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### **Déjà vu? The Debate Over Any Willing Provider Laws May Return, Sad To Say**

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## Déjà vu?

### The Debate Over Any Willing Provider Laws May Return Again, Sad To Say

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#### *Introduction*

Nobel Laureate and economist Paul Krugman has used many of his allotted New York Times columns of late to lament that repeatedly disproven economic doctrines do not seem to fade away, despite the fact that when implemented, serious and unnecessary harm comes to many people. Instead, these discredited policy ideas – e.g., inflation-phobia and spending cut “austerity” in response to financial crises (e.g., the Great Depression or the recent Great Recession), the “trickle down” theory of tax cuts for the rich while balancing the budget with spending cuts for social programs -- beat tactical retreats only to resurface at a later time. Discredited ideas resurface because powerful interests are well-served by keeping them alive. And freedom of speech (for corporations and for citizens) allows advocates for powerful interests to re-package their ideas for the public without regard to facts over and over again.

It may be time for Krugman to add anti-selective contracting, which includes Any Willing Provider (AWP) and Freedom of Choice (FOC) laws, to his list of discredited but persistent policy arguments. For state legislative interest in expanding and strengthening these kinds of laws seems to be bubbling up, once again, even as every honest analyst of our health care system knows we need now more than ever to focus like a laser beam on lowering cost within our vaunted but overstressed and unsustainable health care system. Improving quality and patient experience are also important and may in the right circumstances actually help lower cost, but the coin of the realm in health policy for the near term and foreseeable future is lowering cost to maintain access to care for the middle class, even more so for the increase in access the Affordable Care Act (ACA) has created. The preponderance of evidence and economic logic would counsel emphatic rejection of new or even existing AWP and FOC laws. Even if the evidence were more mixed than it is, restricting payers’ ability to offer provider networks and

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<sup>1</sup> I appreciate helpful comments from Gilbert Gimm and Kalahn Taylor-Clark, and the generosity of Professor Michael Allgrunn in sharing his unpublished empirical results. All errors or ambiguities are my sole responsibility.

insurance products that can deliver more value per dollar to consumers flies in the face of our greatest need right now, which is to “bend” the cost growth curve.

Yet here we are. South Dakota, Mississippi, and Pennsylvania are considering comprehensive AWP laws as of late 2014, Arkansas, Kentucky and others already have them but have not necessarily enforced them vigorously yet due to court challenges, and other states will likely consider adding or strengthening these provisions if proponents achieve new successes elsewhere. These anti-selective contracting actions are directly contradictory to where market forces are headed in offering “narrow network” products both in the ACA marketplaces and by active purchaser employers.<sup>2</sup> In this Issue Brief I provide an essential but sometimes overlooked history of these laws and then review the arguments and evidence for and against them. Finally, I offer conclusions for both sides to consider as the policy debate moves forward, or backward, or in circles, as the case may be.

### ***A Brief History of anti-selective contracting Laws***

For the non-specialist reader, Any Willing Provider laws require insurers to include in their networks all providers who agree to comply with the stated conditions of participation set by the insurer. Freedom of Choice laws do not require the plan to include the provider, but do require the plan to reimburse the provider at regular in-network rates if the consumer chooses to visit that provider. These laws can each apply to all providers and plans or to some. The strongest versions of these laws apply to more providers – at least physicians and hospitals -- and to multiple types of plans, not just HMOs. Most laws actually passed have applied to pharmacies only, but some apply to all providers, doctors and hospitals alike, and all plans.<sup>3</sup> Both types of laws sound like ways to protect unlimited choice by patients, and indeed that is how some provider organizations describe their intent. Who can object to giving an American consumer more choice? And isn't more choice *always* good for competition, i.e., the American way?

