REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

STUDY OF THE IMPACT OF SUBSECTION B OF SECTION 38.2-3407 OF THE CODE OF VIRGINIA ON THE COMMONWEALTH'S HEALTH CARE MARKET STATUTE PURSUANT TO SJR 158 OF 1994

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 23

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Preface

Senate Joint Resolution (SJR) 158 of the 1994 Session requested the Joint Commission on Health Care to study the impact of subsection B of § 38.2-3407 of the Code of Virginia on the Commonwealth's health care market.

Subsection B, commonly referred to as the "any willing provider" statute, states that health care providers (e.g. hospitals, physicians, and others) willing to meet the terms and conditions of a preferred provider network cannot be excluded from the network. Proponents of this law, mostly provider groups, state that it has little or no impact on cost; protects consumers' choice of providers; and enhances quality of care. Opponents, primarily insurers and the business community, contend that the law unnecessarily limits the ability of preferred provider network managers to negotiate discounted fees, and provides no corresponding increase in quality of care.

A total of 24 states have "any willing provider" laws. Virginia is one of only seven states whose "any willing provider" law applies to a broad range of providers. Fifteen states' laws apply only to pharmacists, while two other states apply to other specific types of providers.

Three studies, two of which were sponsored by the insurance industry, have concluded that "any willing provider" laws increase health care costs. One study conducted by Arthur Andersen & Co. for the Florida legislature concluded that an "any willing provider" law would increase costs significantly. Proponents of "any willing provider" laws question the validity of these studies' findings, and state that any increase in cost is justified by enhanced patient choice of providers.

The Federal Trade Commission has advised several states that "any willing provider" laws "may discourage competition among providers," and "may limit firms' ability to reduce the cost of delivering health care without providing any substantial public benefit." The National Governors' Association adopted a policy opposing "overly restrictive" any willing provider laws.

Little research has been done on the impact that "any willing provider" laws have on the quality of health care. However, proponents argue that preferred provider networks often sacrifice quality of care for lower costs, and that any willing provider laws enhance quality of care by including more "quality" providers. Opponents state that "any willing provider" laws force network managers to accept providers who normally would not be asked to participate. Moreover, they contend that market forces will continue to push

preferred provider organizations to include high quality providers in their networks, and that without quality providers, the networks will not be successful in the marketplace.

The study offers five policy options for consideration. Option I would maintain the status quo. Option II would repeal the "any willing provider" provision. Option III would repeal the "any willing provider" provision, but require insurers to adhere to certain requirements when forming networks. Option IV would limit the application of the law to areas with limited provider competition. Option V would amend the law to clarify some areas of confusion.

Our review process on this topic included an initial staff briefing which you will find in the body of this report followed by a public comment period during which time interested parties forwarded written comments to us on the report. In many cases, the public comments , which are provided at the end of this report, provided additional insight into the various topics covered in this study.

Jane N. Kusiak
Executive Director

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Authority for Study

Senate Joint Resolution (SJR) 158, which was passed by the 1994 Session of the General Assembly, directs the Joint Commission on Health Care, in cooperation with the Bureau of Insurance and other state agencies and private groups, to study the impact of subsection B of § 38.2-3407 of the Code of Virginia on the Commonwealth's health care market. This statute, which is commonly referred to as the "preferred provider organization" (PPO) statute, permits insurers to establish PPO programs. Subsection B of the statute, which requires insurers to accept into their preferred provider networks any provider willing to meet the terms and conditions offered to it or him/her, is referred to as the "any willing provider" provision.

Specifically, SJR 158 directs the Joint Commission to study the impact of this statute on: (i) the Commonwealth's efforts to contain costs, (ii) the quality of health care provided in the Commonwealth, and (iii) competition in the marketplace among health care providers.

Background

Preferred Provider Organizations Seek to Lower Health Care Costs Through Selective Contracting with Providers

In the early 1980s, insurers and Blue Cross and Blue Shield plans began forming "preferred provider organization" (PPOs) plans in an attempt to control increasing health care costs. These PPO plans were developed, at least in part, to compete with Health Maintenance Organizations (HMOs) which had proven successful in controlling costs while providing quality health care services to their members.

Similar to HMO physician panels, PPO plans develop networks of "preferred providers" through selective contracting with hospitals, physicians, mental health providers and other health care providers. Typically, preferred providers agree to provide services to PPO enrollees at a reduced or discounted cost in return for increased patient volume.

Insurers are able to direct increased patient volume to preferred providers through benefit design features which provide a higher level of benefit payment if an enrollee receives services from a provider who participates in the PPO network. Unlike HMOs which routinely do not provide any benefit for services received outside the HMO's provider network, persons enrolled in a PPO plan receive a reduced benefit when accessing care outside the network. The reduced

benefit typically is 20 to 50 percent lower than when enrollees receive care from a "preferred provider."

"Any Willing Provider" Laws Have Been Enacted In Response to Selective Provider Contracting by Insurers

Enrollment in PPO plans has increased significantly over the past 10 years as employers seek ways of reducing health benefit costs without reducing the level of benefits or services covered under their health benefits plans. As more and more patients receive their health benefits through PPO arrangements, participation in PPO networks becomes increasingly important for health care providers.

In order to direct patient volume to preferred providers, insurers state that they must be able to limit the number of providers in the network. However, many health care and mental health providers state that in order to protect their patients' choice of providers, insurers forming PPO networks should accept any provider who is willing to meet the terms and conditions established for the PPO network.

"Any willing provider" laws have been enacted in 24 states thus far as a response to the selective contracting practices associated with PPO networks. In general, these laws require insurers to include in the PPO network any provider willing to abide by the terms and conditions of the network, including price. As discussed later in this issue brief, some states' any willing provider laws pertain only to certain providers (e.g. pharmacists), while others apply to all providers.

"Freedom of Choice" Laws Go Beyond "Any Willing Provider" Laws

By increasing the number of providers in a PPO network, any willing provider laws expand patients' choice of network providers. "Freedom of choice" laws also expand patients' choice of providers. However, rather than increasing the number of providers participating in a network, "freedom of choice" laws go a step further by granting a PPO and/or HMO enrollee the ability to receive services from non-network providers with no reduction in benefits as long as the provider agrees to accept the insurer's level of reimbursement for the service.

Virginia's "Any Willing Provider" and "Freedom of Choice" Laws

"Any Willing Provider" Law Established in 1983 as Part of Legislation Enacted to Establish Preferred Provider Organizations

In 1983, the Prudential Insurance Company had introduced its new Health Maintenance Organization (HMO), PruCare, in the Richmond market. In response to the success of PruCare and the trend toward managed care delivery systems, Blue Cross and Blue Shield of Virginia (BCBSVA) sought to establish a "preferred provider organization" (PPO). However, BCBSVA's enabling legislation did not specify that it could develop such a plan. Therefore, the company requested that legislation be introduced to amend the current statute and permit BCBSVA to develop a PPO plan.

Senator Adelard L. Brault introduced Senate Bill 110 during the 1983 Session of the General Assembly to enable nonstock corporations to form PPO networks. The legislation, as introduced, did not include a provision requiring a non-stock corporation to accept any provider willing to meet the terms and conditions of the PPO. However, health care providers expressed concern over the impact of limiting the number of providers in a PPO network. Consequently, the bill was amended to include the "any willing provider" provision.

The amended bill also included language that permitted commercial insurers to form PPO networks. The "any willing provider" provision was incorporated into the commercial insurers' PPO statute as well. The amended version of SB 110 was enacted by the General Assembly.

Any Willing Provider Laws Affect Commercial Insurers and Nonstock Corporations

The any willing provider provision which pertains to commercial insurers (e.g. Aetna, Trigon, BCBSVA, Metropolitan, Travelers, etc.) is contained in Subsection B of §38.2-3407 of the Code. The provisions which affect nonstock corporations (e.g. Blue Cross and Blue Shield of the National Capital Area) are found in Subsection C of §38.2-4209. The language and requirements of the two statutes are virtually identical. The full text of both §38.2-3407 and §38.2-4209 is provided in Appendix C. The specific any willing provider provisions of the respective statutes are presented in Figure 1.

