Analysis: How Any Willing Provider Makes Health Care More Expensive

By Paul B. Ginsburg, Ph.D.
Norman Topping Chair in Medicine and Public Policy
University of Southern California

September 23, 2014

Key Takeaways

- The preponderance of the evidence shows clearly that AWP laws lead to higher spending.
- Rather than protect consumer choice, AWP laws interfere with meeting consumer and employer demand for lower-priced plans.
- The recent emphasis on narrow network plans and plans sponsored by health systems could lead to greater efforts on the part of providers to pass such laws to resist these changes. But if they succeed, the costs to consumers, employers and taxpayers could be even larger than we have seen in the past.

Background

Any Willing Provider (AWP) laws began appearing in some states in the 1980s. The laws permit providers who are willing to agree to an insurer’s terms and conditions for inclusion in a network to demand inclusion in that network. At present, 17 states have AWP laws that apply to either hospitals, physicians, or both.1 A larger number of states have laws that apply to pharmacies. AWP laws have tended to be supported by physicians but opposed by the business community and health insurers due to their potential to lead to higher health spending and a corresponding increase in health insurance premiums.

AWP laws emerged as a reaction to fears of some physicians that their earlier refusal to join managed care networks would preclude them from having the opportunity to be included in networks of the rapidly growing preferred provider organization (PPO) insurance products. Managed care had become sufficiently mainstream that few physicians could have a viable practice without inclusion in at least some networks. Interest in such laws subsequently declined in the 2000s, when provider networks in managed care plans became broader in response to pressures on health plans from employers sponsoring health benefits to offer greater provider choice.

In recent years, interest in AWP has again increased in response to a narrowing of provider networks in existing health insurance products (most visibly in Medicare Advantage) and the development of new health insurance products (offered as a choice in both public and private exchanges) that have much narrower networks along with a substantially lower premium. Whereas this trend has again alarmed some physicians and hospitals who fear exclusion from some networks, it has also created the potential for AWP to be even more disruptive to

---

approaches used in managed care to constrain health spending and promote quality. Indeed, rather than protect consumer choice, AWP laws now interfere with meeting consumer and employer demand for lower-priced plans that have less choice of provider.

This paper begins with an analysis of how AWP laws impact the financing and delivery of health services. It describes methods that health insurers use to achieve lower prices for services and foster higher quality of care and how AWP laws can undermine these activities. The analysis then focuses on the growing importance of narrower provider networks as a tool to contain costs and foster improved quality and their feasibility when AWP laws are present. Since physician-owned specialty hospitals are a significant part of the delivery system in South Dakota, the paper analyzes their impact on other hospitals and the role they play in provider networks and how this is impacted by AWP laws that apply to hospitals. Next, the paper reviews the empirical literature on how AWP laws affect health care spending. The preponderance of the evidence shows clearly that AWP laws lead to higher spending. A concluding section summarizes the case against AWP laws.

Analysis of AWP Impacts on Health Care

AWP laws have long been controversial and those affecting hospitals and physicians have been enacted in only a third of states. Much of the discussion about the desirability of these laws revolves around their impact on health care spending, specifically whether or not they increase spending. Spending per enrollee is based on the unit prices paid to providers and the efficiency and quality of network providers.

Achieving Lower Prices. To analyze this question, this paper discusses in some depth the workings of provider networks in managed care products. Provider networks are a powerful tool through which health plans obtain lower prices from providers and pursue higher quality care for members. Economists see the provider network as the mechanism through which a health plan purchases services on behalf of its enrollees on a wholesale basis. The context is that in the course of health insurance providing financial protection from high medical spending for enrollees who become ill, most patient incentives to gather price information from providers and to choose those with lower prices are substantially undermined. Until the recent creation of health plans with very large deductibles, most patient responsibility for care came in the form of coinsurance, where the patient pays a proportion, commonly 20 percent of the bill. Alongside this dilution in rewards for choosing a lower-priced provider, searching by individual patients for lower-price providers has been very difficult and time-consuming. Except for routine services, obtaining cost information for a complex medical condition involves making appointments and being examined by different physicians.

