

# MEMO

**To:** MMA Policy Council  
**From:** Janet Silversmith, MMA Director of Health Policy  
**Re:** Narrow Networks  
**Date:** May 15, 2015

## Introduction

The issue of narrow networks (both insurance-created network products and provider-defined/ACO networks) was considered at the MMA Health Policy Conference on April 25, 2015. The various issues associated with narrow networks were identified during a facilitated debate between two advocates supportive of narrow networks (Daniel Trajano, MD, vice president for population health, Medica; Sue Hoel, senior benefits analyst, Hennepin County Human Resources) and two opposed to narrow networks (Stephen Eckrich, MD, South Dakota and Sue Abderholden, Executive Director of the National Alliance on Mental Illness-Minnesota).

This memo provides background information on the issues associated with narrow networks, identifies some of the policy options that the MMA might wish to consider, and summarizes the input captured from attendees at the April conference.

## Background: Network Adequacy Standards

Prior to passage of the Affordable Care Act (ACA), regulation of insurance provider networks in Minnesota was limited to health maintenance organization (HMO) products. Preferred provider organizations (PPO) also use provider networks, but their composition and structure were not regulated. Whereas PPOs generally provide higher benefits for services delivered by in-network providers and lower benefits for services delivered by out-of-network providers, HMOs generally exclude care provided by any out-of-network provider from coverage.

Among the ACA's requirements for insurance products to be sold on health insurance exchanges, known as qualified health plans (QHPs), is that they must maintain a provider network: a) sufficient in number and types of providers, including those who specialize in mental health and substance abuse services, to ensure that all services will be available without unreasonable delay; and b) include a sufficient number and geographic distribution of essential community providers<sup>1</sup> to ensure reasonable and timely access to care for low-income, medically

---

<sup>1</sup> In Minnesota, essential community providers are designated by the MN Department of Health and are generally organizations that are nonprofit; use a sliding fee schedule to charge for services; and, have a demonstrated ability to serve high-risk and special needs populations, and the underserved. (MS § 62Q.19, Subd. 1)

underserved individuals in a QHP's service area.<sup>2</sup> With no further federal guidance offered, states were left to implement the QHP network standards and to ensure compliance.

As part of the 2013 Minnesota Legislature's authorization of MNsure, it established explicit policy intended to "ensure fair competition for all health carriers in Minnesota, to minimize adverse selection, and to ensure that health plans are offered in a manner that protects consumers and promotes the provision of high-quality affordable health care, and improved health outcomes."<sup>3</sup> This policy created a common set of rules for all individual and small-group insurance products, whether or not they were sold on MNsure. Among those rules was a provider network adequacy provision that would apply beyond HMOs to include "all health carriers that either require an enrollee to use or that create incentives, including financial incentives, for an enrollee to use providers that are managed, owned, under contract with, or employed by the health carrier."<sup>4</sup>

Borrowing from the previous network requirements for HMOs, the Legislature created geographic standards for health plan networks. These required that the network be able to ensure enrollee access to care as follow:

- The lesser of 30 miles or 30 minutes to the nearest provider of primary care services, mental health services and general hospital services;<sup>5</sup>
- The lesser of 60 miles or 60 minutes to the nearest provider of specialty physician services, ancillary services, specialized hospital services and all other health services.<sup>6</sup>

In addition, the networks must have enough providers, including those who specialize in mental health and substance use disorders, to ensure that covered services are available to all enrollees without unreasonable delay.<sup>7</sup>

The Minnesota Department of Health is responsible for enforcing the network adequacy standards. To further guide the department's review of network adequacy, the Legislature noted the following:

- Primary care physician services must be available and accessible 24 hours per day, seven days per week, within the network area;

---

<sup>2</sup> 45 CFR 156.230(a).

<sup>3</sup> MS § 62K.02, Subd. 1.

<sup>4</sup> MS § 62K.10, Subd. 1.