Figure 1

Virginia's Any Willing Provider Provisions

Subsection B, § 38.2-3407 (Insurers)

B. Any such insurer shall establish terms and conditions that shall be met by a hospital, physician or type of provider listed in § 38.2-3408 in order to qualify for payment as a preferred provider under the policies or contracts. These terms and conditions shall not discriminate unreasonably against or among such health care providers. *No hospital, physician or type of provider listed in § 38.2-3408 willing to meet the terms and conditions offered to it or him shall be excluded.* (Emphasis added.) Neither differences in prices among hospitals or other institutional providers produced by a process of individual negotiations with providers or based on market conditions, or price differences among providers in different geographical areas, shall be deemed unreasonable discrimination. The Commission shall have no jurisdiction to adjudicate controversies growing out of this subsection.

Subsection C, § 38.2-4209 (Nonstock Corporations)

C. Any such nonstock corporation shall establish terms and conditions that shall be met by a hospital, physician or type of provider listed in § 38.2-4221 in order to qualify for payment as a preferred provider under the subscription contracts. These terms and conditions shall not discriminate unreasonably against or among health care providers. *No hospital, physician or type of provider listed in § 38.2-4221 willing to meet the terms and conditions offered to it or him shall be excluded.* (Emphasis added.) Differences in prices among hospitals or other institutional providers produced by a process of individual negotiations with the providers or based on market conditions, or price differences among providers in different geographical areas shall not be deemed unreasonable discrimination. The Commission shall have no jurisdiction to adjudicate controversies growing out of this subsection.

Source: Code of Virginia

Virginia's Any Willing Provider Laws Apply to Hospitals and Various Health Care and Mental Health Providers

The provisions of Virginia's any willing provider laws apply to hospitals, physicians and other health care and mental health care providers, as provided in §§38.2-3408 and 38.2-4221. Figure 2 identifies these other providers.

Virginia's any willing provider laws do not affect Health Maintenance Organizations (HMOs). Subsection F of §38.2-4312 states that HMOs shall not unreasonably discriminate against physicians as a class or any class of providers listed in §38.2-4221 or pharmacists when contracting for specialty or referral practitioners or providers. However, the statute states that "[N]othing in this section shall prevent a health maintenance organization from selecting, in the judgment of the health maintenance organization, the numbers of providers necessary to render the services offered by the health maintenance organization."

Figure 2

Health Care and Mental Health Providers Subject to Virginia's Any Willing Provider Laws

Physician	Optometrist
Optician	Professional Counselor
Psychologist	Clinical Social Worker
Podiatrist	Physical Therapist
Chiropodist	Clinical Nurse Specialist*
Audiologist	Speech Pathologist
Chiropractor	Hospital

* Applies to Clinical Nurse Specialists who render mental health services.

Source: Code of Virginia

Virginia's Any Willing Provider Laws Have Remained Basically Unchanged; the Types of Affected Providers Have Increased

With few exceptions, the specific provisions of Virginia's any willing provider laws (§38.2-3407(B) and §38.2-4209(C)) have remained unchanged since their passage in 1983.

Senate Bill 552, which was passed by the 1994 Session of the General Assembly, added a new section which prohibits health services plans and health maintenance organizations from excluding podiatrists from participating in these plans solely because the podiatrist does not have active medical staff privileges or admitting medical staff privileges at specified hospitals.

While the specific any willing provider provisions have remained constant, the types of providers to which these provisions apply have expanded. Since 1983, when the any willing provider provisions were enacted, audiologists, clinical nurse specialists, physical therapists, professional counselors and speech pathologists have been added to §§38.2-3408 and 38.2-4221 which identify the providers affected by the any willing provider provisions.

In 1994, House Bill 839 was introduced which would have added pharmacists to the group of providers to whom the any willing provider provisions apply. However, this bill was carried over to the 1995 Session.

House Bill 840: Provides Freedom of Choice of Pharmacists and Ancillary Service Providers

House Bill (HB) 840, which was passed by the 1994 Session of the General Assembly, is a "freedom of choice" law affecting pharmacies and ancillary service providers. (Ancillary services refer to services required to support, facilitate, or enhance medical care and treatment, including durable medical equipment.)

This legislation provides that persons receiving pharmacy or ancillary service benefits may receive these benefits from any pharmacy or ancillary service provider as long as the provider agrees to accept reimbursement for their services at rates applicable to the preferred providers.

Unlike the "any willing provider" laws which apply only to commercial insurers and nonstock corporations, the provisions of HB 840 apply to these entities and HMOs.

Court Decisions Regarding Virginia's Any Willing Provider Statute

Hospitals Have Challenged Insurers' Compliance with the Any Willing Provider Law in Four Court Cases

Since the passage of Virginia's any willing provider law in 1983, several hospitals have challenged the PPO contracting practices of some insurers in four court cases. In each case, a Virginia hospital filed suit against the insurer declaring that the insurer had violated either §38.2-3407 or §38.2-4209.

The following information, which was taken from the court records of each case, summarizes the complaints, court rulings and final resolution of each court case.

HCA Health Services, Inc., Richmond Community Hospital, Inc., and Richmond Eye and Ear Hospital v. Metropolitan Life Insurance Company and MetLife Health Management Corporation

Background: During 1988, MetLife began establishing its PPO network called MetElect in the Richmond area. MetLife established four medical service areas in Richmond, and sought to contract with one hospital per area. MetLife evaluated hospitals on several criteria including geographic convenience, range of services, cost-efficiency and historic utilization.

MetLife excluded Richmond Eye and Ear Hospital because it did not provide the required range of services. Richmond Community Hospital was excluded because it did not satisfy the historical utilization criteria. Neither of these two hospitals received a written invitation for further negotiation with MetLife. MetLife negotiated with Henrico Doctors' Hospital, but rejected its final offer based on price.

The plaintiffs filed suit in the U.S. District Court for the Eastern District of Virginia declaring that MetLife failed to establish nondiscriminatory terms and conditions, and, thus, violated §38.2-3407.

Court Ruling: The Court concluded that the process and selection criteria used by MetLife in developing a "short list" of eligible providers with which to negotiate was appropriate, and that the criteria did not unreasonably discriminate against any provider. The Court further stated that the methods used by MetLife to develop a short list of eligible providers was the "functional equivalent of statutorily required terms and conditions." The Court ruled in favor of MetLife.

Appeal: There were no appeals.

St. Mary's Hospital v. Blue Cross and Blue Shield of Virginia (BCBSVA)

Background: BCBSVA re-negotiated its PPO hospital network in the Richmond area during 1990. BCBSVA sent a hospital agreement to all hospitals in the area. If a hospital agreed to the terms and conditions as contained in the agreement, the hospital was guaranteed admission to the network. If hospitals modified or rejected the terms and conditions, BCBSVA reserved the right not to negotiate with the hospital.

St. Mary's did not accept the terms and conditions as contained in the BCBSVA hospital agreement. BCBSVA and St. Mary's negotiated extensively over the course of several months. BCBSVA also was negotiating with Henrico Doctors' Hospital which had offered BCBSVA two price proposals: one if St. Mary's was included in the network, and a lower priced offer if St. Mary's was excluded from the network. St. Mary's had offered to match the final price terms offered by Henrico Doctors' Hospital. However, BCBSVA reasoned that it was impossible for St. Mary's to match Henrico Doctors' lowest price proposal since its proposal was based on St. Mary's not being in the network. BCBSVA, thus, excluded St. Mary's from the network due to price.

St. Mary's filed suit against BCBSVA declaring that it had discriminated unreasonably against the hospital in its negotiations, and that BCBSVA's exclusive contract with Henrico Doctors' Hospital, which was included in the network, violated the PPO statute.

Court Ruling: The Circuit Court of Henrico County concluded that BCBSVA had negotiated in good faith with St. Mary's and did not unreasonably discriminate against St. Mary's. The Court ruled in favor of BCBSVA.

Appeal: St. Mary's appealed the Circuit Court's ruling to the Virginia Supreme Court. The Virginia Supreme Court agreed with the lower court ruling that BCBSVA did not discriminate unreasonably against St. Mary's. In reaching its decision, the Court indicated that BCBSVA's contract agreement with Henrico Doctors' Hospital, which provided a lower cost if St. Mary's was excluded from the network, worked to the overall benefit of the PPO participants; and, therefore, did not violate the PPO statute.

Stuart Circle Hospital v. Aetna Life Insurance Co. and Aetna Health Management

Background: In 1992, Aetna decided to reconfigure its hospital PPO network in Richmond. It decided that it would contract with one full service acute care hospital in each of three medical catchment areas. Aetna's stated goal was to ensure availability of all services without duplicating services, and to minimize the cost of services for its PPO participants.

