

## Working Paper Series

### Premium Analysis of South Dakota Any Willing Provider Law Proposal

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Initiated Measure 17, which will appear on the ballot in South Dakota in November 2014, would implement a so-called “any willing provider” restriction on health insurance in the state. It provides that health insurers, including the state’s Medicaid program, may not exclude from its provider network any health care provider that “is willing and fully qualified to meet the terms and conditions of participation as established by the health insurer.”

The declared intent of the proposed law is to make sure that insurers do not “obstruct patient choice.” However, experience in other states with similar laws indicates that this increased flexibility could involve a trade-off for patients, in the form of higher premiums. In short, restricting insurers' ability to negotiate with providers by offering a larger pool of potential patients in exchange for lower prices could result in higher prices for health services. Higher prices for health services necessarily translates into higher health insurance premiums.

In states where insurers have the ability to tailor provider networks any way they want, some insurers establish “broad” networks, including all or a very large percentage of providers, and others establish “narrow” networks, including significantly fewer providers. In some cases, the same insurer will offer different plans with different networks. A study by McKinsey & Company<sup>1</sup> of health plans offered on ACA exchanges found that in most parts of the country, enrollees have a choice of both types of plans: 90 percent of prospective enrollees had at least one broad network plan among their options, and 92 percent had at least one narrow plan.

Why might a person or family with both options choose a narrow-network plan? It turns out that narrow-network plans have, on average, lower premiums. The median additional premium enrollees need to pay for a broad network plan is about 13 to 17 percent, according to the McKinsey study. Some enrollees prefer to accept a smaller set of provider options in return for a lower premium; other enrollees prefer a larger network of potential providers and are willing to pay a higher premium to get it.<sup>2</sup>

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1 Noam Bauman, Erica Coe, Jessica Ogden, and Ashish Parikh, “Hospital Networks: Updated national view of configurations on the exchanges,” McKinsey Center for U.S. Health System Reform, June 2014.

2 Strictly speaking, there are two separate reasons why one might want to pay for a broad network. One is a desire for more provider options should the need for treatment arise. Another is that a patient might have an ongoing relationship with a provider or a need for a particular service, and that might be available only in one of the broad-network plans.

One might imagine that this reflects a “race to the bottom,” in which insurers try to lower prices by cutting payments to providers, leaving fewer providers willing to join their networks. If that were the case, one might imagine that a law forcing all insurers to include all providers would prevent this price-cutting, leaving lower-priced health plans with broad networks. However, research on other states with any-willing-provider laws indicates that this is not actually the case. Michael Vita examined fifteen years of data, in which some states had or enacted any-willing-provider laws and others did not. After adjusting for various characteristics of each state's population, workforce, and health care markets, Vita found that a “strong” any-willing-provider law (similar to the one proposed by Measure 17) was associated, on average, with a 1.8 percent increase in overall per capita costs than would have been the case without an any-willing-provider law.<sup>3</sup> Given that overall per capita costs include Medicare and Medicaid spending, which were not affected by AWP laws (since provider reimbursement rates for these programs are set by the government) the impact on private health insurance premiums is likely to be significantly higher than 1.8 percent (since private health insurance accounts for less than one-half of total per capita spending).

## Methods

Estimates of the subsidy eligible premiums available in the Marketplace are calculated using publicly available data on plans offered in the 36 Federally Facilitated Marketplaces. Premium estimates for unsubsidized health insurance are calculated from a sample of plans available on ehealthinsurance.com. In both cases, we use the default age rating curve put forth by the Department of Health and Human Services to impute the applicable premium for a particular household. For simplification and comparability, we use a standard family size of four (two adults and two children) when estimating family premiums. Subsidy payments and tax revenue are adjusted for the appropriate average family size in budget impact estimates.

Subsidized insurance plans offered in the Marketplace are divided into four categories—Platinum, Gold, Silver, and Bronze—that correspond to four approximate actuarial values—90 percent, 80 percent, 70 percent, and 60 percent. The actuarial value refers to the expected percentage of annual medical expenses covered by the insurance plan.

To gauge the impact of any-willing-provider law, we use the Health & Economy microsimulation model to create an alternative South Dakota insurance demand where premiums increase according to prior health economic analyses<sup>4</sup>. The simulation permits a 10 year

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<sup>3</sup> Michael Vita “Regulatory Restrictions on Selective Contracting: An Empirical Analysis of Any-Willing-Provider Regulations,” *Journal of Health and Economics* v. 20 (2001):955B66.

<sup>4</sup> Parente, S., Feldman, R., Abraham, J.M., and Xu, Wendy. "Consumer Response to a National Marketplace for



estimation. We generate two scenarios, one with the any willing provider law and one without to model impact on premium.

## Results

It turns out that the seemingly small percentage increase can add up to a large number of dollars over time. The model results predict that the average South Dakota family enrolled in an exchange plan could end up paying as much as almost \$5,000 more over a 10-year period if the any-willing-provider law is enacted. The impact varies with the level of plan selected. Table 1 (below) indicates the forecasts for the various metal levels.

Average Projected Premium Increase Due to Any-Willing-Provider Law (South Dakota Exchange Family Plans)	
Bronze	\$3160
Silver	\$4050
Gold	\$4350
Platinum	\$4980

As noted above, some families prefer to accept a smaller set of provider options in return for a lower premium; other enrollees prefer a larger network of potential providers and are willing to pay a higher premium to get it. In an environment in which many health plans participate in the market, and are free to choose their networks in response to market conditions such as consumer preferences and provider costs, health plans will offer different networks, and families will have the opportunity to make the choice between broader networks on the one hand, and lower premiums on the other. An any-willing-provider law effectively takes this choice away, by forcing individuals and families to take the broader network with the higher premium. While it guarantees more choice of provider, it does that at the cost of fewer choices of health plans and less control by consumers over the price they pay for health coverage.

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Individual Insurance". Journal of Risk and Insurance, Volume 78, Issue 2, pages 389 - 411, June 2011.