Creation of a provider network can achieve lower prices for health plan enrollees because the plan is creating a wholesale mechanism for purchasing services. The key tool in this process is the threat that a provider who chooses not to sign a network agreement will become less attractive to many current patients and potential future patients because these patients will have to either pay more or pay in full (such as in certain HMO products) for services from providers outside of the networks. Some providers may have a strong enough following to do this—or health plans may decide that they are important enough to the attractiveness of the network that the health plans will enter into negotiations with the providers and possibly pay higher rates to entice them into the network. A significant benefit of network exclusion is the potential for those providers who join the network to gain many of the patients of those providers not included in the network. This combination of a threat of losing patients and an opportunity to gain patients leads providers to agree to discount their charges to meet network requirements, resulting in lower premiums for the employers and individuals who purchase coverage.

This approach to gaining lower prices for enrollees will not work as well if providers declining to be in the network can subsequently decide to agree to the insurer's
terms and conditions and—through AWP laws—demand to be included in the network. This undermines the effectiveness of the network at gaining lower prices in two ways. First, providers are less likely to agree to discount their charges and/or engage in negotiations if they have an opportunity to try out being a non-network provider first and then decide whether the loss of patients is larger than they expected. Second, the greater uncertainty for those providers joining the network about gaining additional patients undermines their incentive to agree to join the network.

More Efficient and Higher Quality Providers.

Network creation can reduce health spending for enrollees in ways beyond obtaining lower prices. For example, plans can exclude from the network those providers with problematic practice styles. Physicians whose rates of use of certain tests and procedures are so far above typical patterns of use that insurers suspect fraud (services not delivered) or abuse (services are delivered but are unnecessary) can be excluded from a network.

Some physicians have practice styles that are relatively inefficient, meaning that they have high rates of use of some services that do not benefit their patients. Over time, insurers have become far more sophisticated in analyzing claims data to identify which physicians and hospitals are more efficient. They also can measure some aspects of quality of care. The tools have become more sensitive and reliable over time and likely will continue to do so. Insurers can now look broadly not only at the services that physicians provide, but also at services delivered by other providers (specialists, outside laboratories, imaging, hospital care) that are ordered by these physicians. Quality measurement allows insurers to favor only those efficient physicians that also have acceptable quality and to identify low-quality physicians for possible exclusion from networks. AWP laws interfere with the ability of health plans to use this information to make decisions on which providers to seek to include in the network or whether to drop some from the network, thus raising health insurance premiums and undermining quality of care.

A less important cost factor, but one where the situation is very clear cut, is administrative costs. Having fewer providers in a network reduces the costs of checking credentials and interacting with providers. Less frequently measured are the legal costs connected with AWP laws. In 1995, discussions by a joint legislative committee in Virginia considering changes in the state’s AWP law documented the expense of several suits by hospitals over their exclusion from insurer’s networks.\(^2\)

Growing Importance of Narrow Network Plans.

Catalyzed by intensified employer concerns over the costs of health benefits and implementation of public exchanges and new tax credits for purchasing coverage, provider networks have become an even more powerful tool to reduce spending. Most striking has been the importance of insurance offerings with narrow networks on the public exchanges. As shown by McKinsey & Co., approximately half of the offerings on public exchanges in 2014 had narrow networks.\(^3\) Ninety percent of those using public exchanges had access to a plan with a broad network while 92 percent had access to a plan with a narrow network. Premiums for broad network plans were 13 to 17 percent higher on average than those with narrow networks. So narrow networks provide more affordable options for those obtaining coverage on public exchanges, a population that is large and that is expected to grow rapidly.

The Federal Trade Commission recently conducted a literature review and found that the theoretical and empirical economic literature indicates that limited networks can and do, on average, yield lower costs and prices. The FTC’s review found no countervailing evidence.\(^4\) A very recent study of Massachusetts state employees’ experience with narrow network plans showed very substantial reductions in spending, which came

---


not only from lower unit prices but also from reductions in the quantity of services. With spending increasing for primary care, all of the spending reduction came from specialists and hospital care, including emergency department care.

It is not at all surprising that narrow network plans are so prominent on public exchanges. Because consumers can choose among many plans with narrow networks and plans with broad networks as well, exchanges do not face the problem than many employers face in needing to make sure that the single plan that they can offer is acceptable to a large majority of their employees. On an exchange, a narrow network plan can be attractive to only a minority of those obtaining coverage through the exchange and still be very successful. The structure of tax credits also causes a favorable marketplace environment for narrow network plans. In contrast to most employer plans, where those choosing a more expensive plan receive a larger employer contribution than those choosing a less expensive plan, federal tax credits for persons with incomes less than 400 percent of the federal poverty standard are pegged to the premium of the second least expensive silver plan in an area and do not depend on the premium of the plan chosen. So consumers considering a more expensive plan with a broader network will pay the full difference in premiums.