<sup>5</sup> MS § 62K.10, Subd. 2.

<sup>6</sup> MS § 62K.10, Subd. 3.

<sup>7</sup> MS § 62K.10, Subd 4.

- The network must have a sufficient number of primary care physicians who have hospital admitting privileges at one or more participating hospitals within the network area so that necessary admissions are made on a timely basis;
- Specialty physician service must be available through the network or contract arrangement;
- Mental health and substance use disorder treatment providers must be available and accessible through the network or contract arrangement;
- Non-physician primary care providers must be available and accessible, to the extent permitted under state scope of practice law;
- The network must have available (or through arrangements) appropriate and sufficient personnel, physical resources and equipment to meet the projected needs of enrollees for covered health care services.<sup>8</sup>

Networks are also required to offer a contract to any essential community providers within the service area.<sup>9</sup>

The Legislature's standards for network adequacy include a provision allowing insurers to apply for a waiver of the geographic standards. A waiver for up to four years can be granted if complying with the 30 minutes/miles and 60 minutes/miles standards is not feasible in a particular service area.<sup>10</sup> According to the Department of Health, it is not uncommon to authorize waivers, often due to limited availability of specialty physicians in certain geographic areas.<sup>11</sup>

#### Background: Role of Narrow Networks

Prior to passage of the ACA, insurers had a variety of ways of designing price-competitive policies, from limiting or excluding certain benefits to employing complex cost-sharing options. In a move aimed at improving coverage and making it easier to compare products, the ACA eliminated some of those options by establishing new standards for cost sharing (bronze, silver, gold and platinum benefit levels) and creating a set of essential health benefits that must be included in all non-grandfathered plans.<sup>12</sup> As a result, many insurers have moved toward limiting or narrowing their provider networks as a way to create less expensive products.

---

<sup>8</sup> MS § 62K.10, Subd 4 (1-6).

<sup>9</sup> MS § 62K.10, Subd. 7.

<sup>10</sup> MS § 62K, Subd 5.

<sup>11</sup> Personal communication with Tom Major and Diane Konecny, Minnesota Department of Health, November 18, 2014.

<sup>12</sup> Under the ACA grandfathered plans are exempt from several provision of the law (e.g., preventive visit coverage without cost sharing, essential benefits, out-of-pocket maximums) if the plan covered a worker at the time of ACA passage and the plan has not had significant changes that reduce benefits or increase employee costs. Approximately 26% of insured workers were enrolled in grandfathered plans in 2014 (Kaiser Family Foundation/Health Research Educational Trust. Employer Health Benefits: 2014 Summary of Findings, 2014 Annual Survey).

There is significant price competition among insurance products on insurance exchanges. In its first year (2014), MNsure boasted insurance products with the lowest average premiums compared to other states and the federal exchange, although it also had among the highest average deductibles (\$4,061 in MN, compared to \$2,762 average of all others for silver plan deductibles).<sup>13</sup>

A general review of qualified health plans (QHPs) sold on MNsure in 2014 suggested variation in network breadth among the five health plans offering products (BCBS, PreferredOne, HealthPartners, Medica, UCare). Some of the networks' names offered insight into their provider make up (e.g., Medica North Memorial Acclaim, UCare Fairview Health, BCBS Sanford). The smallest network identified was the Medica North Memorial Acclaim Network, which included only 22 clinics—all of which were North clinics or Buffalo clinics. The insurance product associated with this network was only available in Anoka County.

