tr>
<tr>
<td>1990</td>
<td>13.4</td>
</tr>
<tr>
<td>1995</td>
<td>19.4</td>
</tr>
<tr>
<td>1998</td>
<td>28.6</td>
</tr>
<tr>
<td>2000</td>
<td>30</td>
</tr>
<tr>
<td>2003</td>
<td>24.6</td>
</tr>
<tr>
<td>2004</td>
<td>23.4</td>
</tr>
</tbody>
</table>


Note: the report by the NCHS lists several different types of HMOs, all of which are included in the statistics cited above. The NCHS uses the following definition for their report:

HMO: “a health care system that assumes or shares both the financial risks and the delivery risks associated with providing comprehensive medical services to a voluntarily enrolled population in a particular geographic area, usually in return for a fixed, prepaid fee.” This definition, in practice, encompasses almost all MCOs as they are defined in this report. Therefore, the term MCO has been substituted into this table, as it is interchangeable for the purposes of this report.

The two tables above illustrate the connection between MCO market penetration and the rate of personal healthcare costs. From 1990 – 2000, the rate of growth of personal health expenditures was, on average, the lowest among all available data. Simultaneously, those years saw the largest rate of growth in MCO market share and the largest total percentage of the population enrolled. Furthermore, a recent, general movement away from MCOs after the year 2000 has seen a new resurgence in personal healthcare costs. This impact has been especially significant given that few other options have been effective—or even available, for that matter—to help curb the steady increase of healthcare costs in America, which have consistently out-paced economic inflation.
their lower level of involvement with the PPO’s administrative and oversight functions. Still, like HMOs, patients of PPOs are usually restricted to attending only the providers that are a part of the network. Table 3 illustrates HMO membership distribution across three different types of HMOs (as defined by the NCHS).

**TABLE 3**

Percent of enrollees per type of plan as a percentage of total HMO members

<table>
<thead>
<tr>
<th>Year</th>
<th>IPA*</th>
<th>Group</th>
<th>Mixed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1976</td>
<td>6.6</td>
<td>93.4</td>
<td></td>
</tr>
<tr>
<td>1980</td>
<td>18.7</td>
<td>81.3</td>
<td></td>
</tr>
<tr>
<td>1985</td>
<td>30.4</td>
<td>69.6</td>
<td></td>
</tr>
<tr>
<td>1990</td>
<td>41.6</td>
<td>58.4</td>
<td></td>
</tr>
<tr>
<td>1995</td>
<td>39.4</td>
<td>26</td>
<td>34.5</td>
</tr>
<tr>
<td>1998</td>
<td>42.6</td>
<td>18</td>
<td>39.2</td>
</tr>
<tr>
<td>2000</td>
<td>41.3</td>
<td>18.9</td>
<td>39.9</td>
</tr>
<tr>
<td>2003</td>
<td>38.9</td>
<td>22.4</td>
<td>38.7</td>
</tr>
<tr>
<td>2004</td>
<td>35.8</td>
<td>22.2</td>
<td>42</td>
</tr>
</tbody>
</table>


Note: the following definitions are used by the NCHS in this report:

*Individual Practice Association: a healthcare provider organization composed of a group of independent practicing physicians who maintain their own offices and band together for the purpose of contracting their services to HMOs, PPOs, and insurance companies.

Group Model HMO: an HMO that contracts with a single multispecialty medical group to provide care to the HMO’s membership.

Mixed Model HMO: combines features of more than one HMO model.

For the purposes of this report, most IPAs could be defined as PPOs and most Group Models as HMOs. Due to the differences in how each MCO operates as well as differences in the definitions used, the definitions and data results may vary.

**PROS AND CONS OF THE MCO INDUSTRY**

In exchange for all the obligations and restrictions placed on them by MCOs, doctors and hospitals that choose to join the network get something in return: patients. Providers who are members of an HMO or PPO usually get exclusive access to the patients insured by the organization. In exchange for adhering to their end of the deal – namely price discounts and quality standards – doctors are promised a certain volume of patients by the MCO. If, for example, an MCO has five doctors on their panel and 100 patients, they can guarantee 20 patients to each provider. This allows doctors and hospitals to accept the rates set forth by the MCO, which are often lower than rates found in the open healthcare market, since they are being fed a guaranteed number of patients without the need to recruit or advertise. This volume discount is therefore one of the most powerful tools MCOs have in keeping healthcare costs low. Also, doctors and clinics can usually cut down on their administrative costs dramatically by becoming members of an MCO. Since many patients will be coming from the same organization, the healthcare provider does not have to spend as much time dealing with the different procedures and bureaucracies of various insurance companies, which can be in itself a very complicated and time-consuming challenge.