These issues are not new to health policy. Insurers and providers have been arguing about control of who should be included in networks since the early 20<sup>th</sup> century when health insurance was invented. In

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<sup>2</sup>Sarah Kilff, “Obamacare’s Narrow Networks Are Going to Make People Furious – But They Might Control Costs,” *Washington Post*, January 13, 2014; Jonathan Gruber and Robin McKnight, “Controlling Health Care Costs Through Limited Network Insurance Plans: Evidence from Massachusetts State Employees,” *National Bureau of Economic Research Working Paper*, September 2014.

<sup>3</sup> See Marsteller et al for a good introduction and explanation of why these laws were passed. Jill Marsteller, Randall Bovbjerg, Len M. Nichols, and Diana Verilli, “The Resurgence of Selective Contracting Restrictions,” *Journal of Health Policy, Politics, and Law* 22(5):1133-88 (October 1997).

most states the original Blue Cross and Blue Shield enabling legislation in the 1930s in most states included free choice of provider (FOC) and any willing provider provisions, for even though insurance was brand new, providers feared being left out of what might become a popular way of financing access to health care.<sup>4</sup> As a practical matter, most Blues plans became for many years after the 1930s monopolists or at least dominant in most states and they did tend to include all providers in their networks for at least some if not all of their products.

As reducing health cost growth became more central to federal policy in the 1970s – signified by passage of the HMO Act in 1973<sup>5</sup> – existing AWP and FOC state law provisions meant that specific HMO enabling legislation had to be passed by the states in order to permit HMOs – with tighter networks of providers more committed than their peers to managing care coordination and limiting unnecessary utilization and costs -- to be formed. It is worth remembering that the federal HMO Act essentially forced competition among health plans to be possible by requiring employers to offer HMO products IF an HMO existed and was ready to compete with traditional Blues and other indemnity insurers. Federal and state policy essentially created a market competitor in limited network insurance products that would never have come to be if traditional anti-competitive domination of state legislatures by state medical societies had been maintained.

State HMO enabling laws, and the federal policy they implemented, recognized that a central myth of the American organized medicine lobby was false: all health care providers do *not* provide equal levels of quality and efficiency. The federal HMO Act tried to shift the balance of power from organized medicine – whose members feared competition among themselves and largely aimed to stifle it through state legislation – to insurers and HMOs in the name of promoting efficiency and cost growth reduction. Clearly the power to limit participation in networks gives insurers bargaining power over providers they would not have otherwise had. But it is important to understand that federal and state policy, while trying to encourage HMOs, was essentially pro-market in that had those policy makers not acted, HMOs would have been stifled by existing state law, and we never would have been able to take the steps we have toward managed and coordinated care. Federal and state policy makers also expected that if HMOs tried to market insufficiently broad provider networks then they would never catch on or would suffer market share losses. Thus, by creating HMOs and giving them the ability to offer *selective* provider networks to patients, both federal and state policy labored to create a larger range of

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<sup>4</sup> E. Rolph et al, *State Laws and Regulations Governing Preferred Provider Organizations*. Pub No. R-3442/2-HHS/FTC. Santa Monica, CA:Rand.

<sup>5</sup> P.L. 93-222.

premium-provider network choices than existed before the 1973 HMO Act. Physicians and hospitals did not always like this new competition, and those HMOs did not always succeed in the marketplace, but it was pro-competitive policy nonetheless.

A new wave of AWP-FOC laws bubbled up in the 1990s in what appeared to have been a reaction to the proposed Clinton health reform legislation,<sup>6</sup> which was designed to rely on large managed care plans and exclusive networks. The debate around this approach to health reform engendered a new level of fear among providers of being “left out.” Even then most laws applied only to specific providers, but some were broad in scope, including laws in Kentucky, Arkansas, Georgia, Idaho, Illinois, Indiana, Minnesota and Wyoming. These laws, in turn, gave economists and other analysts a “natural experiment” to measure and assess the effects of these laws in comparison with states that did not pass such laws or who passed weaker (less expansive) versions of AWP/FOC laws.

