Managed Care Regulations: Patient Protections

Health Insurance Regulation
Working Paper No. I-19

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Section I. Introduction

Background

Rationale
Over the past decade, many health care consumers have become frustrated and even angry at the managed care techniques used to control costs employed by their managed care organizations (MCOs). Such techniques include utilization review (UR), capitated physician payments, gatekeeping by primary care physicians, discounted fees, and practice guidelines and protocols. The main concern among unsatisfied consumers is that these techniques could lead to a decrease in quality of and access to care; a parallel fear is that incentives will do likewise. As a result, many states and the federal government have enacted legislation that mandates or forbids certain behaviors by MCOs, with the end goal being improved quality and access to care for consumers. The following discussion evaluates seven different types of regulations that fall into this category: any-willing-provider (AWP), continuity of care rules, external review, drug formularies, financial incentives, and patient bill of rights.

Statutory Authority
Patient protections arise from the power of state governments to regulate commerce generally, health insurance specifically and protect public health and safety. However, in light of ERISA, there sometimes are disputes about where the boundaries of state regulation end. The state’s authority to regulate health plans using independent review was recently upheld by the U.S. Supreme Court in Rush Prudential HMO, Inc. v. Moran (2002). The question before the court in this case was whether Rush had to comply with an Illinois law and submit to an independent review of their decision to deny treatment to Ms. Moran. The Court decided that Rush did have to comply, and based this decision on a technical interpretation of the ERISA preemption clause (Mariner 2002).

In addition to some mandated benefits discussed earlier, the federal government attempted to get involved in this domain with the Bipartisan Patient Protection Act of 2001 (S. 1052/ H.R. 2563) which aimed to provide comprehensive patient protections for all Americans. These bills included patient protections such as: access to emergency care, access to specialty care, access to non-formulary drugs, access to clinical trials, direct access to pediatricians and obstetricians and gynecologists, continuity of care for those with ongoing health care needs, and access to important health plan information. The bills also outlined criteria and framework for claims review and appeals processes. In addition, the House bill addressed the concerns with liability and punitive damages for managed care plans currently covered under ERISA. Both the U.S. House of Representatives and Senate passed this legislation. However, there was no resolution of differences in the two bills through conference committee prior to the end of the 107th Congress. Thus these federal patient protection regulations are not currently in place.
Key Elements

Many managed care patient care laws which aim to ensure quality and access to care for patients.

- **Any-willing provider** (AWP) laws are state statutes that require a managed care organization to accept any provider who is willing to accept the plans terms and conditions (i.e. give the same discount as offered by the preferred provider).

- **Continuity-of-care** laws allow patients to continue seeing their provider for a period of time after the provider leaves the managed care network. These laws may also allow new patients joining a health plan to continue seeing their providers for a period of time even if that provider is not a member of the plan network. Some state regulations only provide these continuity-of-care protections to patients with very serious conditions, such as pregnancy, terminal or severe chronic illnesses.

- **External review** laws create a review process for coverage denials that is independent from the health plan, in contrast with internal grievance or appeal procedures.

- **Drug formularies** are lists of medications that a payor (usually the insurer) will cover as a benefit. Decisions about what medications are included on formularies are usually made by medical experts and are based on clinical and scientific information. Drug formularies have been used in managed care as a method to control costs. Hospitals, health plans, and state and federal government all use formularies.

- Another practice used by health plans to contain costs is the use of **financial incentives** to reward providers for cost savings. The nature of these financial incentives varies depending on the type of plan and contract used. For example, increasingly more and more physicians are sharing financial risk with managed care organizations through capitation of payments.

- In the absence of substantial federal patient’s rights legislation (discussed above) many states legislatures have enacted their own **patient protection** laws. Concerns addressed in these laws are similar to those addressed by federal legislation: access to specialty care, coverage for cancer treatments, holding HMOs liable for denial of coverage decisions, and barring financial incentives for providers to deny, reduce, or delay medically necessary care.