However, in order to guarantee a certain volume of patients to their providers, MCOs can only accept a certain number of doctors and clinics into their system. This is why they are often referred to as closed-panel organizations; the number of patients insured by the program usually dictates provider membership in the network. If the MCO hires on too many doctors, they will not have enough patients to spread around to keep all of the providers satisfied, and therefore will not be able to negotiate such deep discounts. This is the trade-off for consumers covered by an MCO: choice. Since their health insurance will only cover procedures administered by a member of the network or panel, patients who do not want to pay for the treatment themselves must go to one of the providers on the list – and a general rule of thumb in the insurance industry is the lower your insurance premiums, the shorter your list of approved doctors will be.

These restrictions can create a tough set of problems for those insured by an MCO. If a patient’s preferred doctor is not a member of the closed panel, their insurance will simply refuse to pay for the clinic’s services – regardless of any pre-established personal or professional relationships. This presents an especially problematic dilemma when an employer decides to switch the company’s health coverage from one insurer to another (or even sometimes just switch plans within the same company). If an employee’s current doctor is not covered by the new health plan, they are forced to switch to someone who is – unless, of course, they want to pay for the continued service out of their own pocket.

Mandating this kind of switch in personal physicians can incur other costs as well. When one doctor’s office has been caring for a patient for a long time, they have accumulated not only a personal and professional relationship with that patient, but also a plethora of past medical records. Transferring these physical files can sometimes be only a minor hassle, but transferring the personal and professional relationship and knowledge is obviously another matter. If the patient’s medical history does not become familiar to the new physician even more serious problems can occur, such as allergic reactions or even a misdiagnosis of symptoms which arise under some pre-existing condition.

Furthermore, this lack of choice can be an especially tough problem for those in rural areas – or, for that matter, anyone who is not located geographically close to a provider of their MCO. There may be a clinic or doctor’s office just
down the road, but if they are not on the panel of a patient's MCO, that patient will have to pay for their services out-of-pocket.

Sometimes, patients in emergency situations can run into problems as well. While MCOs recognize emergency care and will cover the cost of essential emergency care (often this is a legal requirement), patients that require an imminent procedure but can stand to be transferred first, will sometimes be moved to a participating provider to receive treatment. Other times, a patient awaiting treatment can be made to wait until the participating doctor returns to work, even if another, equally qualified doctor is available. In some cases, the delay or transfer before receiving treatment can incur some further medical problems, and usually carries some additional financial cost. At any rate, it seems illogical and unnecessary that a patient should be made to wait or be moved before treatment if there is another qualified doctor or hospital just standing idly by.

Given all of these potential benefits as well as drawbacks, Americans usually find themselves facing a tough choice: lower insurance premiums through an MCO or expanded choice of providers through standard indemnity insurance – commonly known as fee-for-service. This model allows patients to see whomever they want, leaving the provider responsible for billing the insurance company directly. However, since about 63% of Americans who have insurance receive it through their employer, there is often little choice available to them as to where they get their coverage (Congressional Budget Office, 2003, p.1).

**ANY WILLING PROVIDER**

Solving these pesky problems of patient choice and physician access has been the major stated goal of Any Willing Provider legislation. The first laws of this kind were passed in the early and mid-1980s, but most of them were passed in the 1990s, mostly on the coat-tails of the national debate on healthcare started by the proposed Clinton-era reforms. These laws, in general, require an MCO to either accept into their panel any healthcare provider willing to meet the terms of the contract or just outright pay for services rendered by out-of-network providers, regardless of network membership. (The latter is sometimes referred to as Freedom of Choice (FOC) or Mandatory Point-of-Service (MPOS) legislation, but for the purposes of this paper both types of legislation will be generally referred to as AWP, unless otherwise specified). Therefore, by requiring health plans to cover procedures performed by out-of-network providers, AWP legislation strives to restore patient choice and prevent the mandatory switches in care providers that have long been a point of contention. AWP would also alleviate the problems faced by those rural patients who sometimes find themselves somewhat isolated from the nearest in-network provider.

**ANY WILLING PROVIDER IN UTAH**

During the Utah Legislature's 2005 General Session, Senator Chris Buttars sponsored Senate Bill 34 – Patient Access Reform. The bill was proposed several years prior and had failed under the moniker of being only an amendment to the state's reimbursement laws, but Sen. Buttars brought it back anew in 2005 under a fresh slogan: Any Willing Provider (Buttars, 2005).

