Cost of Health Services Regulation
Working Paper Series

General Insurance/HMO Regulation

Health Insurance Regulation
Working Paper No. I-16

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Section I. Introduction

Background

Rationale
States historically have regulated health insurance in various ways, principally on consumer protection grounds. Regulation has included solvency regulation and review of rate filings to ensure they can be justified and are not taking advantage of consumers. This same sort of regulation has also been applied to HMOs (more focused regulations on patient protection and similar sorts of managed care regulation aimed at ensuring quality are discussed in a later section). In lieu of income taxes, states traditionally have levied premium taxes on insurance carriers, including health insurance carriers. While taxes normally would not fall under the domain of regulation, in health insurance such taxes have been used as an instrument of policy, not just for revenue collection. That is, many states accord their nonprofit Blue Cross or Blue Shield plan a lower premium tax rate than commercial insurers. Likewise, states sometimes favor domestic or out-of-state firms when determining the premium tax to be paid.

Statutory Authority
The McCarran-Ferguson Act enacted in 1945 makes clear the primacy of state authority to regulate the insurance business, including health insurance.

Key Elements
States generally regulate health insurance through licensure, business practices, financial standards, access to coverage (discussed earlier under insurance market reforms) or services requirements (discussed earlier under mandated benefits), and premium pricing/rating. Licensure typically entails a review of the company’s financial status to assess current and future solvency. Business practices would encompass marketing, advertising and claims processing systems. Some states regulate pricing through minimum loss ratios whereas others simply review rates to confirm that increases can be justified by underlying medical trends (Schneiter, Riley and Rosenthal 2002). Typically, the regulatory requirements for Blue Cross plans are different than for commercial carriers, e.g., requiring a public hearing to discuss rate approvals, requiring community rating or expecting the plan to serve as payer of last resort.

Scope
All states regulate health insurance carriers and HMOs to varying degrees.

Enforcement
Virtually every state has a Department of Insurance that plays the role of overseeing the insurance industry in general and health insurance (broadly defined to include HMOs or other types of managed care) and handling any related consumer complaints about such matters.
**Theoretical Impact**

**Costs.** The most obvious costs of general insurance regulation relate to state agency administrative costs and the parallel costs imposed on the insurance industry to comply with regulations and/or pay premium taxes. For example, state solvency requirements would add to costs if they exceeded the prudent practices that carriers would follow if unregulated (GAO August 1996). Should these costs result in higher numbers of uninsured, there would be additional indirect costs in the form of the external costs of being uninsured and elevated mortality risk.

**Benefits.** To the extent that approval of rate filings and processing consumer complaints are carried out competently, there is the theoretical possibility that insurance regulation could result in lower prices in markets where carriers might otherwise exercise too much market power and improve patient satisfaction. To the degree that not-for-profit Blue Cross plans outperform their commercial counterparts in terms of playing a carrier-of-last-resort role or lowering carrier administrative costs, these could all produced various benefits to the public.

**Research Questions**

This working paper covers two major topic areas framed within six research questions, all of which are related to the impact of general insurance regulation 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 regulation; 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 General Insurance Regulation**

**Question 1a.** What is the amount of government regulatory costs related to general insurance regulations? This includes all administrative costs and enforcement penalties borne by providers subject to federal or state privacy regulations. Monetary penalties may be viewed as a transfer, but the remaining costs represent real resource losses to society.

**Question 1b.** What is the amount of health industry compliance costs related to general insurance regulations? This includes all administrative costs and enforcement penalties borne by providers subject to federal or state privacy regulations. Monetary penalties may be viewed as a transfer, but the remaining costs represent real resource losses to society.

**Question 1c.** Are general insurance regulations related to use of health care services? Regulation may lead to increased insurance coverage for those previously not eligible or unable to afford it. Theoretically, improved access to primary care might result in fewer avoidable hospital admissions or less emergency room care.

**Question 1d.** Are general insurance regulations related to the cost of health care services? Whether market reforms 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.

**Benefits of General Insurance Regulation**

**Question 2a.** *What is the value of general insurance regulations in health service use?* To the extent that regulations may increase access to insurance and thus increase service use to through lower premiums for otherwise uninsured individuals, we wanted to measure the benefit associated with this.