The rapid development of private exchanges in employer-based coverage is also likely to lead to a rapid growth in narrow network plans in this much larger sector of health care financing. With extensive choice of plans offered to employees and, in most cases, a fixed contribution from the employer, enrollment in narrow network plans is likely to grow rapidly in this segment for the same reasons as it has become important on public exchanges.

Another trend leading to growth in narrow network products has been the development of additional provider-sponsored plans by prominent health systems. Driven by the broadly-acknowledged need to increase the degree of clinical integration in the delivery of care, health systems have been creating insurance products, either obtaining an insurance license or partnering with an insurer. Networks in these products are often limited to a hospital system and its affiliated physicians and additional hospital facilities and physicians needed for adequate access in a market area. These plans have been offered on public exchanges, on private exchanges and in Medicare Advantage.

In all of these contexts in which plans with narrow networks are evolving, AWP laws have the potential to be far more disruptive to network strategies than in contexts where broad networks are the norm. With a smaller proportion of providers included in the network, there is much greater potential for demands for inclusion in a network. This will undermine the potential for gains in patient volume for those providers agreeing to participate in the network despite the lower fees. It has the potential to be particularly disruptive to provider-sponsored plans, which often emphasize working with a smaller number of providers to achieve clinical integration.

**Impact Posed by Physician-Owned Specialty Hospitals.** As noted above, the ability of plans to structure networks to best provide their members with high quality, lower cost care is of great importance to consumers. AWP laws disrupt this process and harm consumers, by removing the ability of plans to make network decisions in the best interest of their members. Forcing plans to include physician-owned specialty hospitals through AWP laws is of particular concern in South Dakota. This discussion focuses on those hospitals devoted to services in one or more specialties (cardiovascular surgery, orthopedics) or to surgery in general and that are owned by a practicing physician or group of physicians. These hospitals are a more significant factor in a handful of states, including South Dakota, than in the nation overall.

There are numerous reasons that a health plan might choose not to include one or more specialty hospitals in their networks. These hospitals have been highly controversial for some time and have attracted substantial

---

attention from policy makers at the national level. One particularly relevant concern is the strong incentive for physician owners to recommend a higher number of surgeries and other services than would occur if the physician were sending the patient to a hospital in which the physician did not have an ownership interest. This is because surgeon owners of specialty hospitals gain from additional revenues for the hospital as well as from professional fees. Moreover, these hospitals typically do not accept Medicaid and uninsured patients.

The federal government has acted against physician-owned specialty hospitals on a number of occasions dating to 2003, with the latest a provision of the Affordable Care Act. Participation in Medicare is not permitted for those hospitals that were constructed after a certain date or had expanded their facilities after that date. Given the actions of federal policymakers, it would not be surprising if some private insurers had similar concerns and, consequently, did not include some or all such institutions in their networks. Private insurers might have concerns, for example, about the cost and quality implications of the incentives for higher rates of surgery among patients sent to such hospitals. AWP laws would interfere with the ability of a private insurer to pursue the best interests of their members in deciding whether to include any or all specialty hospitals in its network.

Research on the Impact of AWP Laws on Health Spending

The research literature on this key question is very limited. The most credible studies of AWP have mostly concluded that AWP laws increase spending on hospital and physician services—as well as pharmacy, which is outside the focus of this paper. Vita (2001) is perhaps the first of the sophisticated empirical studies. It is meticulous, uses a wide variety of model specifications and is published in a particularly prestigious peer-reviewed journal. It finds that strong AWP laws increase hospital and physician spending by a substantial amount, results that are statistically significant.

Durrance (2009) is another strong study, also published in a peer-reviewed journal. It finds that strong AWP laws increase private spending by 3.9 percent, a result that is statistically significant. Klick and Wright (2014) focus mostly on pharmacy spending but in an analysis using particularly recent data and drawing heavily on Vita and Durrance for methods, it examines effects of AWP laws on hospital and physician spending and does not find an impact. Interestingly, the study does find that freedom of choice laws (that require plans to cover services obtained by any provider regardless of network participation) increased hospital spending by 5 percent, a result that is statistically significant. The study’s inclusion of separate variables for whether the state has an AWP law and a FOC law applicable to hospital and physician spending, variables that are highly correlated, might explain the absence in AWP impacts on spending. In intuitive terms, an AWP effect might have been picked up instead as a FOC effect.