### ***Arguments Pro and Con***

The very fact that AWP and FOC laws were perceived to be necessary by some providers from time to time tells you something about how insurer-provider negotiations were perceived as well. Insurers want providers to deliver necessary and quality care efficiently. Efficiency can come from lower prices or from reducing inappropriate or ineffective utilization, both of which lower insurance costs and in turn premiums (in competitive insurance markets) to employers and consumers. It is often much easier to get providers to agree to lower unit prices or modify utilization practice styles IF they can be promised a hefty volume of patients by the insurer. It is not possible to deliver the same volume of patients to any provider if all providers are in the network, thus AWP/FOC laws are a threat to lower cost insurance. And in a world in which quality measurement is much more common and effective, as 2014 is compared to either 1993-1994 (the Clinton reform era) or 1973 (the HMO Act), insurers today have much better tools to select high valued providers into their networks than ever before, and consumers likewise have far more opportunities and devices to evaluate the insurers’ choices. That is, AWP / FOC laws run counter to insurer-led attempts to deliver more value at lower cost to consumers.

Proponents of AWP<sup>7</sup> legislation argue that selective contracting is inherently anti-competitive, that any limits which insurers place on providers who would like to be included or covered by a given insurance product harm competition. They argue quite sincerely that *they* are the pro-market competition

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<sup>6</sup> S. 2296, Report 103-317, Second Session.

<sup>7</sup> I will henceforth use AWP as shorthand for AWP-FOC, since their practical market effects are so similar, until we get to empirical work, where sometimes distinctions occur.

people in this debate. They argue that permitting insurers, including insurers with large market share, to exclude some providers will drive the excluded providers into bankruptcy and then there will be less provider competition, not more, and that consumers will therefore be helped by AWP laws. The fact that these arguments almost always come from provider organizations, typically state medical societies or specialty provider trade groups or societies, has led wags to quip these laws would be more accurately described as Expensive Provider Protection (EPP) laws, but the logic of the arguments should be examined on the merits, not on the motives of the proponents (or opponents for that matter).

One complicated fact of market competition in health care is that it occurs on at least three levels within a given year; at the insurer level in consumer or employer choice of plan, at the provider level in which providers compete to be included in plans, and at the consumer/point of service level in which provider will be chosen or visited by the patient. Proponents of AWP laws focus on the point of service level, for they see AWPs as enhancing consumer choice there, as they surely do, all other things equal. But all other things are rarely equal, especially when what goes on at one level of competition in health care affects what is possible at other levels.

The irony of arguing the pro-AWP position as a pro-competitive position is that the laws themselves suppress competition at the provider level in the name of enhancing competition at the point of service level. And by design they also suppress price competition at the point of service level, since all agree to the insurers' terms of what to charge consumers. They want consumers to have access to all providers but for price variation to the consumer to be off the table. But if all providers offer the same price to consumers and if all providers are in every plan, then no plan is different from another, either. So in practical effect, strong AWP laws that apply to physicians and hospitals and all plans also suppress competition at the plan level. Thus, the only competition "enhanced" by strong AWP laws is non-price competition at the point of service level. Not many health care analysts are optimistic that this restricted form of competition alone can enable our health care system to bend the cost growth curve.

Another practical effect of AWP laws is that no providers "lose" in the competition to be included in a plan. This is exactly the opposite of what competitive insurance plans claim they need in order to negotiate incentive contracts with high value providers. If no one can "lose" in the competition to be included in covered provider networks, then what kind of market competition is that?

Answering that question gets us to the heart of the matter. Proponents of AWP laws clearly prefer a world in which insurers are mere financiers of health care, and providers compete for patient business

with cost to the patient off the table. Admittedly this is the way American health care was organized for the middle decades of the 20<sup>th</sup> century, but in a country now spending over 17% of GDP on health care, twice the OECD country average, this world view is quaint at best and hopelessly outmoded and unsustainable at worst. For it turns out, taking provider cost at the point of service off the table raises premiums over time, and workers actually pay for premiums with lower wages, even though employers who trade health benefits for wages write the checks. It also turns out, over time, some would say at last, insurers, employers, workers, and our federal government have fully awakened to this reality, and they are all trying to do something about it with new tools like patient centered medical homes, bundled payments, reference pricing, and accountable care organizations, whether organized pursuant to the ACA or by the private sector in partnership with state governments or even more frequently, by the private sector alone.