According to Aetna, Stuart Circle Hospital was deemed to be ineligible for the network because it lacked obstetric and pediatric units. As such, Aetna did not invite Stuart Circle Hospital to submit a proposal.

Stuart Circle filed suit against Aetna declaring that its exclusion of the hospital violated §38.2-3407 (the PPO statute). Prior to determining the merits of Stuart Circle's complaint, the Court reviewed the issue of whether Virginia's PPO statute was preempted by the Employee Retirement Income Security Act (ERISA) of 1974.

Court Ruling: The U.S. District Court for the Eastern District of Virginia concluded that the PPO statute does not regulate the "business of insurance," and relates to employee benefit plans. Accordingly, the Court ruled that the PPO statute is preempted by ERISA, and is unenforceable.

Appeals: Stuart Circle Hospital appealed the ruling of the District Court which held that ERISA preempted the PPO statute. The U.S. Court of Appeals for the Fourth Circuit ruled that ERISA did not preempt the PPO statute, and remanded the case for further proceedings.

Aetna requested that the U.S. Supreme Court review the decision. However, the Supreme Court decided not to review the case.

Final Disposition: Following the decision of the appeals court, Stuart Circle Hospital was purchased by Bon Secours Health Systems, Inc. Bon Secours also owns St. Mary's Hospital, which is in Aetna's PPO network. Stuart Circle decided to drop the suit against Aetna.

HCA Health Services of Virginia, Inc. v. Aetna Life Insurance Company

Background: HCA owns and operates Reston Hospital in Reston, Virginia. Reston Hospital had been in Aetna's PPO hospital network from 1987 to 1991. Aetna advised Reston Hospital that it was terminating the hospital's participation in the network. Prior to being terminated by Aetna, Reston had not received any indication that Aetna was displeased with the hospital nor any prior warning that it would be terminated.

Following discussions with INOVA Health Systems, which owned three other northern Virginia hospitals, Aetna decided that its PPO network would include the three INOVA hospitals plus Alexandria Hospital. Reston Hospital was excluded from the network.

HCA sued Aetna alleging that its exclusion of Reston Hospital violated the PPO statute. Specifically, HCA claimed that Aetna failed to establish terms and conditions for participation in the network. HCA also claimed Aetna wrongfully failed to negotiate with Reston Hospital.

Court Ruling: In its review of this case, the U.S. District Court for the Eastern District of Virginia referenced the case of HCA Health Services v. Metropolitan in which the court found that Metropolitan's process of evaluating hospitals to form a "short list" of eligible hospitals with which to negotiate was appropriate. Aetna argued that it followed the same process in excluding Reston Hospital that Metropolitan used in excluding two hospitals. However, the court concluded that Aetna did not conduct the same "thorough comparative analysis" in excluding Reston Hospital as Metropolitan had used to develop its "short list" of eligible hospitals.

The Court found that Aetna violated the PPO statute by excluding Reston without affording it an opportunity to negotiate terms and conditions. The Court ordered Aetna to negotiate with Reston Hospital and to report the results of its negotiations to the Court.

As ordered by the Court, Aetna negotiated with Reston; and, based on its negotiations, decided it was unable to admit Reston to the network. Aetna requested the Court for a summary judgment to dismiss the case. HCA argued that Aetna did not negotiate in good faith and asked the Court to order its admission into the network.

The Court found that Aetna negotiated in good faith and that Aetna's arrangement with INOVA was not in violation of the PPO statute. Accordingly, Aetna's motion for summary judgment was granted.

Appeals: The District Court's final ruling was issued on June 16, 1994. It is unknown at this time whether HCA/Reston Hospital will appeal the ruling.

Court Rulings Provide Guidance Regarding the Impact of the Any Willing Provider Law on Insurers' Ability to Negotiate PPO Networks

The four court cases are instructive in several ways regarding the ability of insurers to develop cost effective PPO networks.

* The court rulings have held that ERISA does not preempt the any willing provider statute; and, thus, it is an enforceable state law.
* Taken as a whole, the court rulings indicate that insurers have latitude in how they develop their PPO networks. As outlined in the previous cases, the courts have upheld insurers' varying methods of establishing terms and conditions, negotiating with hospitals, and excluding hospitals from PPO networks.
* The courts have indicated that developing a "short list" of eligible providers with whom an insurer wants to negotiate is an acceptable practice as long as the insurer uses a "thorough comparative analysis" to develop the short list.
* Based on the courts' decisions, the any willing provider statute has not forced an insurer to include in its PPO network a hospital that it wanted to exclude. While Aetna was ordered by the court to negotiate in good faith with a hospital it had previously excluded, the District Court's final ruling did not result in Aetna having to admit the hospital into the network.

Some Confusion Exists Regarding Specific Aspects of the Laws

While the preceding court decisions have provided guidance regarding certain features of the any willing provider laws, there is lingering confusion regarding some aspects of the laws.

Virginia's inclusion of its "any willing provider" provision in the PPO statute rather than as a "stand-alone" provision, as enacted by other states, has created some confusion. Subsection A of §38.2-3407 states that insurers "...may offer preferred provider policies or contracts that limit the numbers and types of providers of health care services eligible for payment as preferred providers." However, Subsection B, the "any willing provider" provision, says that insurers cannot exclude a provider who is willing to accept the terms and conditions offered to it or him. This language generates some confusion among insurers and providers.

One issue that has not been addressed specifically by the Courts is the language contained in the law which references the offering of terms and conditions to a provider. Virginia's any willing provider law states: "No hospital, physician or type of provider listed in §38.2-3408 willing to meet the terms and conditions *offered to it or him* (emphasis added) shall be excluded." (The any willing provider law applicable to nonstock corporations includes the same language.)

One interpretation of the terms "offered to it or him" would suggest that the "any willing provider" provision does not apply unless and until the insurer specifically offers a contract or network proposal to the provider. Under this interpretation, insurers could limit the number of providers in a network simply by not offering any terms and conditions to certain providers. The other interpretation regarding this language is that if an insurer establishes terms and conditions for a PPO network, any provider willing to meet these terms and conditions shall not be excluded.

The HCA/Reston Hospital v. Aetna case, in which the Court ruled that Reston could not be excluded from Aetna's network until a "thorough comparative analysis" was completed, seems to suggest that an insurer cannot exclude a provider by simply not offering terms and conditions. Nonetheless, this is an issue that may be tested in future cases.

Another aspect of the laws which causes some confusion among providers and insurers alike is the definition of "terms and conditions." The Code provides no direction or definition of what may be included in a PPO's terms and conditions.

Due to the lack of guidance on this issue, there is no agreement as to what insurers can include in their network terms and conditions. For example, in addition to more typical terms and conditions such as professional and economic credentialing, some insurers have included "network capacity" in their terms and conditions. By doing so, if an insurer believes its network capacity for providers has been met, these insurers are not accepting providers who meet the other professional and economic criteria.

The confusion over the types of terms and conditions that can be established by insurers has resulted in some discord between some insurers and providers.

To Date, There Have Been No Court Rulings Involving Other Providers

As of this date, there have been no court rulings involving any willing provider lawsuits filed by other types of providers, such as physicians, counselors, etc. However, the Medical Society of the District of Columbia filed suit against Blue Cross and Blue Shield of the National Capital Area (BCBSNCA). The physicians' group accuses BCBSNCA of using arbitrary factors in determining which physicians will participate in its PPO network. They also contend that the plan excludes physicians whose costs are higher because they treat patients in the city's poorer areas who tend to be sicker. The lawsuit was filed in the U.S. District Court of the District of Columbia.

Impact of Any Willing Provider Laws on the Cost of Health Care

As previously noted, the concept of preferred provider organization (PPO) networks is that insurers can lower health care costs by selectively contracting with certain hospitals and other providers who agree to discount their fees in return for increased patient volume. Providers are selected not only on the basis of cost discounts, but also on various "quality" criteria such as appropriate licensure, board certification, education and training, years of experience, and professional conduct.

According to insurers and managed care organizations, a provider's willingness to participate in limited provider networks (i.e. PPO networks) and agree to discounted fees is contingent upon the provider being assured of a certain patient volume. Without a known volume of patients, the provider is less likely to agree to cost discounts. Without lower provider discounts, the insurers' cost of providing health insurance to an employer is increased.

Any Willing Provider Laws Increase the Number of Providers Participating in a PPO Network.