**Scope**

Currently, nine states have AWP laws, and an additional 17 states have limited AWP laws, applying only to specified types of providers. Currently 20 states provide continuity of coverage protection and 17 states provide this protection only for limited conditions. A total of 42 states have an external review law (Sloan and Hall 2002). However, these state regulations vary in what types of decisions they apply to, who conducts the review, what rules the reviewers must use, and whether reviewed decisions are binding. Twenty-nine states have laws regarding drug formularies (BCBS 2001). These laws address concerns about how insurers manage their costs through formularies and attempt to provide patient protections. For example, 26 states have a law requiring insurers to pay for some non-formulary drugs. Eight states have laws requiring insurers to cover drugs after their removal from a formulary. Legislation has been passed in 29 states that
restricts health plans use of such incentives (Sloan and Hall 2002). Certain state laws regulate the types of incentives that are permissible, while others require the disclosure of financial incentives to consumers. Six states have “strong” comprehensive patient bill of rights protections and 8 have “weak” PBOR laws.

**Enforcement**

Most of these laws reliance on patients to blow the whistle on plans that are non-compliant.

**Theoretical Impact**

**Costs.** The main purpose of these regulations is to maintain or improve the quality of health care provided to consumers. However, it has been contended that by increased mandates on MCOs, these regulations will increase premium costs. Specifically:

- Opponents argue that AWP laws are anti-competitive and interfere with the MCOs ability to control costs. MCOs are able to negotiate lower prices with providers because they can assure a volume of patients in exchange for a favorable price. Thus AWP laws decrease the incentive of providers to lower their costs. As such, it is expected that AWP laws increase costs.

- **Drug formulary restrictions** may add to costs since such formularies have the potential to reduce costs in three ways: 1) negotiating drug manufacturer rebates, 2) encouraging generics where appropriate, 3) encouraging other cost-effective medicines.

- Concern regarding **financial incentives** is greatest for large incentives, those that involve a high percentage of a physician’s income, a small pool of physicians or patients, or a direct relationship between treatment for a particular patient and the physician’s income (Miller 1997).

- Federal and state patient protection regulations mainly target the behaviors of health insurers and managed care organizations.

**Benefits.** Supporters argue that AWP laws are necessary to ensure quality of care in managed care. First, proponents argue that AWP laws protect patients’ freedom of choice, allowing a patient to choose an alternative provider who, in his or her judgment, provides better care. Second, these laws increase access to care by decreasing the travel distance for patients in small communities through allowing local providers to have access to the managed care network. Another argument for maintaining AWP laws is that they protect small providers, such as the “mom and pop” drug store and sole physician practices. Without AWP laws, they argue, these small providers would be shut out of the managed care network by larger providers (Ohsfeldt et. al. 1998). The importance of continuity-of-care lies in the benefits of a long-standing relationship between physician and patient. Quality of care is improved not only because of increased trust and improved communication, but also because the physician is more familiar with the patient and their medical history. Relationships that occur over time may also be more efficient (Emanuel and Dubler 1995). The goal of these laws is to conduct the external reviews prior to any harm occurring from denial of treatment, hopefully decreasing social and private costs. External review has been widely recognized as an
important consumer protection that provides a way for dispute resolution between the health plan and consumers.

**Research Questions**

This working paper covers two major topic areas framed within six research questions, all of which are related to the impact of patient protections in the U.S. insurance market. Our primary goal was to identify, review, and evaluate the published literature to answer the research questions with the intent of developing an interim estimate of the costs and benefits of such protections; our secondary goal was to identify areas where no evidence exists or where the evidence has important limitations and then describe the type of data that would be needed to more fully address the question. The questions are listed below by topic area, along with a brief description of our analytical approach, including outcomes of interest.

### Costs of Professional Rights

**Question 1a.** What is the amount of government regulatory costs related to patient protections? This includes federal costs to monitor and enforce these protections.

**Question 1b.** What is the amount of health industry compliance costs related to patient protections? This includes all administrative costs and enforcement penalties borne by parties subject to these protections.