The 84 individual products available in 2015 have a total of 15 different health care provider networks, with Medica offering the most (five networks) among its 40 products. By contrast, HealthPartners has just one network for its 11 products. Several networks are designed to support accountable care-type models; in those cases, many—if not most—of the providers belong to a specific health system. With only one year of experience, it is still too early to know if products with limited provider networks will prove to be popular choices. That said, concerns about limited networks have been raised throughout the country

Although narrow networks may be of interest to individuals purchasing coverage on their own, they do not appear to be widely adopted by employers (who are still the dominant means by which coverage is provided – both in Minnesota and nationally). National employer survey data (nonfederal public and private employers) suggests reluctance to adopt narrow networks broadly, with only 6% of employers with 50 or more employees reporting that they had eliminated hospitals to reduce cost and only 8% offered a plan considered a narrow network plan. In addition, only 6% of employers with 50 or more employees that offered coverage believe that narrow networks are a very effective strategy to contain cost.<sup>14</sup>

### Responses to Narrow Networks

In response to both consumer and physician complaints about extremely narrow qualified health plan networks in states from Texas, to New Hampshire, to California, the Centers for Medicare and Medicaid Services (CMS) tightened requirements and network review processes for products offered on the federal exchange for 2015. CMS has also signaled that it may further develop time, distance or other standards for future network review.<sup>15</sup> Minnesota's network

---

<sup>13</sup> Breakaway Policy. Robert Wood Johnson Foundation. Looking Beyond Technical Glitches: A Preliminary Analysis of Premiums and Cost-Sharing in the New Health Insurance Marketplaces. November 2013.

<sup>14</sup> Kaiser Family Foundation/Health Research Educational Trust. Employer Health Benefits: 2014 Summary of Findings, 2014 Annual Survey.

<sup>15</sup> "2015 Letter to Issuers in the Federally-facilitated Marketplaces." Baltimore:

standards remain more explicit than federal requirements and are unlikely to be effected by further CMS action.

Reaction in Minnesota to network design was most pronounced when the original plan choices for 2014 were announced and only one product, from Blue Cross Blue Shield, was offered for sale to residents of the City of Rochester. Subsequent efforts to increase product choices resulted in more plans from Medica, none of which included the Mayo Clinic, however.

Narrow network concerns have also prompted grassroots reactions. South Dakota, for example, passed an “any willing provider” ballot initiative this past November that was initiated by three physicians motivated to preserve broad patient choice of physicians and other providers.<sup>16</sup> The law will allow any health care provider to join an insurance company's network, assuming the provider is willing, qualified and meets the conditions of participation established by the insurer.

National polling data suggest that many patients dislike narrow networks. A Kaiser Health Tracking poll conducted in February 2014 found that 51% of Americans surveyed would rather have a plan that costs more money but allows them to see a broader range of doctors and hospitals, while 37% prefer a plan that is less expensive but provides access to a more limited range of providers.<sup>17</sup> But the same survey also found that those who are either currently uninsured or purchase their own coverage, said they would prefer less-costly narrow network plans over more expensive plans with broader networks by a 54% to 35% margin.

How broadly such movements against narrow networks will grow remains to be seen. Similar protests against narrow managed care networks were common in the mid-1990s and, eventually, narrow networks fell out of favor.

#### Narrow Network Responses: Policy Options – AWP/FOC

Several policy responses to narrow network concerns exist, a few of which were pursued in the 1990s during the height of managed care.

- *Any Willing Provider*

Any willing provider (AWP) laws generally require insurers/health plans to allow any physician, hospital or other provider into their networks if they are willing to meet the terms

---

Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight, 2014, <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/draft-issuerletter-2-4-2014.pdf>.

<sup>16</sup> Letter from Office of Attorney General of South Dakota Marty Jackley to Secretary of State Jason Gant, Health Care Provider Initiated Measure, August 12, 2013.

<sup>17</sup> . Kaiser Health Tracking Poll: February 2014. Feb 26, 2014. Accessed online at <http://kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-february-2014/>.

and conditions of the plan. AWP laws *do not necessarily require health plans to contract with any and all*, but rather require them to explicitly state evaluation criteria for those providers wishing to contract with them.