Virginia's any willing provider law, which is similar to those enacted in several other states, requires that insurers accept into their networks any provider willing to meet the terms and conditions for participating in the network. Because insurers must accept "any willing provider," they argue that they cannot assure providers of a given volume of patients. According to insurers, the end result is that providers become reluctant to join such PPO networks, or agree to participate, but for higher fees.

Three Studies Have Concluded that Any Willing Provider Laws Increase Health Care Costs

Proponents and opponents disagree on the extent to which any willing provider laws increase the cost of health care, if at all. However, three studies conducted since 1991 have concluded that any willing provider laws do increase the cost of health care. Two of the studies, Wyatt (1991) and Atkinson & Company (1994), were commissioned by health insurance trade associations. Neither of these studies used empirical data that measure the cost of health care in a state before and after the enactment of an any willing provider law. Rather, the studies are based on economic models which the authors developed to estimate the cost impact of such laws. The Wyatt and Atkinson studies examined the cost impact of any willing provider laws in general, and not Virginia's specific statute.

Wyatt Company Study: In 1991, the Wyatt Company was commissioned by the Health Insurance Association of America to estimate the impact of various legislative mandates on managed care programs, including any willing provider laws.

Based on the responses of 29 PPO networks, Wyatt developed an average network's size, staffing and percent of provider penetration as a baseline. Wyatt then developed a range of possible network participation assumptions to show the impact caused by increases in the number of providers participating in a network.

Wyatt separately analyzed the impact of any willing provider laws on administrative costs and claims costs. Administrative costs include such costs as the processing of providers' applications, provider credentialing, training and monitoring, problem resolution and other network maintenance activities. Wyatt concluded that, depending on the number of additional providers

included in a PPO network as a function of any willing provider laws, these administrative costs would increase between 34% and 52%.

Wyatt's fundamental premise for analyzing the impact of any willing provider laws on claims costs was that expanding the number of providers in a PPO results in providers being less likely to grant as deep a discount as they would otherwise because each provider will have fewer patients directed to him/her. Wyatt developed an economic model to estimate the impact of any willing provider laws on claims costs, and concluded that depending on the number of additional providers participating in a PPO network, the claims savings would be reduced between 8.8% and 14.2%.

While the Wyatt study is perhaps the most frequently cited study in the literature, it is not without critics. The American Medical Association issued a response to the study which questioned the methodology used to estimate costs.

Atkinson & Co. Study: In June, 1994, Atkinson & Co. (Atkinson), which is an independent actuarial firm, completed its study of the cost impact of any willing provider statutes on HMOs. This study was commissioned by the Group Health Association of America. While Virginia's any willing provider statute does not affect HMOs, the results of this study are nonetheless useful in attempting to ascertain the impact of this type of legislation.

Atkinson used actuarial and economic models similar to those used by Wyatt in its 1991 study. Based on its analysis, Atkinson concluded that depending on the number of additional providers participating in a HMO network as a result of an any willing provider law, administrative costs would increase by 43%, or in the worst case scenario, as much as 127%. Atkinson also concluded that, as a result of a reduced ability to negotiate discounts with providers, HMO health care costs would increase by 5.8%, or in the worst case scenario, as much as 18.4%.

Lastly, Atkinson estimated that the combined impact of increases in administrative costs and claims costs would increase HMO premiums 9.1%, or in the worst scenario, as much as 28.7%.

Arthur Andersen & Co.: The analysis conducted by Arthur Andersen & Co. (Andersen) differed from that completed by Wyatt and Atkinson. Andersen was requested by the House Appropriations Committee of the Florida General Assembly to provide advice regarding certain aspects of Florida's proposed Health Security Program. One of the specific aspects that Andersen was requested to analyze was the possible impact of adding an any willing provider provision to the program.

Andersen was asked to estimate the impact of: (i) an any willing provider provision which applied to primary care physicians and specialists, (ii) an any willing provider provision that applied only to specialists, and (iii) a freedom of choice provision which would allow an individual to use any independent pharmacy which provides services at or below the cost of the network pharmacies. (According to the lead analyst from Arthur Andersen who conducted the analysis, Florida was interested only in extending a freedom of choice provision to independent pharmacies in Florida, which are few in number.)

Andersen concluded that the impact of the any willing "primary care physician and specialist" provision would be significant. In its actuarial report to the Florida House Appropriations Committee, Andersen stated that under such a provision, "[P]ayors would have far less leverage to negotiate fees with physicians. In addition, utilization management programs would be spread over a far greater number of physicians, diluting their effectiveness and focus. The combination of these effects would eliminate much or all of the cost savings achievable through managed care. Furthermore, administrative expenses would increase, due to greater network size."

With respect to the "any willing specialist" provision, Andersen concluded that the impact would be less than that associated with a provision that applied to both primary care physicians and specialists. However, Andersen estimated that such a provision would "...reduce the program's managed care savings by 70%, from 5.0% to 1.5% of acute care service costs."

Regarding the pharmacy "freedom of choice" provision, Andersen concluded that, assuming the independent pharmacy must abide by the formulary adopted by the managed care organization, this provision would result in only a modest increase in administrative costs, and a negligible increase in health care expenses. The lead analyst with Arthur Andersen indicated their analysis would have produced different results had the freedom of choice provision extended to all pharmacies in Florida.

Lewin-VHI Study Links Patient Volume to Lower Health Care Costs

In addition to the three studies which analyzed the cost impact of any willing provider laws, Lewin-VHI, Inc. recently completed a study which estimated the savings of managed care programs. While the study did not focus on the impact of any willing provider laws, the Lewin-VHI study concluded that an increase in a primary care physician's volume of managed care patients can significantly reduce health care costs. Specifically, they indicate that when an insurer can increase a primary care physician's volume of managed care

patients above 100, cost savings result. For example, Lewin-VHI states that a volume of 500 managed care patients reduces per patient costs approximately 4.5%, and that the amount of savings increases up to 6.4% with a volume of 1,000 managed care patients. Lewin-VHI note that further increases in volume appear to have little relationship with costs.

They attribute their findings to the notion that a larger managed care patient volume results in the insurer having a greater impact on a provider's practice patterns.

Insurers Incur Litigation Costs Defending Lawsuits

In addition to administrative and claims cost associated with any willing provider laws, insurers argue that the cost of defending lawsuits associated with Virginia's any willing provider laws must be considered. Aetna estimates that it has spent approximately $.7 million in legal fees defending the Stuart Circle and Reston Hospital cases. Trigon, Blue Cross Blue Shield indicated that it spent a significant amount in legal fees defending the St. Mary's case, and that the amount was somewhat less than the $.7 million spent by Aetna.

Insurers argue that these legal fees add to the overall cost of developing and administering PPO networks, which ultimately must be recouped through premiums.

Federal Trade Commission Warns States that Any Willing Provider Laws May Limit Insurers' Ability to Lower Health Care Costs

The U.S. Federal Trade Commission (FTC) has been requested by a number of state legislatures to advise them on the possible impact that any willing provider laws could have on competition and health care costs. States requesting formal opinions from the FTC include Massachusetts, Texas, South Carolina, Pennsylvania, New Jersey, New Hampshire, and Montana. (Several of these states requested advice regarding any willing pharmacy legislation.)

While each state's any willing provider law varies somewhat, the FTC consistently has advised states that such legislation "...may limit firms' ability to reduce the cost of delivering health care without providing any substantial public benefit." The FTC further states:

> To the extent that opening programs to all providers reduces the portion of subscribers' business that each contracting provider can expect to obtain, these providers may be less willing to enter agreements that contemplate lower prices or additional services.

> Moreover, since any provider would be entitled to contract on the same terms as other providers, there would be little incentive for providers to compete in developing attractive or innovative proposals.

The FTC concluded each of its letters to the state legislatures with a closing statement similar to the following statement included in its response to the state of Montana:

> In summary, we believe that "any willing provider" requirements may discourage competition among providers, in turn raising prices to consumers and unnecessarily restricting consumer choice in prepaid health care programs, without providing any substantial public benefit.

Proponents of Any Willing Provider Laws Question the Impact on Cost and Argue that Any Potential Cost Increases are Justified by an Increase in Patient Choice

Proponents of any willing provider laws question whether there is any impact on the cost of health care. They state that because the insurer sets the price or fees in the PPO's terms and conditions, and controls cost through utilization review and management, there should be a minimal cost impact.