**Question 2b.** *What is the impact of general insurance regulations on health outcomes?* Without adequate insurance, patients not covered by insurance may not receive health care services that those with undisputed access to insurance receive. In theory, improved access to care could result in less avoidable morbidity and mortality, along with increased patient satisfaction.

**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 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 findings related to costs of general insurance regulations.

- **Government Regulatory Costs.** A GAO survey found that the median state spent $5.0 million on total insurance regulation in 1992; the average percent devoted to health insurance regulation was 24 percent (GAO 1993).

- **Indirect Costs: Insolvency Risk.** A review of Blue Cross and Blue Shield plans conducted in 1994 found that 8 of 11 plans having financial difficulties operated in states that impose the greatest number of rate-setting and coverage requirements on Blues plans. Similarly, external consultants found that nearly 90 percent of Empire Blue Cross’s losses in the early 1990’s occurred in the plans lines of business that were subject to rating and coverage requirements (GAO April 1994).

- **Indirect Benefit: Reduced Uninsured Risk.** Goodman and Musgrave (1988) examine the impact of state insurance rate regulation in the model described earlier under mandated benefits. They distinguish between states having explicit authority to regulate rates, those having implicit authority and those with no implicit authority. States without explicit authority are the omitted reference group. In three different models, implicit authority had a statistically significant effect in reducing the risk of being uninsured among the non-elderly, ranging from 5.3 to 9.8 percent; having no implicit authority reduced uninsured risk by 2.9 to 5.7 percent and explicit authority was not statistically significant. Gruber (1992) has severely critiqued this study, arguing that the dependent variable is inappropriate for studying laws that would only be expected to affect employer propensity to offer coverage (since the authors do not control for other major factors such as Medicaid eligibility policies that might affect the uninsured rate) and noting that results are very sensitive to their specification and weighting. He re-runs their results with corrected data on mandates and a preferable specification, but unfortunately does not report the updated results for the regulatory variables.

There also was very little literature on the costs of general HMO regulations.

- **Indirect Benefits: Premium Savings.** A nationwide study of HMOs from 1990-1995 showed that controlling for a large number of plan characteristics, area characteristics and regulatory factors, premiums were 11.5 percent lower in states having no explicit HMO regulations; such states accounted for 12.2 of the HMOs in the sample. Yet at the same time, premiums also were 11.3 percent lower in states requiring rate approval\(^1\), constituting 78.3 percent of the sample, while states requiring subscribers to play a policymaking role had 5.2 percent lower premiums (61.4 percent of the sample). State regulations requiring employers to

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\(^1\) But in an earlier analysis on all non-Medicaid HMOs using data from 1985-1993, rate approval regulation had no effect on HMO premiums (Feldman, Wholey and Christianson 1996).
offer HMOs or open enrollment periods had no statistically significant effect (Feldman, Wholey and Christianson 1998).

- **Indirect Costs: Enrollments.** A study of enrollment in prepaid group practices (PGPs) showed that state reserve and capital requirements had no statistically significant effect on PGP enrollments (Welch 1984).

- **Indirect Costs: Plan Availability.** In a study of HMOs in 1996, Balla found that three regulatory variables, reserve, capital and deposit requirements, benefits mandates and patient hold-harmless clauses (which prohibit physicians from billing patients in the event of HMO nonpayment) all were significant predictors of whether at least one HMO operated in a geographic area or the number of HMOs operating (conditional on any operating), but that the regulatory variables had no significant difference on HMO market shares. The reserve, capital and deposit requirements, along with benefits mandates, decreased the likelihood of an HMO being operational in an areas, whereas hold harmless clauses increased this likelihood (Balla 1999).

We found a handful of studies that evaluated the cost of premium taxes.

- The Jensen, Cotter and Morrissey (1995) study cited earlier found no effect of either Blue Cross Blue Shield or commercial premium taxes on the decisions of mid- to large-sized firms to self-insure.

- The Gruber (1992) study cited earlier finds no effect of premium taxes on the likelihood of health coverage on the job except in a regression that excludes state fixed effects. He also replicates the the Goodman and Musgrave (1988) findings, correcting the mandate data used, and still finds no effect of premium taxes.

- The Gruber (1994) study cited earlier also finds no effect of premium taxes on the likelihood of health coverage on the job.