**Question 1c.** Are patient protections related to use of health care services? Patient protections may decrease incentives to limit use of medical services and thus may lead to an increase in use of unnecessary care.

**Question 1d.** Are patient protections related to the cost of health care services? Whether professional rights had a net impact on cost, positive or negative, would depend on relative changes in use for different types of insurance as well as their respective unit costs.

**Question 1e.** What is the magnitude, if any, of efficiency losses associated with patient protections? In decreasing incentives for use of cost-effective care, there may be a resultant loss of efficiency savings.

### Benefits of Professional Rights

**Question 2a.** What is the value of patient protections in health service use? In theory, protection of patient rights will increase quality of care as and increase general access to care, reducing morbidity and mortality, as well as market efficiency.

**Limitations of Working Paper**
Section II. Methods

Literature Search and Review

Sources

Peer-Reviewed Literature

We performed electronic subject-based searches of the literature using the following databases:

- MEDLINE® (1975-June 30, 2004) and CINAHL® (1975-June 30, 2004) which together cover all the relevant clinical literature and leading health policy journals
- Health Affairs, the leading health policy journal, whose site permits full text searching of all issues from 1981-present
- ISI Web of Knowledge (1978-June 30, 2004) which includes the Science Citation Expanded®, Social Sciences Citation Index®, and Arts & Humanities Citation Index™ covering all major social sciences journals
- Lexis-Nexis (1975-June 30, 2004) which covers all major law publications
- Public Affairs Information Service (PAIS), including PAIS International and PAIS Periodicals/Publishers (1975-June 30, 2004) which together index information on politics, public policy, social policy, and the social sciences in general. Covers journals, books, government publications, and directories.
- Books in Print (1975-June 30, 2004)

A professional librarian assisted in the development of our search strategy, customizing the searches for each research question. In cases where we already had identified a previous literature synthesis that included items known to be of relevance, we developed a list of search terms based on the subject headings from these articles and from the official indexing terms of MEDLINE and other databases being used. We performed multiple searches with combinations of these terms and evaluated the results of those searches for sensitivity and specificity with respect to each topic. We also performed searches on authors known or found to have published widely on a study topic. In addition to performing electronic database searches, we consulted experts in the field for further references. Finally, we reviewed the references cited by each article that was ultimately included in the synthesis. We did not hand search any journals. This review was limited to the English-language research literature. A complete listing of search terms and results is found in Appendix A.

“Fugitive” Literature

In some cases, relevant “fugitive” literature was cited, in which case we made every effort to track it down. We also performed systematic Web searches at the following sites:

- Health law/regulation Web sites
- Health industry trade organizations
- State agency trade organizations and research centers
- Major health care/health policy consulting firms
• Health policy research organizations
• Academic health policy centers
• Major health policy foundations

These searches varied by site. In cases where a complete publications listing was readily available, it was hand-searched. In other cases, we relied on the search function within the site itself to identify documents of potential relevance. Because of the volume of literature obtained through the peer-reviewed literature, including literature syntheses, we avoided material that simply summarized existing studies. Instead, we focused on retrieval of documents in which a new cost estimate was developed based on collection of primary data (e.g., surveys of state agencies) or secondary analysis of existing data (e.g., compilation of agency enforcement costs available from some other source). We excluded studies that did not report sufficient methodological detail to permit replication of their approach to cost estimation.

**Inclusion Criteria**

We developed the following inclusion criteria:

- **Sample:** wherever results from nationally representative samples were available, these were used in favor of case studies or more limited samples.
- **Multiple Publications:** whenever multiple results were reported from the same database or study, we selected those that were most recent and/or most methodologically sound.
- **Outcomes:** we selected only studies in which a measurable impact on costs was either directly reported or could be estimated from the reported outcomes in a reasonably straightforward fashion.
- **Methods:** we only selected studies in which sufficient methodological detail was reported to assess the quality of the estimate provided.