- *Freedom of Choice (FOC)*

Freedom of choice laws are similar to AWP, but instead of focusing on provider network participation, FOC laws instead focus on enrollee benefits. FOC laws generally allow health plan enrollees to obtain reimbursable health care services from any qualified provider (e.g., licensed, able to provide services covered by the enrollee's benefit contract) even if the provider has not signed a contract with the health plan. These laws often compel health plans to pay the same amount to an out-of-network provider chosen by an enrollee as they would pay to a network provider. The impact on enrollee out-of-pocket spending, however, could be impacted as they would generally be required to pay for any charges above the health plan allowed amount. As such, FOC laws are less appealing to many patients/consumers.

In the 1990s, state efforts to enact AWP and FOC laws were fairly common. According to the National Conference of State Legislatures, 22 states enacted any willing provider laws.<sup>18</sup> The scope and focus of these laws, however, is quite variable. Minnesota previously had an AWP law. Adopted in 1994, the Minnesota law was limited to allied health providers<sup>19</sup> and it was repealed in 2012. There is some recent state activity to again pursue AWP laws. South Dakota, for example, adopted an AWP ballot initiative in the November 4, 2014 ballot.<sup>20</sup>

- *Arguments For and Against AWP/FOC Laws (see also the comparative chart)*

The primary arguments in support of AWP/FOC laws are patient choice, continuity of the physician-patient relationship, and fairness. For small and independent providers, it may also be about economic livelihoods. Proponents are not convinced that costs would increase because payment for services would be reimbursed at the same rate as other network providers.

Opponents of AWP/FOC laws argue that health plans should have the ability to selectively contract with the providers of their choice. Such flexibility, it is argued, allows health plans to negotiate discounts with particular providers in exchange for patient volume, or create

---

<sup>18</sup> Managed Care State Laws and Regulations, Including Consumer and Provider Protections. Update May 2010. Accessed at <http://www.ncsl.org/research/health/managed-care-state-laws.aspx>.

<sup>19</sup> § 62Q.10. If a health plan company, with the exception of a community integrated service network or an indemnity insurer licensed under chapter 60A who does not offer a product through a preferred provider network, offers coverage of a health care service as part of its plan, it may not deny provider network status to a qualified health care provider type who meets the credentialing requirements of the health plan company solely because the provider is an allied independent health care provider as defined in section [62Q.095](#)

<sup>20</sup> If approved by voters, the measure, which is sponsored by three South Dakota doctors, would end the restrictions put in place by insurance companies regarding which health care providers their clients can and cannot see. The measure would allow any health care provider to join an insurance company's network, assuming the provider agrees to the company's terms and conditions and works within the company's coverage area. This concept is known as "any willing provider."

networks of providers that meet particular quality or cost efficiency standards. Insurers often point to cost-savings as evidence of the value of narrow networks, although the empirical evidence is somewhat limited.<sup>21</sup>

- *Role of Competition*

The role and nature of competition in health care is complex and controversial. Opponents of AWP/FOC laws would contend that the use of selective or narrow networks is a critical competitive market tool available to health plans. They would also argue that selective networks will ultimately succeed or fail as a result of the purchasing decisions made by individuals and employers. Some physicians and other health care providers, however, worry that such competitive forces unfairly hamper their ability to negotiate with insurers and threaten their access to insured patients.

The Federal Trade Commission (FTC) has generally taken a negative view of AWP/FOC laws, citing concerns about anti-competitive effects and higher costs for consumers.<sup>22</sup> Such laws are not, however, explicitly prohibited and courts have upheld their legality on other terms.<sup>23</sup>

- *Politics*

Prior to 2015, the politics of any willing provider-type laws had not been tested in Minnesota in many years. In 2015, however, legislation was advanced that would have enacted an any willing pharmacy provision. This bill was strongly opposed by the Chamber of Commerce and was not adopted by the House. It was included in the Senate omnibus bill, but was dropped from the final budget agreement.