Proponents further believe that if these laws do increase the cost of health care, the cost is justified by the resulting increase in patients' choice of providers. Proponents point to research that indicates consumers identify "choice of provider" as one of the most important aspects of their health benefits plan as evidence of the importance of broader PPO networks.

Impact of Any Willing Provider Laws on the Quality of Health Care

Research is Very Limited

There is very little research that has analyzed the impact of any willing provider laws on the quality of health care. One likely reason is that there are numerous definitions of quality, and very little agreement on which definition is most appropriate. Consequently, measuring quality and the impact of various factors on quality becomes quite difficult.

In the absence of a concrete definition of quality and of any research on this issue, the analysis of whether any willing provider laws impact quality falls

to a presentation of the various arguments put forth by the proponents and opponents of this legislation.

Proponents Believe Choice of Providers and Providers' Allegiance to Patients are Key Quality Indicators

Proponents of any willing provider legislation assert that limited provider networks often sacrifice quality for lower costs. Specifically, their argument is that many providers who are allowed to participate in PPO networks are included not on the basis of the quality of care they provide, but on their willingness to grant price discounts.

One positive impact on quality that proponents point to is that consumers' choice of providers is enhanced through any willing provider laws. Specifically, proponents believe that the continuity of the patient-provider relationship is very important. Accordingly, networks which require patients to pay additional costs in order to continue this relationship are viewed as having a negative impact on the quality of health care. Continuity of the patient-provider relationship is seen as being particularly important with respect to mental health care where this relationship is critical to successful treatment.

Proponents also assert that any willing provider laws prevent insurers from being in a position of control wherein the insurer dictates to a physician how he/she will practice medicine. As noted in the previous discussion of the Lewin-VHI study, insurers generally believe that to accomplish the objectives of the PPO, each participating provider must have a critical mass of PPO patients. Insurers believe that this critical mass of patients results in the PPO having more influence on the provider's practice patterns. Proponents of any willing provider legislation say this is precisely the problem. And, that when this occurs, the provider's actions often are driven more by his/her dependence on the PPO for patients than what he/she believes is appropriate for the patient.

Opponents of Any Willing Provider Legislation Contend That the Marketplace Will Prevent Networks from Having Too Few Providers, and That These Laws Allow Lesser Quality Providers in Their Networks

Insurers believe that any willing provider laws are not necessary to police the number of providers included in a PPO network. They contend that a PPO network which does not have a sufficient number of quality providers will not be marketable to employers. Thus, it is in the interest of the insurer to make certain that the network offers patients a reasonable choice of providers.

Most insurers and other opponents of any willing provider laws believe that these laws force them to accept providers who normally would not be invited to participate in their networks; and, thus, reduce the quality of the network. While proponents argue that insurers are able to control the quality of providers joining their networks by including "quality" criteria in their network contract terms and conditions, insurers counter that these criteria have limited effectiveness in screening out lesser quality providers.

Some opponents of any willing provider laws also assert that there is research which indicates the quality of health care can be improved through increased volume. Specifically, these opponents point to research such as a recent study published in the Journal of the American Medical Association which concluded that the risk of mortality associated with cardiac transplants is substantially higher in low-volume cardiac transplant centers than in higher volume centers. The argument here is that the more a provider performs a given treatment or service, the better the results become.

The concept of "greater volume equals higher quality" is one of the tenets of "Centers of Excellence" programs wherein insurers contract with only a few medical centers for complex treatments. These centers have a high volume of cases and proven track records of successful treatment and low mortality rates. Insurers contend that the success of these Centers of Excellence programs is evidence that increased volume results in enhanced quality.

Any Willing Provider Laws in Other States and in National Health Care Reform

Any Willing Provider Legislation Was Introduced in 32 States During 1994

Based on information published by the Blue Cross and Blue Shield Association (BCBSA), various any willing provider laws were introduced in 32 state legislatures during 1994. In 19 states, the proposed legislation applied to all licensed providers; in 10 states, the legislation applied to pharmacies only; and in three other states, the legislation applied to a limited number of other providers.

Of the 32 states which considered any willing provider laws in 1994, the legislation failed in 13 states. Eight states (Delaware, Idaho, Kansas, Kentucky, Minnesota, Mississippi, New Jersey, and South Carolina) passed their respective any willing provider measures. With the exception of the laws passed in Idaho and Kentucky, which apply to all providers, the laws passed in the other six

states apply only to pharmacies. Final action is still pending in the remaining 11 states.

As of July 1, 1994, 24 States Have Any Willing Provider Laws

According to information published by the Blue Cross and Blue Shield Association, as of July 1, 1994, 24 states have any willing provider laws. Eight states (Delaware, Idaho, Kansas, Kentucky, Minnesota, Mississippi, New Jersey, and South Carolina) passed their laws in 1994.

In 15 of the 24 states, the any willing provider provisions apply only to pharmacies. In 7 states, including Virginia, the provisions apply to nearly all providers. The provisions apply only to physicians and chiropractors in Illinois, and only to allied providers in Minnesota. Figure 3 identifies the 24 states with any willing provider laws.

Figure 3

States With Any Willing Provider Laws (July 1, 1994)

Pharmacies Only		All Providers
Alabama	Mississippi*	Idaho*
Arkansas	New Hampshire	Indiana
Connecticut	New Jersey*	Kentucky*
Delaware*	North Carolina	Utah
Florida	North Dakota	Virginia
Kansas*	South Carolina*	Washington
Louisiana	South Dakota	Wyoming
	Wisconsin	

Physicians and Chiropractors	Allied Providers
Illinois	Minnesota*

* Enacted in 1994

Source: Blue Cross and Blue Shield Association

While the specific provisions of the states' laws vary, the basic tenet of each law is the same: insurers and others who develop PPO networks must

accept any affected provider who is willing to meet the terms and conditions of the network.

"Freedom of Choice" Legislation Was Introduced in 14 States During 1994

Based on information published by the Blue Cross and Blue Shield Association, freedom of choice legislation was introduced in the 1994 legislative sessions of 14 states. Seven proposals applied to pharmacies only; four applied to all providers; two affected physicians only; and one applied to physicians and mental health providers only. Three states (Mississippi, New Jersey, and Virginia) passed freedom of choice bills, all of which apply only to pharmacies. Freedom of choice laws were defeated in seven states. The final action on legislation proposed in the remaining four states is still pending.

As of July 1, 1994, "Freedom of Choice" Laws for Pharmacies Exist in 13 States

"Freedom of choice" laws which provide that patients may purchase their prescriptions from any pharmacy willing to accept the insurer's reimbursement fees provided to pharmacies in the network existed in 13 states as of July 1, 1994. These 13 states, which include some of the same states with any willing provider laws, are identified in Figure 4.

Figure 4

States With Freedom of Choice Laws for Pharmacies (July 1, 1994)

Alabama	Connecticut
Georgia	Iowa
Louisiana	Maryland
Mississippi*	New Jersey*
North Dakota	Rhode Island
Tennessee	Texas
Virginia*	

* Enacted in 1994

Source: Blue Cross and Blue Shield Association

Some States Have Enacted Alternative Approaches to Any Willing Provider Laws

Some states have enacted laws which regulate managed care networks, but do not mandate any willing provider requirements. For example, Colorado, Michigan, and Oregon require that insurers issue public notices of any PPO network offering. Five states (California, Georgia, Michigan, Oregon and Texas) require that providers be given an opportunity to apply for inclusion in PPO networks.

National Association of Insurance Commissioners' Model Legislation for Preferred Provider Laws Does Not Include "Any Willing Provider" Provisions

The National Association of Insurance Commissioners (NAIC) has developed the Preferred Provider Arrangements Model Act to assist states in establishing PPO statutes. Section 6 of the model legislation, which addresses provider participation requirements, does not include an any willing provider requirement. Section 6 of the model act is provided below.

> Health care insurers may place reasonable limits on the number or classes of preferred providers which satisfy the standards set forth by the health care insurer, provided that there be no discrimination against providers on the basis of religion, race, color, national origin, age, sex or marital status, and further provided that selection of preferred providers is primarily based on, but not limited to, cost and availability of covered service and the quality of services performed by the providers.

National Governors' Association Adopts Policy Opposing Any Willing Provider Laws

The National Governors' Association (NGA) passed a policy statement at its recent conference opposing overly restrictive "any willing provider" laws. Section 9.2 of the policy states:

> "So-called "any willing provider" legislation has appeared in a number of state legislatures recently and is usually framed as a patient choice issue. Such legislation may undermine state health care reform efforts and could roll back our significant state-by-state progress in this area."