Actually, the bill is merely an amendment to Utah's already existing reimbursement law, or Freedom-of-Choice (FOC) law as it could be known. However, the current Utah law is, for all intents and purposes, useless. Utah Code Section 31A-22-617 stipulates that an insurance provider must pay for the services rendered by an out-of-network provider, but it only requires that "the insurer shall reimburse the insured for at least 75% of the average amount paid by the insurer for comparable services of preferred health care providers who are members of the same class of health care providers" (Utah Code, Sec. 31A-22-617). As a customer of an MCO, then, a patient must follow several steps; first pay for the services of an out-of-network provider out-of-pocket, and then request reimbursement from their insurance company. Then, once they get the reimbursement check, the amount is still only 75% of the average cost for that procedure, which is usually substantially lower than their original out-of-pocket costs.

Senate Bill 34, had it passed, would have amended that section of the Utah Code to change the reimbursement rate and created another section requiring an MCO to make the payment for services rendered directly to the provider, therefore no longer requiring the patient to seek reimbursement themselves. It would have further stipulated that the MCO pay up to 95% of what they would otherwise pay for the same procedure to one of their in-network providers. Therefore, SB 34 would have a discount built in for MCOs; they could save that 5% on their normal reimbursement rate when patients go to an out-of-network provider. The only catch would be whether the chosen doctor or clinic would be willing to accept that particular reimbursement rate. Supporters of the Utah bill argue this discount would prevent MCOs from having to pay higher prices and, in turn, forcing them to raise their premiums.

**LEGAL CHALLENGES**

Any Willing Provider laws have faced a substantial amount of legal trouble during their tenure, leaving several laws overturned completely and many others caught in tough battles for several years. Many of these challenges have arisen from an alleged conflict with a federal statute known as the Employee Retirement Income Security Act (ERISA). Passed by Congress in 1974, this law was designed to protect consumers and their retirement assets, at that time accumulated primarily in pension plans, from abuse. Providers of such plans must meet several requirements: they must disclose most of their...
Any Willing Provider: An Unacceptable Risk for a Marginal Gain

Samuel Sutton

plan's terms and conditions; provide coverage to at least a certain proportion of employees; provide for accountability of the plan's "fiduciaries" (or financial stewards); allow participants to sue over alleged abuses or lack of benefits; and provide for their plans to pay out a certain level of benefits if they go under.

When ERISA was passed, Congress stipulated that "ERISA would pre-empt all state laws insofar as they may now or hereafter relate to any employee benefit plan except that those state laws which regulate insurance, banking or securities are saved from pre-emption" (Blumenreich, 2003, p. 260). In other words, the federal concept of pre-emption (that federal laws override any state laws that may create a conflict) applies to laws that regulate employee benefit plans — but it does not apply if they regulate insurance. This definition of pre-emption by ERISA was used during the 1990s to overturn some AWP laws (such as in Virginia, Kentucky and Massachusetts, when these courts decided that the laws regulated benefit plans, not insurance providers), but uphold others (such as in Virginia, Kentucky and Massachusetts, when these courts decided that the laws regulated insurance providers, not employee benefit plans) (Butler, 2003, p.2).

THE KENTUCKY AWP CASE – KENTUCKY ASSOCIATION OF HEALTH PLANS V. MILLER.

In 1994, the Kentucky Legislature passed the Kentucky Healthcare Reform Act, which contained its own version of Any Willing Provider. The Kentucky law is one of the broadest AWP statutes to date, as it required MCOs to accept into their panel any provider willing to meet the terms of the contract. Only a few exceptions were made, and the law applied to virtually all classes of healthcare providers and treatments. The statute has become arguably the most studied and cited law of its kind to date, partially due to its lengthy and eventually triumphant legal battle and the importance of the precedent that it subsequently established.

The challenge to AWP contained in Miller arose out of a perceived conflict with ERISA that was similar to previous cases. The association of HMOs that challenged the Kentucky AWP legislation alleged that the law applied to employee benefit plans, thus making it inapplicable in the face of ERISA. The State of Kentucky countered that the law regulated insurance, thus placing it under the pre-emption clause of ERISA and granting it exemption from the federal mandate.

The case went all the way to the Supreme Court, where the decisions of lower courts were upheld, as the justices unanimously agreed with the State of Kentucky. It was decided that Kentucky's AWP law regulated insurance, not employee benefits, and thus was exempt from the federal pre-emption of ERISA. While the court acknowledged that the law might affect healthcare providers — and thus those who provide employee benefits — it decided that the law "regulated insurance by imposing conditions on the right to engage in the business of insurance. A statute that imposed conditions on the right to be an insurer regulated the "business of insurance" (Blumenreich, 2003, p. 261). As a result of this 2003 decision, Kentucky's AWP law was upheld and one of the major legal obstacles utilized by AWP opponents was effectively nullified by the Supreme Court. Indeed, in the aftermath of the court's decision, the injunction against Arkansas' AWP law was lifted (Albert, 2004, p.1), and action on other states' laws is sure to follow.

