At the state and federal levels, some physicians are lobbying policy-makers to enact legislation that will make it harder for insurers to limit the number and type of doctors they enlist in managed care networks. These measures are called "any willing provider" statutes because in their purest form, they require managed care organizations (MCOs) to enlist in their network any provider who is willing to abide by the terms and conditions of a contract. For example, Virginia's statute says: "No hospital, physician or type of provider listed ... willing to meet the terms and conditions offered to it or him shall be excluded".1

Because of the spread of managed care throughout the country, some people in the medical community have argued that federal health reform legislation should contain an any willing provider provision.
Background

Some physicians have argued that any willing provider laws are needed because otherwise patients are denied freedom of choice of doctors. In addition, physicians who practice in low-income areas believe that they have been, and will be, excluded from health plan networks because plans will not want to cover their patients. Doctors say that any willing provider laws merely "level the playing field" in their negotiations with health plans. This is a particular concern of minority physicians who worry that they, and the patients for whom they provide care, may be excluded from health plans.

Opponents of any willing provider laws argue that they increase health system costs by restricting health plans' ability to determine the mix of physicians, hospitals, and other providers that will best meet the needs of their subscribers. According to this line of reasoning, exclusion of some doctors promotes efficiency, reduces administrative costs, and eliminates the incentives in the current system that drive up health costs.

A recent study entitled "The Cost Impact of 'Any Willing Provider' Legislation" confirms that costs can increase under any willing provider statutes. According to the study, administrative costs for a typical non-staff model HMO would rise by 43% under an any willing provider mandate. This would increase premiums for this HMO's subscribers by 9%.

Moreover, a recent Congressional Budget Office (CBO) study concludes that for a managed care entity to restrain costs, it must be selective about using cost-conscious providers. According to the study, an IPA that is required to accept any willing provider will be unable to contain costs.
As health spending escalates, health plans will be under even greater pressure to contain costs in order to stay competitive. Without the power to reduce costs through selective contracting, health plans may be forced to micro-manage physician practices, reduce reimbursements, and use other cost-cutting devices that will be onerous for physicians.

Physicians who run health plans feel this pressure acutely. In order to compete with other health plans, they try to hold costs down. As physicians, however, they are sensitive to the other doctors in their plan and try to avoid using intrusive cost-cutting methods. Consequently, many of these physicians have recognized that the realities of today's market highlight the need to contract selectively with other doctors, and develop criteria to determine the number, geographic distribution, and specialties of physicians needed in their health plan.

In addition, any willing provider laws do not help -- and in some cases can hurt -- internists. In some areas, non-physician health providers have used these laws to become part of a health plan's network. For example, in 1994 Minnesota passed a law that requires its largest non-staff model health plans to establish expanded networks of allied independent health providers. According to the statute, these providers must be included in the network if they are willing to meet the terms and conditions of the plan's contract. Since health plans need internists to provide primary care to their subscribers they are less likely to be excluded from any networks, and therefore do not need the "protection" from any willing provider laws.

Other Approaches

Very few groups are advocating pure any willing provider language at the federal level. In fact, neither the AMA nor the NMA support national any willing provider legislation.
Instead, medical organizations including the ACP have expressed support for other concepts—such as due process protections and point-of-service requirements—that would protect physicians' rights in their business dealings with MCOs, and help ensure patient choice of physicians.

**Due Process Protections**

The last Congress saw a great deal of activity on these issues. A notable example is the "Patient Protection Act" (PPA) introduced by Senator Wellstone and Congressman Peterson in the last Congress. This proposal reflects AMA policy that "ensures that physicians are not excluded inappropriately by managed care organizations."%6%

Under the provisions of the PPA, physicians will be guaranteed certain protections when negotiating a contract with managed care organizations, including that a plan's hiring criteria must be objective and available to applicants. In addition, the PPA provides for certain "due process" protections for physicians when a health plan decides to terminate or not renew a contract. These protections include sufficient notice and the opportunity to appeal the plan's decision. The ACP has consistently supported the PPA.

**Point-of-Service Requirements**

In addition, the College has strongly supported the requirement of a "point-of-service" option in all managed care plans. There are two versions of this idea. The first forces all HMOs to allow a patient at any time to use any doctor outside the HMO's panel, provided the enrollee pays an additional fee. The second requires HMOs to offer a point-of-service HMO plan during open enrollment for a higher premium. If a subscriber wants the freedom of choosing providers outside the network, they would choose the point-of-
service plan during the open enrollment period. Otherwise, they would be restricted to the doctors on the panel.

The ACP has also spearheaded an effort to protect physicians from onerous oversight practices by insurers. Specifically, the College has advocated eliminating the current system of routine reliance on case-by-case review, and replacing it with a system that relies primarily on practice pattern evaluation. In addition, the ACP has argued for federal utilization review standards to protect physicians from intrusive and burdensome insurance company practices.*

Moreover, although African-American groups have spoken out against the discriminatory practices of health plans that exclude their members, most national organizations have not endorsed a federal any willing provider statute as the solution. Although some minority physicians have seen any willing provider legislation as a possible means to assure inclusion, these organizations are concerned that these laws will allow non-physician providers to be substituted inappropriately for physicians. Consequently, they emphasize the need to mandate that all health plans include "essential community providers", including physicians, in underserved communities.

An essential community provider program would require health plans to contract with primary and preventive care providers and safety net hospitals currently providing care in underserved inner-city and rural communities. This would help residents of these communities have access to necessary health services.

The College has consistently argued that discriminatory practices by insurers should be prohibited, and that special provisions should be enacted to ensure that the underserved have access to care.10
Conclusion

The College should not endorse any willing provider legislation at the federal level because these laws may not help, and may hurt, internists. However, any willing provider advocates correctly raise issues of fairness in the evolving health care marketplace. Physicians need protection from overly intrusive health plans, minority physicians need relief from discriminatory practices, and patients need the freedom to see a doctor of their choice.

Consequently, the ACP will continue to fight for protections for physicians, advocating utilization review reform and due process protections for doctors in their contract negotiations with health plans. In addition, the College will continue its opposition to discriminatory practices by insurers and will support efforts to provide access to services for residents of underserved areas. Moreover, the ACP will work to ensure patient choice by supporting a requirement for a point-of-service option.

All of these proposals provide meaningful and appropriate protections for physicians and will improve the quality of care for patients. At the same time, unlike a federal any willing provider law, they recognize the cost pressures of the health system, as well as the need for health plans to use their contracting power to stay competitive.

Nonetheless, in individual states, circumstances may warrant consideration of an any willing provider law. However, prior to endorsing this type of proposal, ACP state chapters should be certain that other solutions are insufficient. In addition, they must be sure that the proposed law is not written in a way that will hurt internists.
1 Va. Code Section 38.2-3407.
3 "Effects of Managed Care: An Update". Congressional Budget Office, March, 1994.
4 "Laws of Minnesota, Chapter 625, Article 1, Section 6, 1994."
6 Ibid.
7 "The Patient Protection Act, S. 2196 and H.R. 4527, 103rd Cong., 2nd Session"
8 ACP Testimony on Quality Assurance and Quality Improvement, presented to The Subcommittee on Health for Families and the Uninsured, U.S. Senate Committee on Finance, April 29, 1994.