Where possible, we limited the review to studies using from 1975 through June 30, 2004 reasoning that any earlier estimates could not be credibly extrapolated to the present given the sizable changes in the health care industry during the past two decades. Other exclusions were as follows:

- **Unless:** unless we had no other information for a particular category of costs or benefits, we excluded qualitative estimates of impact.
- **Estimates of impacts derived from unadjusted comparisons were discarded whenever:** high quality multivariate results were available to control for differences between states or across time.
- **Estimates that focused on measuring system-wide impact generally were selected over narrower estimates (e.g., per capita health spending vs. cost per inpatient day) on grounds that:** savings achieved in one sector may have induced higher spending elsewhere in the system; hence narrower comparisons might inadvertently lead to an inappropriate conclusion.
Section III. Results

Empirical Evidence

- We found several studies of the cost impact of AWP laws.
  - **Compliance Costs: Higher Health Spending.** Vita (2001) used panel data on state expenditures to compare per capita spending levels in states with and without AWP laws. He found that states with “strong”\(^1\) AWP laws were associated with a 1.8 percent increase in per capita total health spending, a 2.1 percent increase in hospital spending, and a 2.7 percent increase in physician spending.
  - **Compliance Costs: Administrative Costs.** The Wyatt Company (1991) and Atkinson and Company (1994) studied the effect of AWP laws on the size of PPO networks and their administrative costs. Wyatt found that AWP laws resulted in an increase of 170 percent in administrative costs in addition to lost claims saving. Atkinson estimated 86 percent increase in administrative costs. Both of these studies, however, were simulations and did not actually evaluate real effects.
  - **Indirect Costs: Lower HMO Enrollment.** Sheils, Stapleton, and Haught (1995) directly studied the effects of AWP laws using state-level data on HMO enrollment between 1985 and 1994. They hypothesized that AWP laws lead to lower enrollment. Using enrollment estimates, they determined that healthcare spending in the U.S. would be as much as $92.8 billion higher over the 1996-2002 period as a consequence of these laws.

- We found no cost analysis of continuity-of-care laws.
- We found little impact analysis of state external review laws. Politz et. al. (2002) assessed state external review laws and found that consumers were granted relief about half of the time, on average. They also found that consumers use external review infrequently. For example, in New York, only 902 consumers (out of the 8.4 million covered by that state’s external review laws) filed for external review in the reporting year ending June 2000. This translates into one percent of one percent of covered lives and represents the highest instance of external reviews of any state.
- We found no studies evaluating the broad cost impact of drug formularies.
- We found no studies evaluating the broad cost impact of financial incentives.
- We found several estimates related to patient bill of rights.
  - An analysis of a Massachusetts patient protection bill found that premiums would rise by at least 2.7 percent and possibly as high as 7.6 percent (Altman et. al 2000).
  - An analysis of CBO cost estimates for the Bipartisan Patient Protection Act of 2001 showed that premiums would increase by 4.2 percent. CBO (2001a, 2001b) estimated that in the first full year of implementation (2007), costs for

\(^1\) Vita (2001) uses the classification scheme developed by Marsteller et. al. (1997), which ranks AWP laws based on three criteria: 1) entities regulated, 2) range of providers covered, and 3) stringency.
the private sector would amount to $22 billion. Their estimates are identical for both the House and Senate versions.

• An analysis of patient liability legislation in North Carolina showed that managed care premiums would increase by 121 million, that there would be an additional $148 million in annual spending due to reductions in the “spillover” effect of HMO cost discipline on non-HMO spending, and that there would be an increase of 20,183 in the average daily number of uninsured (Conover 2001).

Net Assessment

We have calculated the regulatory costs in the following fashion (minimum and maximum parameter estimates are shown in parentheses: full details of methods and sources are in Table E-19).

• AWP Compliance Costs: Higher Health Spending. We used Vita’s (2001) value for the percent increase in per capita total health spending and applied it to the portion of personal health expenditures accounted for by the states with strong AWP laws. For this purpose, we used the spending of the five states having strong AWP laws listed by Marsteller et. al. (1997). The result is an expected compliance cost of $1 billion.