COMMON ARGUMENTS FOR AND AGAINST AWP

Proponents of AWP legislation argue that the increased competition it will bring to the market will help drive down the cost of healthcare. They point out that by allowing the doctors on a specific network access to those patients only, the MCOs are stifling competition (as doctors that are under specific contracts with an MCO are often not allowed to see patients from outside the network). AWP proponents also present the issue as a patient-choice matter, arguing that letting an MCO's administrative panel dictate which doctors can be seen and which treatments will be approved, compromises market competition, and is thus bad for consumers. Proponents argue that denying patients the choice to see whomever they want for medical treatment is not putting their interests first, which should be a priority for the healthcare industry. This reasoning also extends to situations where patients are forced to change doctors, such as when their employer switches health plans or their physician is suddenly no longer a member of their MCO's panel. Not only is an established personal and professional relationship eroded, but the consequences previously discussed may be incurred. The previously discussed transportation problems faced by rural patients can also make for a strong case against closed panels. Finally, proponents of AWP often cite instances of certain treatments being denied to patients by their MCO's administration, even if they — and sometimes even their doctor — prefer it to other alternatives.

On the other hand, opponents of AWP legislation argue that this system undermines the cost-saving mechanisms employed by MCOs. If MCOs are required to accept all eligible doctors into their network, they may not be able to guarantee a sufficient number of patients to their panel, thus undermining their volume discount advantage. Another allegation is that AWP laws will undermine the ability of MCOs to manage the care their patients receive, potentially leading to unnecessary or redundant procedures. Opponents also argue that AWP may actually reduce healthy competition in the market, as providers currently must work to keep their costs low enough to participate, thrive, and profit within selective and competitive networks. Since there are often many providers trying to qualify to serve on an MCOs panel, the MCO gets to choose those that offer the highest quality services for the lowest price. Passing an AWP law would
Furthermore, the Carroll study is limited in its scope to examining the financial impact of AWP legislation on HMOs. The study focused on seven states where AWP laws were in place: Arkansas, Idaho, Kentucky, New Hampshire, New Jersey, North Carolina, South Carolina, South Dakota, Texas, and Wisconsin. These states were selected because they had AWP laws that were similar in nature and application.

The researchers went to great lengths to ensure that the data was representative of the states included in the study. They used statistical methods to control for the effects of differences in the regulatory environment, market structure, and demographic factors. The results of the study were reported in the December 2002 issue of the *Journal of Health Politics, Policy and Law*.

The study reached four distinct conclusions which support proponents of AWP legislation in varying degrees. Perhaps the most important for their argument is that “there is clear evidence that the increase in numbers of uninsured Americans can be partly tied to [legal] mandates.” They also cited the findings of another study that buttresses their conclusion: “The best work on this topic has been done by Sloan and Conover (1998), indicating that a fifth to a quarter of the uninsured are without health insurance because of state mandates.” (Jensen and Morrissey, 1999, p. 425); however the legal mandates that were included in the study covered a very wide variety of state and federal legislation – AWP being just one example. Other types of legislation included were state or federal mandates that, among other things, required health insurance plans to cover specific treatments, provide benefits in certain areas (such as dental or psychiatric), or simply to cover the costs associated with some specific conditions or diseases.

Unfortunately, unambiguous data supporting any one conclusion is rare at best. Members of both sides of the debate continually point to a plethora of studies done by various organizations, but there always seems to be some kind of string attached to each one. Other contributing factors are that most AWP legislation is fairly recent, and much of it has been tied up in various levels of the court system. Even the currently available data is rarely impervious to criticism.

With these caveats in mind, some of the most commonly cited studies over the past decade are:

**THE CARROLL STUDY.**

AWP supporters like to point out one particular study, published in the December 2002 issue of the *Journal of Health Politics, Policy and Law*, and entitled “Any-Willing-Provider Laws: Their Financial Effect on HMOs.” Conducted by Anne Carroll of Rider University and Jan M. Ambrose of La Salle University (and thus commonly referred to as “The Carroll Study”), it focused on two different types of AWP laws: those that applied only to pharmacies and those that applied to all healthcare providers. However, they kept their study limited only to AWP laws that explicitly affect HMOs. They studied the effects in seven states that apply the law to all healthcare providers (Arkansas, Idaho, Kentucky, Louisiana, Minnesota, New Mexico, and Wyoming), and thirteen that apply it only to pharmacies (Arkansas, Delaware, Georgia, Louisiana, Massachusetts, Mississippi, New Hampshire, New Jersey, North Carolina, South Carolina, South Dakota, Texas, and Wisconsin).