In their policy statement, the NGA indicated that "[T]his type of legislation can have devastating effects on current managed care delivery systems..." The conclusion of the policy includes the following statement:

> "The Governors do not support, at either the state or federal level, overly restrictive "any willing provider" laws. We remain committed to retaining the state flexibility that managed care delivery systems provide to us as we move to reform our health care system."

Any Willing Provider Laws Are Preempted By Some National Reform Proposals and Included in Others

The National Health Security Act proposed by President Clinton and the current version of the Senate Finance Committee's health reform bill would have preempted any willing provider laws. The reform plan proposed by U.S. Senate Minority Leader Bob Dole (R-Kansas), entitled "Alternative Reform Proposals" (June 29, 1994), also would have preempted states' any willing provider laws.

The House Ways and Means Committee approved an amendment that would have included an any willing provider provision in its health reform bill. Similarly, the Senate Labor and Human Resources Committee approved a bill which included an any willing provider provision that was supported by the American Medical Association.

None of the national health care reform proposals were approved by the Congress. However, any willing provider laws will likely continue to be the subject of reform debate.

Summary

Virginia is one of only seven states which have enacted any willing provider laws that affect a broad range of health care providers. Virginia's recently enacted pharmacy freedom of choice legislation (HB 840 - 1994) is similar to legislation passed in 13 other states. As seen in the legislative agendas of other states and the national reform efforts in Washington, these laws continue to be a focus of the health care debate.

Based on the findings of several researchers, it appears that any willing provider laws do impact the cost of health care. While there are those who question the results of these studies, the research suggests that such legislation increases both administrative costs as well as claims costs. The critical question is whether there is a corresponding public benefit equal to or greater than the

additional health care costs. Clearly, the proponents of such legislation feel that the costs which may result from any willing provider laws are justified as a result of greater patient choice of providers, and enhanced quality of care.

Opponents of any willing provider laws argue that this legislation protects providers from competition, as opposed to protecting patients' choice of providers. Moreover, opponents hold that the marketplace will keep insurers from developing PPO networks that are too restrictive and that do not provide quality health care. They maintain that the any willing provider law unnecessarily increases health care costs, with no corresponding increase in the quality of care.

The issue of whether Virginia's any willing provider law is appropriate in the context of increasing health care costs versus patients' choice of providers was capsulated in the published opinion of the United States Court of Appeals for the Fourth Circuit in the case of Stuart Circle Hospital v. Aetna Health Management. Even though the Court ruled in favor of Aetna, Senior Judge Butzner wrote in his opinion that the any willing provider law reflects "... the decision of the Virginia General Assembly to give priority to an insured's freedom to choose doctors and hospitals over the possibility of reduced insurance premiums."

In reviewing the impact of the any willing provider law, the critical question is whether there is a need to revisit the decision made in 1983 to enact the any willing provider law, and decide anew whether this legislation serves the public need of all Virginians.

Options for Consideration

There are several options that the Commission may want to consider in light of the analysis presented in this issue brief. Five such options are discussed below.

Option I: Maintain Status Quo

This option would continue the any willing provider law in its current form with no changes in the provisions of the law or the providers to whom the provisions of the law apply.

This option reflects a recognition that while some research has shown there is an increase in the cost of health care as a result of the any willing provider law, the costs are justified in terms of enhanced patient choice of

providers. Option I also suggests that insurers have sufficient latitude within the existing statute to develop cost-effective PPO networks.

Option II: Repeal the Any Willing Provider Provisions Contained in §§38.2-3407 (B) and 38.2-4209 (C)

This option would reflect a decision that the any willing provider laws increase the cost of health care with no equal or greater public benefit being derived. This action would indicate that such legislation is not necessary to ensure that Virginians receive quality health care services from PPO programs. Moreover, Option II suggests that the marketplace provides appropriate incentives for insurers to develop PPO networks that are responsive to patients' desire for provider choice and quality health care.

Option III: Require Insurers to Notify All Providers of PPO Network Offerings, Accept and Review Proposals from Licensed Providers, and/or Advise Providers of The Reasons for Their Decisions Regarding Participation in the Network, and Amend the PPO Statutes to Repeal the Any Willing Provider Provisions

Option III would recognize that providers should be: (i) informed about networks being developed in their area; (ii) given an opportunity to submit a proposal to an insurer, and have the proposal reviewed by the insurer; and (iii) advised in writing of the insurer's decision to exclude the provider from the PPO network. However, this option would repeal the any willing provider provisions.

Option IV: Restrict the Application of the Any Willing Provider Laws to Areas of the State Where There is Limited Provider Competition

This option would restrict the application of the any willing provider laws to areas where there is limited competition among providers. Option IV recognizes that in areas of the state where competition among providers is strong, the any willing provider laws are reducing the impact that this competition could have on reducing the cost of health care.

This approach would allow insurers to limit the providers participating in their PPO networks in these areas to maximize competition among providers and the price discounts such competition can produce. However, in certain designated areas (e.g. medically underserved areas) where there are fewer providers and less competition, the any willing provider provisions would continue to apply. In this way, the law would apply only in areas where

patients already have a limited choice of providers, and where PPO networks could further reduce patients' choice of providers.

Option V: Amend Any Willing Provider Laws to Resolve Areas of Confusion

Option V could be characterized as a "fine-tuning" of the existing laws, wherein amendments are proposed to clarify certain areas of confusion. For instance, Option V could involve amending §§ 38.2-3407 and 38.2-4209 to identify what criteria insurers can include in their network terms and conditions. Another possible "refinement" may be to clarify what is meant by "offering" terms and conditions to providers.

APPENDIX A

SENATE JOINT RESOLUTION NO. 158

Requesting the Joint Commission on Health Care, in cooperation with the Bureau of Insurance and other state agencies and private groups, to study the impact of subsection B of § 38.2-3407 of the Code of Virginia on the Commonwealth's health care market.

Agreed to by the Senate, March 1, 1994

Agreed to by the House of Delegates, February 25, 1994

WHEREAS, the rising cost of health care in the United States and in the Commonwealth of Virginia is of concern to the General Assembly and to all citizens of the Commonwealth; and

WHEREAS, the need to identify ways to control hospital and medical costs while assuring access to quality health care is currently the focus of attention in the United States Congress and in numerous states, including the Commonwealth; and

WHEREAS, one of several ways in which the General Assembly has addressed the health care issue has been through the authorization, contained in § 38.2-3407 of the Code of Virginia, of insurance arrangements under which an insurer may offer or administer a health benefit program which provides a higher level of benefit payment for services rendered by health care providers selected by and under contract with the insurer than for services rendered by other health care providers; and

WHEREAS, the theory of such "preferred provider" arrangements is that as a result of the benefit incentives favoring services of contracted providers, providers included in such networks will experience an increased volume of patients and thus be willing to accept discounted rates as well as to participate in the insurer's utilization management programs; and

WHEREAS, the General Assembly has qualified the ability of an insurer to selectively contract with health care providers by providing, in § 38.2-3407 B, that no health care provider that is willing to meet the terms and conditions offered it by an insurer in conjunction with selecting health care providers may be excluded from such a "preferred provider" arrangement; and

WHEREAS, the list of health care providers affected by this "any willing provider" provision includes hospitals, physicians, chiropractors, optometrists, opticians, professional counselors, psychologists, clinical social workers, podiatrists, physical therapists, chiropodists, clinical nurse specialists, audiologists and speech therapists; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Commission on Health Care, in cooperation with the Bureau of Insurance and other state agencies and private groups, study the impact of the "any willing provider" provisions contained in § 38.2-3407 B on the Commonwealth's efforts to contain costs, on the quality of health care provided in the Commonwealth, and on competition in the marketplace among health care providers.