• Patient Bill of Rights Compliance Costs: Higher Health Spending. Given the confusing patchwork of patient protections now in place across states, we estimated the collective impact of PBOR-style provisions as follows. We use the CBO estimate of the percent increase in premiums as our most likely figure and the Thorpe figures as upper and lower bounds. We multiplied these percentage effects times the gross total amount of private health insurance premiums in the U.S. in 2002 times the estimated share attributable to HMOs and by the assume share of states have PBOR-equivalent protections; we use 33% (20%, 90%) as our most likely value of this share.

• Patient Liability Compliance Costs: Higher Health Spending. North Carolina’s PBOR is considered a “strong” law. Since 6 states have strong laws and 8 have weak laws, we assume as a lower bound that there are 6 states with NC-equivalent PBOR protections and as an upper bound 10 such states (6 + 8/2 = 10). We use the average of these for our most likely case. The NC-equivalent estimates were multiplied by the predicted increase in health expenditures and number of uninsured to obtain the nation-wide effect in 2002. We then multiply the uninsured estimates times the average per capita external cost of being uninsured and the mortality loss figures used for EMTALA.

• In the absence of any formal analysis, we are unable to make a reasonable approximation of the cost of continuity-of-care regulations. Similarly, given the low utilization of external review reported by Politz et. al. (2002), and considering the lack of formal impact analysis, we assume that the cost of external review laws is relatively small. We had no reasonable basis for estimating the net impact

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2 The five states with strong AWP laws include: Alabama, Arkansas, Idaho, Kentucky, and Wyoming.
of drug formularies. Our sense is that the impact is relatively small. We had no reasonable basis for estimating the net impact of financial incentives.

- **Social Welfare Losses: Efficiency Losses from Tax Collection.** To account for the efficiency losses associated with raising taxes to pay for government regulatory costs, we multiply the latter times the marginal cost of income tax collections (see Table B-1 for how these costs are calculated).

- **Social Welfare Losses: Efficiency Losses from Regulatory Costs.** All industry compliance costs are presumed to be roughly equivalent to an excise tax, i.e., raising prices and reducing demand/output correspondingly. We therefore multiply these costs times the marginal excess burden associated with output taxes, using 21% (15%, 28%) as the expected value of MEB (see Table B-1 for details of how MEB is calculated).

These calculations result in estimated costs of $6.9 billion (2.5, 24.0). Total benefits are $3.7 billion (2.0, 11.1).

**Acronyms**

- MCO: Managed Care Organization
- UR: Utilization Review
- AWP: Any-Willing Provider
- PPO
- ERISA: Early Retirement Income Security Act

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**Net Assessment**

**Acronyms**

- ERISA: Early Retirement Income Security Act
- MCO: Managed Care Organization
- CBO: Congressional Budget Office

**Acronyms**

- HMO: Health Maintenance Organization
Listing of Included Studies


Listing of Excluded Studies

Key for Reasons for Exclusion

1. Studies with no original data
2. Studies with no outcomes of interest
3. Studies performed outside U.S.
4. Studies published in abstract form only
5. Case-report only
6. Unable to obtain the article

Appendix A. Evidence Tables

Table I-19.1. Summary of studies of relationship between Patient Protections and the impact on health costs, health outcomes and access to services

<table>
<thead>
<tr>
<th>Study</th>
<th>Design/Data Sources</th>
<th>Regulation Measure/Covariates</th>
<th>Outcome Measure</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Bill of Rights</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attman et al. 2000</td>
<td>Massachusetts patient protection bill</td>
<td></td>
<td></td>
<td>Premiums rise by at least 2.7 percent and possibly as high as 7.6 percent.</td>
</tr>
<tr>
<td>CBO 2001a, 2001b</td>
<td>Bipartisan Protection Act of 2001</td>
<td></td>
<td></td>
<td>Premiums would increase by 4.2 percent</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Implementation year (2007): private sector costs = $22 billion</td>
</tr>
<tr>
<td>Conover 2001</td>
<td>North Carolina patient liability legislation</td>
<td></td>
<td></td>
<td>Managed care premiums would increase by 121 million</td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
<td>Additional $148 million in annual spending due to reductions in the &quot;spillover&quot; effect of HMO cost discipline on non-HMO spending</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Increase of 20,183 in average daily number insured.</td>
</tr>
</tbody>
</table>
Appendix B. Search Strategies