The researchers went to great lengths to ensure that the study accurately reflected an average HMO by controlling for differences in both the administrative structure of the HMOs and the markets they in which they operate. They acknowledge that many outside factors may influence the financial profitability of an HMO, and they were quite meticulous in controlling for these factors to determine the impact of AWP legislation. They concluded that “all-provider AWP laws do not appear to present a financial constraint to HMOs”, but do concede that “pharmacy AWP laws have a greater effect on the financial performance” (Carroll and Ambrose, 2002, p. 943). In other words, general AWP laws do not seem to have an effect on the profitability of HMOs that are subjected to them.

Initially, this conclusion does appear to support the claim made by proponents that AWP will not in itself raise costs in the healthcare market. After all, if their profitability remains the same, why would an HMO need to raise its premiums? Unfortunately, the findings in the Carroll study are not anywhere near conclusive, as the researchers admit:

> Because the scope of this study is limited to investigating how AWP laws affect HMO financial performance, we are unable to draw conclusions about the other effects that AWP laws may have in HMO markets. Whether AWP laws affect enrollment, market entry and exit, premium levels, physicians’ incomes, patient health, or patient satisfaction are some of the larger questions remaining for future research (Carroll and Ambrose, 2002, pp. 943-944).

The Carroll Study simply evaluated past data and concluded that AWP legislation did not directly impede the bottom line of HMOs – but the question of why that did not happen needs to be addressed. Perhaps AWP legislation really does not have a major effect on the functionality of HMOs, or maybe the industry has simply kept their bottom lines intact by increasing their premiums or co-payment levels.

**THE JENSEN STUDY.**

In January of 1999 the Health Insurance Association of America (HIAA) published a study entitled “Employer Sponsored Insurance and Mandated Benefit Laws”. Gail A. Jensen of Wayne State University and Michael A. Morrissey of the University of Alabama-Birmingham performed the study.

The HIAA asked Jensen and Morrissey “to examine the cost and consequences of [health] benefit mandates” (Jensen and Morrissey, 1999, p. 425); however the legal mandates that were included in the study covered a very wide variety of state and federal legislation – AWP being just one example. Other types of legislation included were state or federal mandates that, among other things, required health insurance plans to cover specific treatments, provide benefits in certain areas (such as dental or psychiatric), or simply to cover the costs associated with some specific conditions or diseases.

The study reached four distinct conclusions which support opponents of AWP legislation in varying degrees. Perhaps the most important for their argument is that “there is clear evidence that the increase in numbers of uninsured Americans can be partly tied to [legal] mandates.” They also cited the findings of another study that buttresses their conclusion: “The best work on this topic has been done by Sloan and Conover (1998), indicating that a fifth to a quarter of the uninsured are without health insurance because of state mandates.” (Jensen and Morrissey, 1999, pp. 453-454). Furthermore, the study found that this rise in costs “falls disproportionately on workers in small firms because these firms are less able to self-insure and avoid the consequences of the mandates.” They also concluded that “workers pay for such health insurance mandates in the form of lower wages”. (Jensen and Morrissey, p. 453). While this would tend to indicate that employers are passing on the higher costs of health insurance by lowering wages instead of (or before they are)
decreasing their insurance coverage, either outcome is undesirable and AWP critics cite both as reasons to oppose the idea.

However, it is important to remember that the Jensen study did not focus specifically on AWP legislation or even exclusively on only state-level mandates. Since AWP was a relatively small part of the study, one cannot conclude that AWP legislation by itself will cause the consequences cited in their conclusion. In addition, the authors find federal mandates have the greatest impact on the healthcare market, while AWP has only been enacted at the state level thus far (Jensen and Morrissey, 1999, p. 454). While the Jensen study does provide some ammunition for AWP opponents, it turns out to be rather inconclusive and far from irrefutable.

The Lewin-VHI Study.
The “Lewin-VHI Study” was completed and published in 1995, and despite its age, its findings are still important and are widely cited by AWP opponents. It was prepared for the Healthcare Leadership Council, the Alliance for Managed Care and the Health Insurance Association of America by the Virginia-based health firm Lewin-VHI, Inc. John F. Sheils, David C. Stapleton, and Randall A Haught conducted the study, entitled “The Cost of Legislative Restrictions on Contracting Practices: The Cost to Governments, Employers, and Families”.

The study focused solely on the costs associated with restricting the contracting practices of MCOs, thus making it one of the most relevant studies to date in the AWP debate. The study begins by citing several other studies, most of them also from Lewin-VHI, indicating that MCOs have been able to secure healthcare savings of up to 23% (Sheils et al., 1995, pp. ii-iii). That same data also indicates that the more restrictive a MCO plan becomes, the more savings it is able to secure.