The Joint Commission on Health Care shall complete its work in time to submit its findings and recommendations to the Governor and the 1995 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

APPENDIX B

Joint Commission on Health Care

Summary of Public Comments on Draft Issue Brief 4: Any Willing Provider Statute

Comments regarding the "Any Willing Provider" Issue Brief were received from the following 37 individuals and organizations:

Secretary of Health and Human Resources, Kay Coles James
Virginia Beach City Public Schools
The Virginia Chamber of Commerce
Hampton Roads Chamber of Commerce
Richmond Area Business Group on Health, Inc.
Blue Ridge Regional Health Care Coalition, Inc.
The Colonial Williamsburg Foundation
Virginia Manufacturers Association
E. I. du Pont de Nemours and Company
Philip Morris
Sperry Marine, Inc.
Allied Signal, Inc.
Union Camp Corporation
Virginia Hospital Association
Metropolitan Hospital
Tidewater Health Care, Inc.
The League of Virginia Health Systems
The Medical Society of Virginia
Virginians for Mental Health Equity
Virginia Society for Clinical Social Work, Inc.
Virginia Academy of Clinical Psychologists
Virginia Optometric Association
Virginia Physical Therapy Association, Inc.
Bryant C. McGann (on behalf of several physical therapists)
Ghent Urgent Care and Family Practice/Oceana Urgent Care and Family Practice
Virginia Chiropractic Association
Virginia Chiropractic Political Action Committee, Inc.
Virginia Association of HMOs

The Travelers Companies
BlueCross BlueShield of the National Capital Area
The Prudential Health Care System
Metropolitan Life Insurance Company
Group Health Association of America
HealthPlus
Aetna Health Plans
Patrick C. Devine, Jr.
Virginia Association of Health Underwriters, Virginia Association of Health Insurance Agents, The Big I, and the Independent Insurance Agents of Virginia

Policy Options Presented in Issue Brief

Five policy options were presented in the Issue Brief for consideration by the Joint Commission on Health Care.

Option I: Maintain status quo.

Option II: Repeal "Any Willing Provider" statute.

Option III: Repeal "Any Willing Provider" statute, but require insurers to: (i) notify providers of network offerings; (ii) accept and review proposals from providers; and (iii) notify providers of network participation decisions.

Option IV: Restrict the application of the "Any Willing Provider" statute to areas of the state where there is limited provider competition

Option V: Amend "Any Willing Provider" statute to resolve areas of confusion

Summary of Comments

Several provider groups, including the Medical Society of Virginia, Virginians for Mental Health Equity, and the Virginia Chiropractic Association, support Option I. The Virginia Hospital Association, the League of Virginia Health Systems and the Virginia Physical Therapy Association support Option III.

Seven of the eight insurers and trade associations as well as the insurance agents which submitted comments support Option II. The Virginia Association of HMOs supports Option I. It indicated that it does not oppose repeal of the

statute. However, because the statute does not affect HMOs, the Association felt it had no standing to seek repeal of the statutes.

All of the individual businesses, business groups and municipalities which submitted comments support Option II.

Secretary James supports Option III.

Summary of Individual Public Comments

Secretary Kay Coles James

Secretary James commented that she supports repeal of the "Any Willing Provider" law so long as such action is coupled with the provision that health plans must give public notice of proposals to contract with providers and must advise providers of the reasons for decisions made regarding participation in their plan(s).

Virginia Beach City Public Schools

Donald A. Peccia, Director of the Office of Personnel Services, commented on behalf of both Virginia Beach City Public Schools and the City of Virginia Beach. Mr. Peccia urged the Joint Commission to consider repealing the "Any Willing Provider" statute.

The Virginia Chamber of Commerce

Sandra D. Bowen, Senior Vice President, stated that the Virginia Chamber of Commerce favors the repeal of the "Any Willing Provider" statute. She also noted that the Chamber urges the Joint Commission to propose legislation to that end. Ms. Bowen indicated that the Chamber is considering Option III in which insurers would be required to (i) notify providers of network offerings; (ii) accept and review proposals from providers; and (iii) notify providers of network participation decisions.

Hampton Roads Chamber of Commerce

Michael J. Barrett commented on behalf of the Board of Directors of the Hampton Roads Chamber of Commerce, and stated that the Chamber supports repeal of the "Any Willing Provider" statute. Mr. Barrett also noted that the Chamber

suggests the Joint Commission review existing anti-trust laws that limit the ability of small providers to form provider networks.

Richmond Area Business Group on Health (RABGOH)

Kim S. Barnes, Executive Director, stated that RABGOH is opposed to "Any Willing Provider" statutes, and supports Option II.

Blue Ridge Regional Health Care Coalition, Inc.

Lisa Britts Craft, Executive Director, stated that the Coalition strongly opposes the "Any Willing Provider" mandates because of the negative impact on both the cost and quality of health care services.

The Colonial Williamsburg Foundation

Katherine H. Whitehead, Vice President of Human Resources, commented that the Colonial Williamsburg Foundation supports Option II, and strongly encourages the Joint Commission to propose legislation to repeal the "Any Willing Provider" statute.

Virginia Manufacturers' Association (VMA)

John W. MacIlroy, President, and Robert P. Kyle, Vice President of Human Resources, commented that the VMA supports Option II. They also stated that the VMA supports repeal of HB 840.

E. I. duPont de Nemours and Company (DuPont)

John L. Grohusky, Plant Manager, stated that DuPont has chosen a managed care network approach to providing health care benefits to its employees. Mr. Grohusky noted that "Any Willing Provider" provisions are a barrier to creating successful networks, which, in turn, translates into higher consumer cost and poor competitive price position. He also indicated that court actions have resulted from confusion caused by the current "Any Willing Provider" statute, and that litigation costs ultimately are borne by the consumer.

Philip Morris

John P. Gavin, Director of Employee Benefits, commented that Philip Morris is opposed to the "Any Willing Provider" statute. Mr. Gavin stated that "Any Willing Provider" provisions are in direct conflict with competitive market forces that yield savings/discounts for increased volume potential.

Sperry Marine

D. A. Maus, Director of Human Resources, commented that Sperry Marine opposes the "Any Willing Provider" concept. Mr. Maus also noted that Sperry Marine supports repeal of HB 840.

AlliedSignal, Inc.

Randy S. Cherkis, Manager of Health Care Programs, commented that AlliedSignal, Inc. strongly opposes "Any Willing Provider" statutes. He stated that AlliedSignal strongly supports Option II.

Union Camp Corporation

Mr. Jon L. Woltmann, Counsel, indicated that Union Camp Corporation believes the "Any Willing Provider" statute only serves to limit the ability of business to address health care issues in a cost-effective manner. Mr. Woltmann commented that the Joint Commission should recommend against further expansion of such legislation in the future.

Virginia Hospital Association

Susan C. Ward, Director of Legal & Regulatory Affairs, commented that the VHA supports Option III which provides for notice and procedures that are fair to providers seeking participation in preferred provider networks. Ms. Ward noted that this approach also ensures that such networks are of a size and composition that economically serve enrollees' health care needs.

Metropolitan Hospital

Malcolm E. Ritsch, Jr, an attorney with the law firm of Williams, Mullen, Christian & Dobbins, commented on behalf of Metropolitan Hospital. He indicated that the any willing provider statute has provided a tremendous amount of public benefit. Mr. Ritsch noted that Blue Cross and Blue Shield of Virginia achieves lower hospital costs in Richmond where there is a larger number of hospitals than in "one-hospital" communities, and that if the any willing provider statute were repealed, hospital costs would increase. Metropolitan Hospital supports Option I.

Tidewater Health Care, Inc.

Douglas L. Johnson, President and Chief Executive Officer of Tidewater Health Care (THC), Inc., indicated that THC supports repeal of the "Any Willing

Provider" statute, and is very much opposed to any further extension of the statute.

The League of Virginia Health Systems

D. Patrick Lacy, Jr. indicated that the League supports Option III.

The Medical Society of Virginia

K. Marshall Cook, General Counsel, indicated that the Medical Society of Virginia would not like to see any change in Virginia's "Any Willing Provider" statutes. He also noted that if change is contemplated, there are a number of patient choice protections that must be included with any amendments.

Virginians for Mental Health Equity (VMHE)

Mark E. Rubin, writing on behalf of VMHE, indicated that there is not sufficient objective evidence on either side of the issue to warrant making significant changes in the current law. VMHE believes that there are modifications which may satisfy some of the insurance and business concerns regarding the "Any Willing Provider" statute. The VMHE recommends that the "preferred provider organization" statute be retained but amended such that insurers would be required to:

* provide notice to providers that a PPO network is being developed (notice should include credentialing requirements);

* accept applications from all providers who wish to apply;

* notify the applicants as to the reasons when participating provider status is denied; and

* reimburse non-preferred providers an amount which is no more than 20% less than the reimbursement provided to participating providers.

Virginia Society for Clinical Social Work, Inc.