Database: Ovid MEDLINE(R) <1966 to July Week 4 2004>
Search Strategy #1: ALL

1. "Patient Freedom of Choice Laws" or any willing provider.mp. (145)
2. prudent layperson.mp. (20)
3. (patient bill of rights or PBOR).mp. [mp=title, original title, abstract, name of substance word, subject heading word] (21)
4. managed care patient protection act.mp. (0)
5. managed care patient protection.mp. (5)
6. (liability and managed care).mp. [mp=title, original title, abstract, name of substance word, subject heading word] (613)
7. (regulation or statute or restriction or limit$).mp. [mp=title, original title, abstract, name of substance word, subject heading word] (1003905)
8. 6 and 7 (71)
9. (managed care and regulation).mp. [mp=title, original title, abstract, name of substance word, subject heading word] (405)
10. 1 or 2 or 3 or 5 or 8 or 9 (617)
11. limit 10 to (english language and yr=1975-2004) (587)

Database: CINAHL - Cumulative Index to Nursing & Allied Health Literature <1982 to June Week 1 2005>
Search Strategy: ALL

1. "Patient Freedom of Choice Laws" or any willing provider.mp. (23)
2. prudent layperson.mp. (16)
3. (patient bill of rights or PBOR).mp. [mp=title, abstract, instrumentation] (8)
4. managed care patient protection act.mp. (0)
5. managed care patient protection.mp. (0)
6. (liability and managed care).mp. [mp=title, abstract, instrumentation] (159)
7. (regulation or statute or restriction or limit$).mp. [mp=title, subject heading word, abstract, instrumentation] (31089)
8. 6 and 7 (12)
9. (managed care and regulation).mp. [mp=title, subject heading word, abstract, instrumentation] (43)
10. 1 or 2 or 3 or 5 or 8 or 9 (98)
11. limit 10 to (english language and yr=1975-2004) (97)
12. from 11 keep 2-8, 10, 12-19, 21, 23, 25-26, 28, 30, 34-45, 47-48, 54, 56, 58-59, 61-71, 73-74, 76, 80, 82, 84, 87-92, 96-97 (65)

Database: ISI Web of Science <1978 to July 31, 2004>
Search Strategy #1: ALL

1. Set limit to 1978-2004 and English language
2. TS=(patient AND freedom of choice) OR TS=(any willing provider) (34)
3. TS=(prudent layperson) (22)
4. TS=(patient bill of rights or PBOR)(9)
5. TS=(managed care AND patient protection)(9)
6. TS=(liability and managed care)
7. #2 or #3 or #4 or #5 or #6 (175)
8. Of these, 101 selected for detailed review
Database: Lexis-Nexis <1975 to July Week 4 2004>
Search Strategy #1: ALL
1 (any willing provider OR AWP(at least 3 times)) OR (prudent layperson health (at least 3 times) OR (patient bill of rights or PBOR (at least 3 times)) (239)
2 Of these, 8 selected for detailed review

Database: PAIS <1975 to July Week 4 2004>
Search Strategy #1: ALL
1 (( (patient and freedom of choice) or (any willing provider) )or( (prudent layperson) or (patient bill of rights or PBOR) )or( (managed care and patient protection) or (liability and managed care) ) ) and (LA:PAIS = ENGLISH) and (PY:PAIS = 1975-2004) (20)
2 Of these, 16 selected for detailed review

Database: Dissertation Abstracts <1975 to July Week 4 2004>
Search Strategy #1: ALL
1 (kw: patient and (kw: freedom and kw: choice)) or ((kw : any and kw: willing and kw: provider)) or ((kw: prudent and kw: layperson)) or (((kw: patient and kw: bill and kw: rights) or kw: PBOR)) or ((kw: managed and kw: care) and (kw: patient and kw: protection)) or ((kw: liability and (kw: managed and kw: care))) and yr: 1975-2004 and ln= "english" (30)
2 Of these, 2 selected for detailed review