What all these payment reforms have in common is a very different world view than that held by AWP proponents. This alternative world view is one in which *only* high-value providers will be included in insurance products offered at attractive prices in the marketplace. There is growing evidence on the positive potential of these approaches.<sup>8</sup> Low value providers are free to compete in the marketplace at every level (point of service, among providers for inclusion in high value plans, and at the plan level with different premiums), and the consumer-patient then will have a much fuller range of options than under the AWP world view of homogeneous plans and homogeneous provider networks and no price competition at the point of service level. That world view is a recipe for the status quo which has not served us well in terms of efficiency, quality, or equity of access.

Now opponents of AWP laws are not all valorous saints, of course. Some of the righteous indignation that physicians in small practices express against insurers in AWP debates is triggered by an imbalance in bargaining power between some such physicians and the insurers in their markets to the point where physicians don't feel like they actually negotiate anything. Insurers, even "non-profit" insurers, are not in this business to be charities. They are either trying to earn a profit for shareholders or to earn a surplus to pursue other goals, which could include community benefits but also include investments in information or quality improvement infrastructure which enhance their ability to select providers and ensure their enrollees get high value care. The fact that they earn profits and surpluses over time by

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<sup>8</sup> James T. O'Conner and Juliet M. Spector. "High-Value Health Care Provider Networks," *Milliman Report*. Prepared for America's Health Insurance Plans. July 2, 2014; Noam Bauman, Erica Coe, Jessica Ogden, and Ashish Parikh. "Hospital Networks: Updated National View of Configurations on the Exchanges," *McKinsey Center for U.S. System Health Reform* July 2014; Gruber and McKnight, op cit.

attracting customers which they can do only if they deliver value to large numbers of them seems to be lost in the shuffle sometimes. Some physicians also resent insurance executive compensation, regardless of how high or low it is compared to insurer revenues or profits/surpluses. This resentment can rival that expressed by advocates for a single payer health care system.

A bit more to the point, physicians express frustration over insurer refusal to publicly specify all the conditions of participation that are required for some network-based insurance products. AWP advocates argue that if the insurer would just specify the conditions in question in full, providers and patients would have a fair chance to assess the costs and benefits of compliance with those conditions. While superficially plausible, the problem with this argument is that the quality and cost-saving incentives the insurer wants to negotiate with providers are proprietary, business model secrets that if released to the public would relinquish all competitive advantage the insurer may have against other insurers. If Aetna knew exactly what Anthem offered its participating physicians, then it would be easier to match those terms than it is now. So in that case, the AWP law would have the effect of suppressing both provider inclusion and plan-level competition.

It is important to remember that none of these facts and beliefs in the previous two paragraphs have anything to do with the analytic question for health policy development: what kind of competition is best for the consumer and most likely to result from the presence or absence of AWP laws?

Opponents of AWP laws argue that full and unfettered competition at each level -- plans offering premium prices, benefits and cost-sharing details, and provider networks; providers competing to be in certain networks, negotiating incentive arrangements with plans; and finally consumers selecting among providers within the network at the point of service level, or opting to pay more out of pocket to visit providers outside the network -- will serve consumers better than non-price competition at the point of service level only. Most economists would agree in most circumstances, but what about the circumstance AWP supporters emphasize, that of a dominant insurer with market power?

If an insurer has monopsony (buying) power over providers in a given market, it does have the ability to lower payments to them from those that would prevail in competitive markets. This could increase insurer profits with no necessary effect on premiums to the final consumer, and thus in this case could lead to no benefit to consumers at all. Note, the net impact on premiums will depend on insurer market power at the *plan* level. Opponents of AWP laws stress that if the insurance market is competitive, potential increases in profit from lower provider payments (with no AWP) will be dissipated into lower



premiums due to competitive insurance market conditions, i.e., all insurers will take advantage of the absence of AWP and lower payments to participating high-value providers *and* lower premiums to consumers.