The study goes on to say that “based upon an analysis of states that already have selective contracting restrictions, we estimate that this type of legislation has been associated with a substantial reduction in the growth of HMO enrollment in states with these laws” (Sheils et al., 1995, p. vi). One might assume that once an MCO is no longer able to restrict patient choice it would become more appealing to consumers – especially if it generally offered lower insurance premiums than other plans. Their analysis also indicates “the rate of growth in health spending generally declines as the percentage of the population enrolled in HMOs increases.” (Sheils et al., p. vi). Based on these findings, the authors projected that if AWP legislation were adopted across America in 1995, healthcare costs would have risen by $74.7 billion between 1996 and 2002. They went on to predict that under a national MPOS mandate (i.e. the type of law proposed in Utah), health costs would have risen by a staggering $92.8 billion in that same period (Sheils et al., p. viii).

However, the Lewin study admits that it is not fully conclusive, acknowledging “several important limitations in the data used”. “For example, [their] analysis of states with AWP legislation may underestimate the impact of these laws on HMO formation because many of these states have enacted only relatively limited forms of selective contracting restrictions affecting only certain groups of plans and providers.” (Sheils et al., 1995, p. xi). In other words, the differences between the various laws make it difficult to assess their impact in a uniform manner. Also, the study’s findings assume that this legislation is adopted on a national level, and their conclusions – despite being based on previous facts and findings – are purely speculative. In addition, their conclusions do not speak to any increases (or decreases) in HMO expenses or insurance premiums, but rather only speculate that a decrease in HMO enrollment will serve to increase costs.

Also, the age of the Lewin study serves to undermine some of its potential importance, as well as the fact that its projections run only through 2002. However, the American healthcare industry has changed little since then, with only minor changes being made in various states and no major national changes to the system as a whole. Therefore, the Lewin study still presents some relevant and potentially powerful findings for opponents of AWP legislation.

The Wyatt and Atkinson studies.
There has been a plethora of other studies conducted by various research and advocacy groups which can help illuminate the debate over AWP. None have been any more solidly conclusive than the three mentioned above, but most lend some relevant ammunition to the fight.

In particular, two studies done by different consulting firms both predict that AWP laws will increase administrative costs and insurance claims for MCOs (Carroll and Ambrose, 2002, p. 932). Although these studies were conducted rather early on in the debate (Wyatt and Company’s study was published in 1991, and Atkinson and Company’s in 1994), both still have some relevance to the AWP opposition since, as previously noted, America’s healthcare system and the structure and operation of MCOs have both changed little since the studies were published. However, these studies “rely heavily on simulation techniques to estimate the effect of AWP laws, rather than assessing actual outcomes” (Carroll and Ambrose, p. 932), and are admittedly fifteen and twelve years old, respectively. As such, they cannot be relied on to provide any rock-solid conclusions or predictions, only speculation.

The Federal Trade Commission
The Federal Trade Commission (FTC) also continues to oppose AWP laws, citing:

“Empirical evaluations [that] indicate that [AWP] policies result in higher health care expenditures. One study found that states with highly restrictive any willing provider/free-dom of choice laws spent approximately two percent more on health care than states without such policies...This interpretation is supported by another study that found that metropolitan areas with a high intensity of any willing...
provider/freedom of choice regulation had HMO market shares approximately seven percent lower than comparable areas without these provisions (Federal Trade Commission, 2004, pp. 29-30).

While much of this evidence strongly hints at solely negative effects caused by AWP legislation, it is important to remember that much of it has not been conclusively proven. In states where AWP has been on the books for some time now, such as Kentucky, for example, only small increases, if any at all, have been measured in health insurance costs. However, since AWP is still relatively young and is only recently overcoming most of its legal challenges, its total impact is not yet fully known and most evidence concerning the subject is inconclusive.

OTHER POSSIBLE USES FOR AWP

There are certainly some problems created by MCOs that deserve to be remedied. The current situation in Utah in particular is problematic in several ways, and AWP may indeed help alleviate some of these current concerns.

GEOGRAPHICAL PROXIMITY

In Utah, for example, some residents of Carbon County have been known to regularly make an hour-long trip north to Utah County just to see an approved provider. Senator Mike Dmitrich, D-Price, even pointed out during a debate on the floor of the Utah State Senate that a shuttle has been arranged to transport patients north to Provo once a week for that very purpose (Bryson, 2005, p. 1). This problem is especially worrisome considering that the vast majority of Americans – Carbon County not excluded – get their health insurance through their employer, which often means they have little or no choice as to who their insurance provider will be. Not having the option to choose another plan while being forced to drive for an hour to obtain services through your current coverage is understandably frustrating.

Perhaps Utah’s AWP law could be made to apply strictly to those who are not geographically close to a preferred or approved provider – as is the case, for example, with Georgia’s version. If an MCO insures patients in a given geographical area, they should make services available to them close to home – or else pay for someone else in that area to provide the care.