Most of the remaining studies are quite old and most have serious weaknesses in methods or data.

The most important limitation in this literature is the measure of spending that is used. Most common is aggregate spending per person in a state (spending in states with AWP laws is compared to that in states without such laws). The problem is that the correlation between this measure of spending and the ideal measure of spending—described below—is likely to be low. Although a large error in the dependent variable does not bias the estimates of the effect of AWP, it substantially reduces the efficiency of the estimate, making it very difficult—if not impossible—to come up with a reliable estimate.

6 For example, MedPAC’s March 2005 report to Congress on physician-owned specialty hospitals. Available at: http://medpac.gov/documents/reports/Mar05_SpecHospitals.pdf?cfid=0
10 Klick 2014.
The ideal measure would be a comparison of the ratio of spending per enrollee in managed care plans to that in other private plans in AWP states versus non-AWP states. It is not feasible today to do such a study because managed care has become close to universal in private insurance, although it might have been feasible during the 1980s with access to data from a major national insurer. A practical alternative today would be the ratio of per enrollee spending in private plans to per-beneficiary spending in Medicare. The best studies have partial, though not total, fixes to this limitation. Vita (2001) subtracts Medicare spending from total spending, which is a modest improvement. Durrance (2009) goes a step further and subtracts Medicaid spending as well as Medicare spending.

The literature has advanced over time to address some other issues. More recent studies have ranked AWP programs according to how restrictive they are and grouped states into those with strong AWP, those with weak AWP and those with no AWP. For estimates of the impact on either total spending or physician and hospital spending, studies now classify states with AWP that applies only to pharmacy as non-AWP states.

Some studies have grappled with the potential endogeneity of the AWP variable. In lay terms, this is a concern about the potential for a state's decision on AWP to be influenced by whether spending per capita is high or low. Although the best methods to address this possibility— instrumental variables—are not feasible for studying AWP impact on spending, some of the studies did conduct some tests for the potential bias and concluded that it was not likely to be an important issue. Knowledge of the political process in states that have considered AWP laws leads this economist to believe that endogeneity is unlikely to be a serious problem.

An outlier in the research literature is a study by Allgrunn and Haia [2012], which was conducted for the South Dakota Association of Specialty Care Providers, which represents physician-owned specialty hospitals. The study is not published. The authors do not appear to have been aware of the Durrance study. The Allgrunn study does not appear to subtract Medicare and Medicaid spending from total spending. It includes an interaction term to allow for the effects of AWP on hospital and physician spending to differ depending on whether there is also AWP that applies to pharmacy. Since the substantive interaction between these two types of AWP laws is unlikely to be very important, it should not explain large differences in results. But the differences in results are indeed large, with the Allgrunn suggesting that AWP laws applying to hospitals and physicians decrease spending by 5.7 percent. Given the shortcomings noted above, these findings do not strike one as credible.

Conclusions

Any Willing Provider laws are generally perceived by economists as physician and independent pharmacy protection initiatives—as opposed to patient protection. Although their merits have been actively debated for 30 years, there is little support in empirical literature for their reducing spending—while there is empirical support for their increasing spending.

The FTC has advised against these laws on the basis of the reduction in competition among hospitals, physicians and pharmacists. For example, in a 2006 letter to a member of the Virginia House of Delegates, the FTC staff stated that the reduced competition is likely to lead to “the suppression of efficient service networks, not the expansion of real consumer choice.”

Changes in the financing and delivery of health care in recent years that are projected to continue in the future could lead to AWP laws becoming substantially more disruptive of managed care, competition and integrated delivery than in the past. Narrow networks are becoming
a very important tool for controlling costs and delivering value to consumers; AWP laws are likely to interfere to a greater degree with narrow networks than with broad networks. Health plans’ ability to assess the efficiency and quality of health care providers is increasing. AWP interferes with health plan efforts to create provider networks that deliver greater efficiency and higher quality. The potential for narrow network plans built around a delivery system to achieve greater clinical integration is also threatened by AWP laws.

The potential for AWP laws to become more disruptive to the health care financing system of the future compared to the one in the past will likely spur greater efforts by providers to pass such laws to protect against competition. But if they succeed, the costs to consumers, employers and taxpayers could be even larger than we have seen in the past.

This paper was prepared for and at the request of America’s Health Insurance Plans.