But suppose the highest level plan market is *not* competitive. Then AWP proponents have a case in which payments to providers could be lower but premiums do not fall and so insurer profits would be high. The medical loss ratio regulations of the ACA will likely help mitigate this, since gaps between premiums collected and payouts to providers are constrained now, but let's assume for the moment these regulations are not binding for the sake of the pro-AWP argument.

MLR regulation aside, introducing an AWP into a situation wherein the insurer was both a monopsonist and a monopolist would raise payouts to providers and lower profits at first, but then since costs went up, the insurers would just raise premiums because they can and because the profit maximizing premium level would now be higher with higher costs. In this case, new AWP laws raise costs to insurers and to consumers, but the providers who would have been excluded from the network are better off. Hence the tag, Expensive Provider Protection laws.

Introducing an AWP into a situation with insurer monopsony power but a competitive plan market (hard as that may be to achieve in the real world) would also raise premiums, as the insurer again just acts as a middleman collector of higher premiums with which to pay all providers who have raised costs collectively. Higher costs will drive competitive equilibrium prices higher in the long run, every time.

But are there circumstances in which an AWP law could actually *lower* cost to the consumer at the plan premium level, the most important level of competition in terms of money spent by far? Only if it induces competitive entry of new health plans which will lower premiums compared to the pre-entry equilibrium. And how might this occur? Proponents argue that in the absence of AWPs, insurers with market power at the plan and purchasing level intend to and will drive non-participating providers out of business. Then the remaining providers will have market power themselves, so they will raise prices and that will force the insurer to raise premium prices also. With not enough "unaffiliated" providers available, entry by competitive health plans is difficult if not impossible. So competitive entry of health plans that enables more providers to survive, which will be easier if an AWP is in place, could theoretically lower costs to consumers even while raising costs to insurers, essentially by squeezing currently high insurer margins, where they exist. The empirical question then is, will AWP laws lead to

more plan entry into potentially monopoly plan markets than their absence? We will address this question in the Evidence section below.

### ***The Evidence***

We ended the last section with a hypothetical question, but the new ACA marketplaces provide a natural experiment to ask a closely related question; was there more plan entry where strong AWP laws already exist, or where they do not? AWP proponents would expect more entry where the laws are most favorable to the providers, for more of them could survive and would be available for new entrants' networks.

Using Marsteller et al's characterizations of the strength of anti-selective contracting laws (as did Vita<sup>9</sup> and others), and using ASPE's reporting of the state marketplace results for 2014,<sup>10</sup> we note that the mean number of insurers that entered marketplaces in states with strong laws was 2.3, while the mean number of insurers in states with no laws was 3.74. So the mean number of insurers was higher for the no law group, which runs counter to the AWP proponents' expectations. A simple t-test revealed no statistically significant difference between the two means of these groups with the most divergent selective contracting rules. Thus, insurer entry patterns in the new marketplaces do not appear at the most basic level to conform to the predictions of the AWP advocates, if costs are to be lowered by AWP laws.

Most prior empirical work in fact has concluded that AWP laws increase costs, as the FTC has argued many times using standard economic logic in the plausible circumstances of real world competition.<sup>11</sup> Vita<sup>12</sup> has done the most thorough job of testing<sup>12</sup> for the impact of comprehensive or strong AWP laws, those that apply to physicians and hospitals and all plans, and that is published in the peer-reviewed scientific literature of health economics. I say most thorough because he tested for the possible endogeneity of HMO market share and the passage of AWP laws along with the impact of those laws. He found that strong AWP laws increase overall per capita costs in a state in a statistically significant way by about 2 percent. He also found that HMO market share lowered costs on average by more than

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<sup>9</sup> Michael Vita, "Regulatory Restrictions on Selective Contracting: An Empirical Analysis of Any-Willing-Provider Regulations," *Journal of Health Economics* v. 20 (2001):955-66.