Database: Books in Print <1975 to July Week 4 2004>
Search Strategy #1: ALL
1 (kw: patient and (kw: freedom and kw: choice)) or ((kw : any and kw: willing and kw: provider)) or ((kw: prudent and kw: layperson)) or (((kw: patient and kw: bill and kw: rights) or kw: PBOR)) or ((kw: managed and kw: care) and (kw: patient and kw: protection)) or ((kw: liability and (kw: managed and kw: care))) and yr: 1975-2004 and ln= "english" (65)
2 Of these, 14 selected for detailed review

Database: Health Affairs <1981 to July Week 4 2004>
Search Strategy #1: AWP
1 any-willing-provider managed care  (all words anywhere in article) (47)
2 Of these, 3 selected for detailed review

Search Strategy #1: prudentlayperson
1 prudent layperson managed care  (all words anywhere in article) (15)
2 Of these, 2 selected for detailed review

Search Strategy #1: PBOR
1 patient bill of rights states managed care empirical  (all words anywhere in article) (159)
2 Of these, 2 selected for detailed review

Search Strategy #1: liability
1 liability managed care empirical  (all words anywhere in article) (80)
2 Of these, 3 selected for detailed review
Appendix C. Web Sites Used in I-19 Literature Search

Health Law/Regulation Web Sites

We began searching at Web sites known to specialize in health law and regulation generally or specific topics included in this review:

- American Health Lawyers Association
  [http://www.healthlawyers.org/](http://www.healthlawyers.org/) (member-only site)
- Findlaw.com—health law
  [http://www.findlaw.com/01topics/19health/index.html](http://www.findlaw.com/01topics/19health/index.html) (no documents found)
- Health Care Compliance Association
  [http://www.hcca-info.org/](http://www.hcca-info.org/) (no documents found)
- HealthHippo
  [http://hippo.findlaw.com/hippohome.html](http://hippo.findlaw.com/hippohome.html) (no documents found)
- National Health Care Anti-fraud Association (NHCAA)
  [http://www.nhcaa.org/](http://www.nhcaa.org/) (member-only site)

Health Industry Trade Organizations

Health Insurance Regulation

For health insurance regulation, we searched the following industry and state agency trade organization Web sites:

- American Association of Health Plans (AAHP) - address converts to website for America’s Health Insurance Plans
  [http://www.ahip.org/content/default.aspx?bc=39|341|327|7576](http://www.ahip.org/content/default.aspx?bc=39|341|327|7576)
- Health Insurance Association of American (HIAA) - address converts to website for America’s Health Insurance Plans
  [http://www.hiaa.org](http://www.hiaa.org) (no documents found)
- Blue Cross and Blue Shield Association (BCBSA)
  [http://www.bluecares.com/](http://www.bluecares.com/) (no documents found)
- National Committee for Quality Assurance (NCQA)
  [http://www.ncqa.org/](http://www.ncqa.org/) (no documents found)
- National Association of Insurance Commissioners (NAIC)
  [http://www.naic.org/index.htm](http://www.naic.org/index.htm) (no documents found)

State Agency Trade Organizations and Research Centers

For state agency trade organizations and health policy research centers specializing in state health policy issues not accounted for above, we searched the following Web sites:

Executive branch

- National Governors Association (NGA)
  [http://www.nga.org/](http://www.nga.org/) (no documents found)
- National Association of State Budget Officers (NASBO)
http://www.nasbo.org/ (no documents found)

- Association of State and Territorial Health Officers (ASTHO)
  http://www.astho.org/ (no documents found)
- National Association of Health Data Organizations (NAHDO)
  http://www.nahdo.org/default.asp (no documents found)
- National Association of State Auditors, Comptrollers and Treasurers (NASACT)
  http://www.nasact.org/ (no documents found)