Given the significant public concerns about the cost of health care, policies that will or are perceived to increase health care costs could face obstacles. It is all but certain that Minnesota health plans and employers would oppose AWP efforts, and some medical groups and health systems might also oppose AWP to the extent that they benefit from current negotiating strength. Further opposition may come from those who favor a more competitive or market-oriented approach to health care, in which case AWP may be viewed as unnecessary

---

<sup>21</sup> Durrance, Christine Piette. 2009. The Impact of Pharmacy-Specific Any-Willing-Provider Legislation on Prescription Drug Expenditures. *Atlantic Economic Journal*, 37:409-423. A University of Pennsylvania study found cost increases of at least 3% on total health care spending as a result of AWP/FOC laws (Klick, Jonathan and Wright, Joshua D., "The Effect of Any Willing Provider and Freedom of Choice Laws on Health Care Expenditures" (2012). *Faculty Scholarship*. Paper 438. [http://scholarship.law.upenn.edu/faculty\\_scholarship/438](http://scholarship.law.upenn.edu/faculty_scholarship/438)). Vita, Michael G. 2001. Regulatory Restrictions on Selective Contracting: An Empirical Analysis of "Any Willing Provider" Regulations. *Journal of Health Economics* 20:955-966.

<sup>22</sup> See, for example, March 7, 2014 FTC letter to CMS re: Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs.

<sup>23</sup> *Kentucky Association of Health Plans v. Miller*, 538 U.S. 329 (2003). The Court held that a state law is deemed to regulate insurance under ERISA if it (1) is specifically directed toward entities engaged in insurance and (2) substantially affects the risk pooling arrangement between the insured and the insurer. AWP laws were found to be outside these provisions.

interference. Support for AWP may be found among patient advocacy groups (particularly those with complex and chronic conditions) to the extent that current products limit choice or harm access to care. Those that are, on principle, opposed to managed care and insurance influence in health care decisions might also support AWP-type laws.

- *Current MMA and AMA Policy: AWP & FOC*

During the debate in the early 1990s, the MMA did not support the proposals. In 2003, the MMA again considered the issue and adopted the following position in response to a resolution referred to the Board:

**290.47 Any Willing Provider (AWP) Legislation**

The Minnesota Medical Association Board of Trustees approves the Executive Committee recommendation to not adopt 2003 Resolution 211: that the Minnesota Medical Association develop and lobby for an Any Willing Provider law in Minnesota and that the MMA delegation to the American Medical Association (AMA) carry a resolution to the AMA urging the AMA to develop model state Any Willing Provider legislation.

The AMA supports the ability of insurers to selectively contract:

**H-285.984 Any Willing Provider Provisions and Laws**

Our AMA: (1) acknowledges that health care plans or networks may develop and use criteria to determine the number, geographic distribution, and specialties of physicians needed;

(2) will advocate strongly that managed care organizations and third party payers be required to disclose to physicians applying to the plan the selection criteria used to select, retain, or exclude a physician from a managed care plan, including the criteria used to determine the number, geographic distribution, and specialties of physicians needed;

(3) will advocate strongly that those health care plans or networks that use criteria to determine the number, geographic distribution, and specialties of physicians needed be required to report to the public, on a regular basis, the impact that the use of such criteria has on the quality, access, cost, and choice of health care services provided to patients enrolled in such plans or networks;

(4) will advocate in those cases in which economic issues may be used for consideration of sanction or dismissal, the physician participating in the plan should have the right to receive profile information and education, in a due process manner, before action of any kind is taken;

(5) opposes any federal effort to preempt state "any willing provider" laws; and

(6) will continue to advocate its "Legislative Specifications for Federal Regulation of Managed Care Plans." (BOT Rep. I-93-25; Reaffirmed: Sub. Res. 110 and 702, A-94;



Reaffirmed: CMS Rep. 3, I-97; Reaffirmed: Sub. Res. 704, A-01; Reaffirmed: CMS Rep. 7, A-11)