Philip B. McLean and James W. Fuller stated that the Virginia Society for Clinical Social Work, Inc. fully supports the position of the Virginians for Mental Health Equity (VMHE). (VMHE's position is outlined above.)

Virginia Academy of Clinical Psychologists

Michael S. Weissman, Chairman of the Health Care Benefits Committee, indicated that it supports the position of the Virginians for Mental Health Equity (VMHE). (VMHE's position is outlined on previous page.)

Virginia Optometric Association

Mr. Christopher J. Renner, writing on behalf of the Virginia Optometric Association, indicated that the issue brief presents no empirical evidence supporting the proposition that "Any Willing Provider" statutes increase health care costs. He further states that empirical data should be obtained and analyzed before any decision on the future of Virginia's "Any Willing Provider" statute.

Virginia Physical Therapy Association, Inc.

Damien Howell, Legislative Chair of the Virginia Physical Therapy Association (VPTA) , Inc. , indicated that the VPTA supports Option III. The VPTA stated that the current "Any Willing Provider" statute has been ineffective at ensuring patients a choice of physical therapists. Mr. Howell also stated that mandating disclosure of PPO offerings should level the playing field among health care providers.

Independent Physical Therapists

Bryant C. McGann, writing on behalf of several independent physical therapists in the Norfolk area, stated that the recently enacted "Freedom of Choice" statute (HB 840) applies to physical therapists, and that it is in the best interest of Virginians. Mr. McGann commented that if the "Freedom of Choice" laws are reviewed by the General Assembly, his clients recommend that the status quo, freedom of choice for physical therapy, be preserved.

Ghent Urgent Care and Family Practice, Inc. and Oceana Urgent Care and Family Practices, Inc.

Frank Westmeyer, writing on behalf of both organizations, recommended that the "Any Willing Provider" statute be strengthened, not repealed.

Virginia Chiropractic Association

Jefferson K. Teass, VCA President, stated that the VCA is firmly against the repeal of the "Any Willing Provider" statute. Mr. Teass indicated that Option I is

a "very desirous option," and that Option V may be the best option if done properly.

Virginia Chiropractic Political Action Committee, Inc. (VCPAC)

J. Kenneth Wood stated that the VCPAC believes the "Any Willing Provider" statute should be left as is, and that it should be expanded to include HMOs. The VCPAC also suggests that the "Any Willing Provider" statute should be examined to make it "more clear and consistent."

Virginia Association of HMOs

Mr. Reginald N. Jones stated that the Virginia Association of HMOs supports Option I. Mr. Jones indicated that the Association does not oppose repeal of the statute. However, because the statute does not affect HMOs, the Association feels it has no standing to seek repeal of the statute.

The Travelers Companies

Timothy F. Ryan, Counsel, indicated that Travelers strongly supports Option II, and "can live with" Option III. Travelers opposes Options I, IV and V.

BlueCross BlueShield of the National Capital Area (BCBSNCA)

Gail M. Thompson, Administrator of Government Affairs, stated that BCBSNCA opposes "Any Willing Provider" statutes. Ms. Thompson also noted that if the "Any Willing Provider" statute is not repealed, BCBSNCA urges the Joint Commission on Health Care to adopt Option I.

The Prudential Health Care System

John E. Sharp, Executive Director, commented that Prudential does not support Virginia's "Any Willing Provider" statute. Mr. Sharp also stated that Prudential would like the "ancillary provider" section of HB 840 (Freedom of Choice bill), if not HB 840 altogether, to be repealed.

Metropolitan Life Insurance Company

Gregory M. Redmond, Government Relations Counsel, commented that Metropolitan's first choice is Option II, and that Option I would be preferred over Options III, IV and V.

Group Health Association of America

Herb K. Schultz, Director of State Health Policy and Legislation, indicated that GHAA strongly recommends that the Joint Commission adopt Option II. If Option II is not adopted, GHAA would recommend that Option III be considered.

HealthPlus

Denise C. Savage, Manager of Regulatory & Legislative Affairs, stated that HealthPlus recommends adoption of Option II.

Aetna Health Plans

Russell R. Dickhart, Vice President of the Mid-Atlantic Area, indicated that Aetna supports Option II. Mark Wysong, Network Director with Aetna, also submitted comments, and urged the Joint Commission to recommend repeal of the "Any Willing Provider" statute.

Patrick C. Devine, Jr.

Mr. Devine, an attorney with Hofheimer, Nusbaum, McPhail & Samuels, commented that "Any Willing Provider" statutes appear to increase costs when the statute applies to the types of providers who control utilization (e.g. physicians, hospitals). However, it is unclear whether the laws increase costs when they apply to other providers who do not control utilization (e.g. pharmacists, laboratories.) He further noted that where consumer access and choice can be enhanced without significantly impacting payor measures designed to manage costs, it seems that "Any Willing Provider" legislation may be helpful. He also stated that "Any Willing Provider" statutes may be helpful to remedy certain conflict of interest situations where a payor may include in its network a hospital that it owns or controls. Lastly, Mr. Devine noted that affording smaller providers greater flexibility to jointly negotiate with payors may address concerns regarding cost and quality of health care.

Virginia Association of Health Underwriters, Virginia Association of Health Insurance Agents, The Big I, and the Independent Insurance Agents of Virginia

Richard Herzberg, Vice President of the Frieden Agency, commented that these groups of insurance agents supported Option II.

APPENDIX C

§ 38.2-3407. Health benefit programs.

A. One or more insurers may offer or administer a health benefit program under which the insurer or insurers may offer preferred provider policies or contracts that limit the numbers and types of providers of health care services eligible for payment as preferred providers.

B. Any such insurer shall establish terms and conditions that shall be met by a hospital, physician or type of provider listed in § 38.2-3408 in order to qualify for payment as a preferred provider under the policies or contracts. These terms and conditions shall not discriminate unreasonably against or among such health care providers. No hospital, physician or type of provider listed in § 38.2-3408 willing to meet the terms and conditions offered to it or him shall be excluded. Neither differences in prices among hospitals or other institutional providers produced by a process of individual negotiations with providers or based on market conditions, or price differences among providers in different geographical areas, shall be deemed unreasonable discrimination. The Commission shall have no jurisdiction to adjudicate controversies growing out of this subsection.

C. Mandated types of providers set forth in § 38.2-3408, and types of providers whose services are required to be made available and that have been specifically contracted for by the holder of any such policy or contract shall, to the extent required by § 38.2-3408, have the same opportunity to qualify for payment as a preferred provider as do doctors of medicine.

D. Preferred provider policies or contracts shall provide for payment for services rendered by nonpreferred providers, but the payments need not be the same as for preferred providers.

E. For the purposes of this section, *"preferred provider policies or contracts"* are insurance policies or contracts that specify how services are to be covered when rendered by preferred and nonpreferred classifications of providers.
(1983, c. 464, § 38.1-347.2; 1986, c. 562.)

§ 38.2-4209. Preferred provider subscription contracts.

A. As used in this section, a *"preferred provider subscription contract"* is a contract that specifies how services are to be covered when rendered by providers participating in a plan, by nonparticipating providers, and by preferred providers.

B. Notwithstanding the provisions of §§ 38.2-4218 and 38.2-4221, any nonstock corporation may, as a feature of its plan, offer preferred provider subscription contracts pursuant to the requirements of this section that limit the numbers and types of providers of health care services eligible for payment as preferred providers.

C. Any such nonstock corporation shall establish terms and conditions that shall be met by a hospital, physician or other type of provider listed in § 38.2-4221 in order to qualify for payment as a preferred provider under the subscription contracts. These terms and conditions shall not discriminate unreasonably against or among health care providers. No hospital, physician or type of provider listed in § 38.2-4221 willing to meet the terms and conditions offered to it or him shall be excluded. Differences in prices among hospitals or other institutional providers produced by a process of individual negotiations with the providers or based on market conditions, or price

differences among providers in different geographical areas shall not be deemed unreasonable discrimination. The Commission shall have no jurisdiction to adjudicate controversies growing out of this subsection.

D. Mandated types of providers listed in § 38.2-4221 and types of providers whose services are required to be made available and which have been specifically contracted for by the holder of any subscription contract shall, to the extent required by § 38.2-4221, have the same opportunity as do doctors of medicine to qualify for payment as preferred providers.

E. Preferred provider subscription contracts shall provide for payment for services rendered by nonpreferred providers, but the payments need not be the same as for preferred providers. (1983, c. 464, § 38.1-813.4; 1986, c. 562.)

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