Legislative branch

- National Conference of State Legislatures (NCSL)
  http://www.ncsl.org/ (no documents found)
- Council of State Governments (CSG)
  http://www.csg.org/csg/default (no documents found)
- National Academy of Public Administration (NAPA)
  http://www.napawash.org/ (no documents found)

State Health Policy Research Centers

- National Academy of State Policy
  http://www.nashp.org/ (no documents found)
- Pew Center on the States
  http://www.stateline.org/index.do (no documents found)
- State Health Policy Web Portal Group
  http://www.hpolicy.duke.edu/cyberexchange/Whatstat.htm#States – website not found, only Duke health policy website

Health Care/Health Policy Consulting Firms

For major health care/health policy consulting firms, we searched the following sites. Some of these specialize in human resource consulting, but were included in the event they had done industry-wide studies of regulatory costs:

- Buck Consultants Inc.
  http://www.buckconsultants.com/ (no documents found)
- Deloitte & Touche
  http://www.deloitte.com/vs/0%2C1616%2Csid%25253D2000%2C00.html (no documents found)
- Ernst & Young LLP
  http://www.ey.com/global/content.nsf/US/Home (no documents found)
- Hewitt Associates LLC
  http://was.hewitt.com/ (no documents found)
- Milliman USA Inc.
  http://www.milliman.com/ (no documents found)
- PricewaterhouseCoopers LLP
  http://www.pwcglobal.com/ (no documents found)
- Towers Perrin
  http://www.towers.com/towers/default.asp (no documents found)
• Watson Wyatt Worldwide  
  http://www.watsonwyatt.com/ (no documents found)

**Health Policy Research Organizations**

For major health policy research organizations, including “think tanks” and some advocacy groups, we searched the following sites:

• Abt Associates  
  http://www.abtassoc.com/ (no documents found)
• Alliance for Health Reform  
  http://www.allhealth.org/ (no documents found)
• AcademyHealth  
  http://www.hcfo.net/pdf.managedcare.pdf
• The Advisory Board Company  
  http://www.advisoryboardcompany.com/ (no documents found – member-only site)
• American Enterprise Institute (AEI)  
  http://www.aei.org/ (no documents found)
• Battelle  
  http://www.battelle.org/ (no documents found)
• Brookings Institution  
  http://www.brook.edu/ (no documents found)
• Cato Institute  
  http://www.cato.org/ (no documents found)
• Center for Budget and Policy Priorities (CBPP)  
  http://www.cbpp.org/ (no documents found)
• Center for Health Affairs (Project HOPE)  
  http://www.projecthope.org/ (no documents found)
• Center for Health Care Strategies (CHCS)  
  http://www.chcs.org/ (no documents found)
• Center for Study of Health Systems Change (CSHSC)  
  http://www.hschange.com/ (no documents found)
• Employee Benefits Research Institute (EBRI)  
  http://www.ebri.org/ (no documents found)
• Heritage Foundation  
  http://www.hschange.com/ (no documents found)
• Institute of Medicine (IOM)  
  http://www.iom.edu/ (no documents found)
• Lewin Group  
  (no documents found)
• Mathematica Policy Research (MPR)  
  http://www.mathematica-mpr.com/HEALTH.HTM  (no documents found)
• National Bureau of Economic Research (NBER)  
  http://www.nber.org/ (no documents found)
• National Health Policy Forum
  http://www.nhpf.org/ (no documents found)
• RAND Health
• Research Triangle Institute (RTI)
  http://www.rti.org/ (no documents found)
• Urban Institute
  http://www.urban.org/ (no documents found)

**Major Health Policy Foundations.** For major health policy foundations, we searched the following sites:

• California Healthcare Foundation
  http://www.chcf.org/ (no documents found)
• Commonwealth Fund
  http://www.cmwf.org/ (no documents found)
• Robert Wood Johnson Foundation
  http://www.rwjf.org/ (no documents found)
• Henry J. Kaiser Family Foundation
  http://www.kff.org/ (no documents found)
• United Hospital Fund
  http://www.uhfnyc.org/ (no documents found)