On a related note, during development of Minnesota's insurance exchange, MNsure, the Legislature considered the amount of authority that the MNsure Board should have with respect to their ability to determine and select the type and quality of products that would be offered on the exchange. The MMA supported this ability for the MNsure Board to selectively work with health plans, as noted in the following policy:

#### **290.64 Insurance Exchange**

The MMA supports a state-based insurance exchange that will function as an active purchaser to support real transformation in the market and to support care and delivery improvements. The MMA will work to ensure physician representation on the insurance exchange governance board. The MMA further supports financing for the insurance exchange through an insurance premium withhold, as currently recommended, but remains open to other sources of revenue. The MMA will strongly oppose efforts to use the Health Care Access Fund to finance Minnesota's insurance exchange. (EC 02-13)

#### Narrow Network Responses: Policy Options – Network Adequacy Standards

Another policy option is an approach aimed at strengthening the regulatory standards for network certification. In Minnesota, the current standards are generally based on distance or time standards and do not address other unique circumstances (such as geography, community makeup, rare conditions, etc.).

#### Narrow Network Responses: Policy Options – Network Transparency Standards

Another policy option, consistent with the trend toward greater transparency in health care costs and quality, is to strive for greater transparency regarding network composition. For example, MNsure has not yet accomplished the functionality that would allow individuals purchasing coverage to search for products based on available physicians, hospitals or other providers. Network directories/lists have also been found to be inaccurate. There is also some concern that network participants may not all be taking new patients, further challenging the level of access associated with some networks.

Transparency may also be applicable to provider/ACO networks. For example, it is not clear to what extent patients are fully informed of policies/practices to limit referrals outside of the system/ACO network. It is also not clear to what extent physicians within systems/ACO networks are being compelled to limit referrals against their preferences.

#### Policy Conference Input

Attendees at the policy conference were polled on their opinions on several narrow network-related topics.



The following summarizes the pre-debate responses to the debate thesis question:

“Limited insurance networks and closed ACO networks undermine the physician-patient relationship by limiting continuity of care and patient choice.”

Strongly agree	50.0%
Agree	19.2%
Disagree	11.5%
Strongly disagree	11.5%
Don't know	7.7%
N	26

The following summarizes the post-debate responses to the debate thesis question. Most attendees continued to agree with the statement, but the level of support softened.

“Limited insurance networks and closed ACO networks undermine the physician-patient relationship by limiting continuity of care and patient choice.”

Strongly agree	30.8%
Agree	26.9%
Disagree	11.5%
Strongly disagree	23.1%
Don't know	7.7%
N	26

Other responses from attendees included:

<b>How big of a threat do narrow <u>insurance</u> provider networks pose to doctor-patient relationships?</b>	
No threat	4.0%
Slight threat	32.0%
Moderate threat	48.0%
Significant threat	16.0%
N	25



<b>How big of a threat do narrow ACO/system networks pose to doctor-patient relationships?</b>	
No threat	13.0%
Slight threat	34.8%
Moderate threat	21.7%
Significant threat	30.4%
N	23

Responses to preferred policy options were as follows:

<b>What policy position would you like to see MMA pursue regarding narrow provider networks?</b>	
Work to prohibit their use	0.0%
Seek greater transparency about network limits for patients	34.6%
Support more stringent definition of network "adequacy"	7.7%
Support "freedom of choice" law	11.5%
Support "any willing provider" law	23.1%
Allow market to determine their value	23.1%
N	26