<sup>10</sup> [http://aspe.hhs.gov/health/reports/2013/MarketplacePremiums/datasheet\\_home.cfm](http://aspe.hhs.gov/health/reports/2013/MarketplacePremiums/datasheet_home.cfm)

<sup>11</sup> Federal Trade Commission and Department of Justice. *Improving Health Care: A Dose of Competition*. Report by FTC and DOJ, July 2004; FTC Comment to the Centers for Medicare and Medicaid Services Re: Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Program, March 7, 2014.

<sup>12</sup> Vita, op cit.

that. Thus AWP laws attenuate the cost-reducing impact of HMOs and managed care, as theory would expect.

Other peer-reviewed empirical studies of the impact of AWP laws on state health spending reach similar conclusions. Klick and Wright found a cost-increasing effect of AWP and FOC laws of 3 percent overall and a 4.7 percent increase in real per capita spending on hospitals, a 6 percent increase in physician spending, and a 5.8 percent increase in prescription drug spending.<sup>13</sup> Durrance concluded that pharmacy-only AWP laws, by far the most common, increase per capita drug spending by 7 percent.<sup>14</sup> Carroll and Ambrose<sup>15</sup> investigated the impact of both general and pharmacy-only AWP laws on HMO profits and found no net effects, which some interpret as proof the laws are harmless for insurers. However, upon close reading it is obvious that savings in care delivery are wiped out by the higher administrative costs of dealing with more providers. Furthermore, their results are consistent with our theoretical scenarios above, in which premiums rise to reflect higher plan cost structures but net profits of the insurer are unaffected (whether the insurer has monopoly power in the plan market or not), since profit maximizing premiums rise. Formerly excluded providers are the only ones who gain, and consumers are the only ones who lose.

I did find one empirical paper that concludes AWP laws actually lower costs. The paper was written by Allgrunn and Haiar at the behest of the South Dakota Association of Specialty Care Providers.<sup>16</sup> Virginia's legislative study committee had recommended against the sweeping kind of law South Dakota's legislature rejected that is now on their ballot as a referendum on the November 2014 ballot, so given that and the preponderance of other empirical work concluding that AWP laws raise costs, I presume the Specialty Care Providers wanted as much supporting analytics as possible.

Professor Allgrunn was kind enough to share the details of his results. His model made innovations compared to previous approaches, most importantly it explicitly modelled every possible interaction vis a vis providers among different types of anti-selective contracting laws: AWP for physicians and

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<sup>13</sup> Jonathan Klick and Joshua Wright. "The Effect of Any Willing Provider and Freedom of Choice Laws on Health Care Expenditures" (2012). Paper 438., Penn Faculty Scholarship, 2012.

<sup>14</sup> Christine Piette Durrance, "The Impact of Pharmacy Specific Any-Willing-Provider Legislation on Prescription Drug Expenditures," *Atlantic Economic Journal* v. 37 (August 2009):409-23.

<sup>15</sup> Anne Carroll and Jan M. Ambrose, "Any Willing Provider Laws: Their Financial Effects on HMOs," *Journal of Health Politics, Policy, and Law*. 27:6 (December 2002):927-45.

<sup>16</sup> Prof. Allgrunn's paper and its origin is described in the September 5, 2013 edition of the Madville Times. <http://madvilletimes.com/tag/initiative/page/2/>

hospitals, FOC for physicians and hospitals, AWP for pharmacies, and FOC for pharmacies. This creates 11 different combinations (including all four laws) one of which was omitted for statistical (collinearity) purposes. This interaction approach allows one to observe the effect of adding one type of law to other previously passed laws, which is the most relevant possible circumstance in South Dakota, for it already has everything but AWP for physicians and hospitals, the strongest form of AWP restrictions and the type of law on the ballot in November.