ANTI-MONOPOLISTIC

An even bigger concern for many in Utah is the sheer size and influence of Intermountain Health Care (IHC), which is seen by some as holding a near-monopoly in the Utah market. Research has suggested that competition among different HMOs in a market does serve to drive costs down and quality up. If IHC does truly hold a monopolistic position in the market, then allowing IHC’s patients to choose other doctors and clinics that are not a part the exclusive network could possibly address and moderate their dominating presence.

However, since such legislation is not expressly designed to be anti-monopolistic, it may prove itself unable to help with such a situation. In fact, if IHC’s prices remain low after they are not allowed to restrict patient choice, they may even attract more business than they did before. Furthermore, if Utah’s AWP law hurts IHC’s profits, it should also be expected to have a similar, negative effect on all of its competitors as well. Still, AWP is designed to help promote competition in the healthcare market, which is one of the necessary steps to mitigate a dominating, monopolistic presence.

DISCUSSION

ECONOMIC IMPACTS

It is no secret that General Motors has been facing some major financial difficulties as of late. Finance reports for the automobile giant have not looked good for some time, as their net losses came out to roughly $1.1 billion in the first quarter of 2005 alone (Hakim, 2005, p.1). That equals roughly 10% of their liquid assets – gone in just three months. The picture has not improved significantly since then, and although the automaker’s largest market is America, where a stagnating economy and consumer movements away from GM’s large, fuel-hungry SUVs have slowed new car sales and hurt profits, there is another culprit to be blamed for the company’s crippling financial hemorrhaging – the rising cost of American healthcare.

General Motors is expected to pay out roughly $5.2 billion dollars this year to provide medical coverage to their current and retired employees. That adds up to about $1,500 in overhead for every car GM produces. In contrast, Toyota Motor Corp. pays about $186 in healthcare costs for every car they make (Zakaria, 2005, p. 43). The rising cost of healthcare has hit American automakers especially hard, due largely to their highly unionized and generally older, better-trained workforce. However, the more expensive it becomes to insure your employees, the deeper the problem will run. “It’s GM’s problem today. It will be GE’s problem tomorrow” (Zakaria, p. 43). Furthermore, the problem of healthcare costs is not isolated to large companies or certain economic sectors. In fact, the Jensen study previously reviewed, found that state mandates on health coverage fall disproportionately on smaller firms, who are less able to self-insure and thus avoid the consequences of mandates as well as absorb the rising rates of coverage (Jensen & Morrissey, 1999, p. 453). As such firms get squeezed tighter, so will the average American.

MARKET COMPETITION

Competition in a free market has proven itself time and again to be an effective regulator – at least when the consumers of that particular good comparison-shop for it, looking for the highest quality at the lowest price. Proponents of AWP laws argue that these laws will help to open up the healthcare mar-
ket, thus leading to more competition among providers and, as a result, lower prices and higher overall quality. While this is a solid argument for most economic sectors, it does not apply to some – and healthcare is one of these.

In the healthcare market, consumers simply do not have the motivation or knowledge to comparison-shop. For example, in a classic fee-for-service model – where an insurance company pays a fee for the services provided by a doctor or hospital – there is no incentive to shop around for the best price. The consumer does not care what the doctor charges the insurance company; they are paying the same price to their insurance company regardless of whether the clinic bills the insurance $100 or $125 for their services. Since the clinic is going to get reimbursed no matter what they charge (within reason, of course), they have no real incentive to keep costs down either in these open systems.

AWP will do nothing to alleviate this problem. MCOs restrict their panels specifically so that they can control prices; if a patient is allowed to see whichever provider they choose, this advantage is undermined. Since AWP introduces no new market forces in its place to address the issue, costs are bound to increase. While most AWP laws do place caps on the amount of payout due to out-of-network providers, the volume advantage discount that most MCOs at least partially rely on is still at risk.

**VOLUME DISCOUNT ADVANTAGE**

Even though most AWP legislation stipulates that the MCO can still dictate the reimbursement rate (the Utah law, for example, requires an HMO to reimburse the out-of-network provider for only up to 95% of what the HMO would otherwise pay to an in-network provider), the laws still undermine the volume discount advantage. For example, if an MCO has 100 patients and five doctors, they can guarantee 20 patients to each provider, thus enabling them to negotiate discounts with their network members. However, if the MCO is forced to pay for services rendered by some out of network providers, their network effectively grows to 10 doctors, allowing them to guarantee only 10 patients to each. Eventually, as the network of willing providers grows and the MCO finds itself unable to guarantee a certain number of patients to the members of their panel, the doctors in the network will not be willing to accept the rates previously offered by the MCO. So, even in situations like Utah, where the law has a five percent discount built in initially, the rate that the MCO will be paying to in-network providers will inevitably increase as the number of doctors serving their patients increases as well and the volume discount advantage is undermined.