**COMPARISON CHART: AWP VS. FOC**

ISSUE	Any Willing Provider (AWP)	Freedom of Choice (FOC)	NOTES
Definition	<p>AWP laws generally require insurers/health plans to allow any physician, hospital or other provider into their networks if they are willing to meet the terms and conditions of the plan</p> <p>For purposes of the AF&amp;D recommendation to the MMA Board, network status was dependent on the physicians' willingness to accept health plans payment and quality assurance terms and conditions.</p>	<p>FOC laws generally allow health plan enrollees to obtain reimbursable health care services from any qualified provider (e.g., licensed, able to provide services covered by the enrollee's benefit contract) even if the provider has not signed a contract with the health plan (payment is generally at in-network rates; enrollees may face additional costs for charges above in-network amount).</p>	<p>AWP/FOC laws have different orientations to a similar problem.</p> <p>AWP laws focus on insurance network status for physicians/other health care providers.</p> <p>FOC laws focus on patients' insurance benefits and provide for payment at network levels to any physician/health care provider.</p>
Application	<p>Would apply to insurance/health plan products that use a defined network.</p>	<p>Could apply to any insurance/health product as well as to other risk management arrangements, such as ACOs (accountable provider networks, M.S. § 62T.01).</p>	<p>Theoretically, FOC laws could be applied more broadly than AWP laws and could help address concerns about "closed" ACO panels.</p>
Impact on health care costs	<p>While the impact of AWP laws on health care costs is not definitive, there is some empirical data that they increase costs somewhat by limiting the negotiating clout of payers,</p>	<p>Similar cost arguments as AWP – the value of network status to physicians or other providers (and, hence, the negotiating clout of payers) is more limited if volume is not an expected return for lower rates. FOC laws</p>	<p>Opponents of AWP/FOC will certainly use cost containment as a primary argument against adoption.</p>

ISSUE	Any Willing Provider (AWP)	Freedom of Choice (FOC)	NOTES
	increasing transaction costs, and challenging utilization management.	make creation of networks more challenging.	<p>FTC opposition – that AWP/FOC is anti-competitive – bolsters this position.</p> <p>Under AWP, insurers still retain other cost-saving techniques such as prior authorization with their network. Under FOC, the reach of insurers to apply these techniques is significantly limited.</p>
Quality	AWP laws generally retain for the insurer/health plan some ability to define network standards/criteria, such as quality or efficiency standards.	FOC laws could be viewed as undermining health plans’ ability to manage quality and efficiency to the extent that health plan enrollees could access care from any physician or other provider – he/she may not otherwise meet the plans’ credentialing or other QI criteria.	<p>The AF&amp;D Committee’s original recommendation included the ability for the health plan to define the quality standards required for network status.</p> <p>Concerns about the impact of FOC laws on quality may be relevant to the extent that insurers/health plans (ACO-type networks) play a role in supporting quality through credentialing standards and care coordination.</p>
ERISA	In <b>Kentucky Association of Health Plans v. Miller</b> , 538 U.S. 329 (2003),	Some legal analysis suggests that FOC laws would be treated similarly as AWP laws	

ISSUE	Any Willing Provider (AWP)	Freedom of Choice (FOC)	NOTES
	<p><b>the US Supreme Court held that a state law is deemed to regulate insurance under ERISA if it (1) is specifically directed toward entities engaged in insurance and (2) substantially affects the risk pooling arrangement between the insured and the insurer. AWP laws were found to be outside these provisions.</b></p>	<p>with respect to ERISA preemption (i.e., not preempted).<sup>24</sup></p>	
Patients	<p>Broad choice of physicians and other providers is generally favored by the public. For those that are more price-sensitive, there is some suggestion that they would sacrifice choice for lower costs (see AWP memo and Kaiser polling data).</p>	<p>FOC laws can be more complex for patients, as choice may be available but financial protection may be limited (i.e., patients may face direct costs above the in-network rate paid by the health plan).</p>	<p>On the face of it, FOC laws appear to be more patient-centered, but the financial exposure patients may face could limit their broad appeal.</p> <p>For example, in QHPs, no patient out-of-network spending may be counted toward annual deductible/out-of-pocket limits.</p>

<sup>24</sup> National Academy for State Health Policy . Kentucky’s “Any Willing Provider” Law and ERISA:Implications of the Supreme Court’s Decision for State Health Insurance Regulation. June 2003.