The point estimate that was derived from this work was \$ -246, which means the model predicted that adding an AWP for physicians and hospitals in South Dakota would *lower* per capita expenditures by \$246. However, four of the seven coefficients relevant to this calculation failed standard tests of statistical significance, which means that while \$ -246 is the best single point estimate, the confidence interval of this point estimate is very large, i.e., the model cannot rule out effects as large as *increasing* costs by \$1,993. In other words, while the model introduces interactions among different types of laws which is a potentially important step, there is much more work to do before it should be used to override all the other statistically significant cost increasing results from the peer-reviewed literature. To strengthen this last point, I observe that the model's point estimate for the impact of passing a strong AWP law – one that applies to physicians and hospitals and most plans – if the state has no other anti-selective contracting restriction, would increase costs by \$229, and this coefficient is highly significant.<sup>17</sup>

### ***Concluding Thoughts***

Anti-selective contracting laws, which originated in the 1930s and have periodically bubbled up ever since, are provider-based reactions to attempts by health plans to control costs through provider selection and incentive arrangements that require more reporting and quality performance accountability than some providers are willing to do. These laws are reflective of a world view that holds insurers should just write checks and leave providers alone to deal with patient care without regard to cost. We simply cannot afford that world view anymore, and by the way quality is often higher today among more efficient providers,<sup>18</sup> so the idea that we must sacrifice quality for efficiency is another myth that has been hard to kill. What must be sacrificed for quality and efficiency is the unlimited choice of all providers at the point of service at the same out of pocket price. This seems like a small price to pay, unless you are one of the “losing” providers.

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<sup>17</sup> Author's derivations from statistical results tables supplied by Prof. Allgrunn.

<sup>18</sup> See Milliman Report cited in note 7.

The policy question then boils down to the following: are we willing to pay or at least seriously risk higher prices for insurance and care in order to enable all providers to be included in all health plans? We have shown the winners from such a policy are not consumers, but providers, as plans are most likely to be able to pass some or all of the provider cost increases along. You may conclude that the cost increases reported in the economics literature are relatively small – 2-7 percent – so why not help out specialty hospitals or specialist physicians who are upset by insurance companies’ tactics?

I would remind the reader that the empirical work in the peer-reviewed literature used as its outcome variable, total per capita costs in a state; the impact on private insurance premiums is likely to be much larger, but those data have historically been much harder to come by for rigorous empirical work. I say this because AWP laws should have little to no impact on Medicare and Medicaid spending per se since their payment rates are set by governments, and they account for as much as half of total spending in most states in the United States. Indeed, private health insurance pays for just about one third of all health spending. Thus, to have estimated a 2-7 percent increase in *overall* spending means the impact among the privately insured, the area where AWP is most impactful, is actually likely 2-3 times that amount, more like 6-21 percent, almost exactly what Milliman actuaries have estimated that high valued networks could save vis a vis broad networks.<sup>19</sup> Suddenly the expected cost of AWP laws does not look so low anymore.

All policies produce tradeoffs, winners and losers, and in a democracy the values of the majority of voters should dictate the choices society makes about those tradeoffs. If most Americans are willing to pay 6-21% higher premiums to enable some specialty hospitals and some specialist providers to avoid effective cost-reducing techniques which insurers and high-value providers use elsewhere in the United States, so be it. I note this would be quite different behavior than we are actually observing in the marketplace, where consumers are flocking to lower priced-products in every market, be they marketplace or employer-based.<sup>20</sup> I would expect, in fact, that if consumers are fully informed about the implications of anti-selective contracting laws, the majority will oppose their expansion or strengthening, at least until we get health care cost growth under more permanent control.

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<sup>19</sup> Milliman Report, cf. note 7.

<sup>20</sup> Amy Burke, Arpit Misra, and Steven Sheingold. "Premium Affordability, Competition and Choice in the Health Insurance Marketplace, 2014." *ASPE Research Brief* June 18, 2014. Gruber and McKnight, cf. note 1.