**PERFORMANCE vs. COST**

As mentioned above, the United States spends more on healthcare – both per capita and as a percentage of GDP – than any other nation, according to the World Health Organization’s (WHO) 2000 report. So what does that extra expenditure buy us? Only the 37th position among all the WHO’s members in overall health system performance. By contrast, France, who placed first in system performance, is fourth on the list of overall expenditure, and Italy, who placed second in performance, is only eleventh in the world on overall expenditure.

While expenditure certainly does not always translate into health system quality (the second and third finishers in expenditure, Switzerland and Germany, finished only 20th and 25th, respectively, in system quality), most other countries are able to provide for a higher quality health system for far less money than the United States. Considering the high burden that the price of healthcare places on American consumers and businesses, we should expect a higher return on our investment.

Only when some management authority steps in do doctors have an incentive to offer services for less. Even managed fee-for-service systems exhibit roughly a four percent savings over standard plans (Sheils, et al, 1995, p. iii). Under managed systems, not only do clinics have to find a way to accept the lower reimbursement rates offered by MCOs, but they have to do it while living up to quality standards. So when ten doctors are trying to get hired into only five spots on an MCO’s panel, the competition between them to meet those standards can be a highly effective market regulator.

Managed care has also been very effective in holding administrative costs down. Private care physicians who cater to patients from a wide range of health insurance companies often must hire some full-time staff just to handle all the billing. Those clinics who offer services to patients from only one company face a much simpler task when it comes time to collect; common reimbursement rates, schedules, procedures and paperwork all help to simplify and streamline the process, thus helping to hold costs down.

**IMPACT ON THE UNINSURED**

With 16% of Americans already lacking health insurance, America simply cannot afford to push any more out of the fold. In fact, not covering those citizens may actually end up costing society even more, as many of them end up with government-sponsored Medicare coverage anyway or no coverage at all, and therefore either cannot or do not seek medical attention until their ailments become serious enough to force them to do so. Emergency care for these citizens, which is often picked up by government programs and charitable contributions, is by far more expensive than preventative care is for those with insurance.

The Congressional Budget Office estimates that for every one percent increase in health insurance premiums nationally, 800,000 Americans lose their coverage. While that number is speculative in nature and national in scope, it suggests that a similar cost increase in Utah alone could push thousands more people into the uninsured category. Even AWP opponents will concede that these laws may increase premi-
ums, albeit by only one to three percent. However, given the current state of affairs, even that small of increase is unacceptable. Until America does more to control its healthcare costs, it may be more prudent to live with some uncomfortable policies and procedures rather than risk leaving even more citizens without health insurance. The consequences of allowing health costs to continue their upward trend are simply too great, and although MCOs are far from perfect, they are one of the few reliable solutions that America has.

**SUMMARY & CONCLUSIONS**

Any Willing Provider legislation certainly sounds good at first. After all, who does not want the freedom to make their own choices, especially on something as intimate as healthcare? And in a free market economy such as the United States, it would seem that open and free competition would only help remedy a system that is already costing us too much. Since AWP would seem to remedy both of these grievances, how could it be bad policy?

Unfortunately, the reality is not that simple. AWP legislation serves to undermine some of the most effective cost-saving techniques of MCOs, and this effect is particularly accentuated in cases concerning FOC or MPOS legislation. The volume discount advantage is the most significant, but an inability to enforce quality standards, control and dictate procedure coverage and referrals and increases in administrative expenses will all serve to increase the costs incurred by MCOs. In turn, their premium rates will have to pick up the slack.

The issues surrounding AWP laws can understandably be emotional; patients have not taken kindly to restrictions on their choice of doctors, for example, and rightfully so. But the bigger problem in American healthcare is not how MCOs operate, but the fact that we need them at all. As health costs continue to rise, the burden on American businesses and consumers will get heavier and heavier, with undesirable results. As the General Motors example illustrates, American businesses may struggle to be competitive in an increasingly global marketplace where most other industrialized nations place the burden of health costs not on businesses alone, but on society as a whole.

Every state has a different market to deal with, and in some situations more specific AWP legislation may have some useful and logical applications. Admittedly, solid evidence conclusively proving that AWP will have some negative impacts is hard to come by. However, the existing empirical evidence indicates that AWP has a strong potential for imposing negative consequences as side effects, and there is precious little data to prove otherwise. Given the current state of affairs in America's healthcare system, none of AWP's potential consequences can be justified or afforded. Until more conclusive data is available, these kinds of laws should be avoided.

**REFERENCES**


Congressional Budget Office. (2003). How many people lack health insurance and for how long?


Webster, Lynn. (2005, April 19). Telephone interview.