- The Jensen and Gabel (1992) studied cited earlier found no impact of premium taxes in their 1985 small firm sample, but found premium taxes reduced the likelihood of offering health coverage among the small, mid-sized and large firms they examined in 1988. Gruber (1992) replicates these findings, correcting the mandate data used and still finds no effect of premium taxes.

**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-16).

- **Government Regulatory Costs.** We updated the GAO figure for 1992 to 2002 using the GDP deflator.

- **Compliance Costs: Premium Taxes.** We estimate total premium taxes at $8.2 billion by applying the median premium tax rate to the estimated $548 billion in private insurance payments in 2002 times (1 minus self-insured share).

- **Compliance Benefits: Premium Savings.** The Goodman and Musgrave result is extremely counterintuitive, and in light of the Gruber critique, we elected to use it only as our upper bound savings and to cut the magnitude in half: even with this
adjustment we end up with savings in excess of $10 billion a year, which may still strike some as very improbable.

- **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 $3.6 billion (2.2, 4.4). Total benefits are $0.5 billion (0.5, 12.6).

**Acronyms**
Listing of Included Studies


47. Remler, Dahlia and others. "What Do Managed Care Plans Do to Affect Care? Results From a Survey of Physicians." Inquiry 34 (Fall 1997): 196-263.


52. Singer, Sara J. and others.


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


25. Singer, Sara J. and others.

## Appendix A. Evidence Tables

Table I-16.1. Summary of studies of relationship between General Insurance Regulations 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><strong>Cost of Premium Taxes</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jensen, Cotter &amp; Morrissey 1995</td>
<td>Study looked at effect of Blue Cross Blue Shield and commercial premium taxes</td>
<td></td>
<td></td>
<td>No effect on premium taxes on the decisions of mid-to large-sized firms to self-insure.</td>
</tr>
<tr>
<td>Gruber 1992</td>
<td>Regression that excluded state fixed effects. Replicates Goodman &amp; Musgrave 1998 findings correcting for the mandate data used</td>
<td></td>
<td></td>
<td>No effect on premium taxes on the likelihood of health coverage on the job except in a regression excluding state fixed effects.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>No effect on premium taxes.</td>
</tr>
<tr>
<td>Gruber 1994</td>
<td></td>
<td></td>
<td></td>
<td>No effect of premium taxes on the likelihood of health coverage on the job.</td>
</tr>
<tr>
<td>Jensen &amp; Gabel 1992</td>
<td>1985 small firm sample 1988 small, mid-sized and large firms sample</td>
<td></td>
<td></td>
<td>No impact of premium taxes Premium taxes reduced likelihood of offering health coverage.</td>
</tr>
<tr>
<td>Gruber 1992</td>
<td>Replicates Jensen &amp; Gabel 1992 findings correcting for mandate benefit use</td>
<td></td>
<td></td>
<td>No effect of premium taxes.</td>
</tr>
</tbody>
</table>
Appendix B. Search Strategies

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

1. premium tax$.mp. (8)
2. (solvency or bankruptcy).mp. [mp=title, original title, abstract, name of substance word, subject heading word] (875)
3. (regulation or statute or restriction or limitation).mp. [mp=title, original title, abstract, name of substance word, subject heading word] (618009)
4. 2 and 3 (31)
5. Insurance, Health/lj [Legislation & Jurisprudence] (2625)
7. 5 or 6 (3874)
8. state.mp. (372135)
9. 7 and 8 (592)
10. (cost$ or burden or impact or outcome or benefit).mp. [mp=title, original title, abstract, name of substance word, subject heading word] (865399)
11. 9 and 10 (185)
12. 1 or 4 or 11 (224)
13. limit 12 to (english language and yr=1975 - 2004) (222)
14. from 13 keep 15,26,28,49,53,60,72,76,86,91-92,96,102-103,107,114,132,179,193-194,197,199,201 (23)

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

1. premium tax$.mp. (0)
2. (solvency or bankruptcy).mp. [mp=title, subject heading word, abstract, instrumentation] (57)
3. (regulation or statute or restriction or limitation).mp. [mp=title, subject heading word, abstract, instrumentation] (7759)
4. 2 and 3 (0)
5. Insurance, Health/lj [Legislation & Jurisprudence] (536)
7. 5 or 6 (708)
8. state.mp. (23417)
9. 7 and 8 (82)
10. (cost$ or burden or impact or outcome or benefit).mp. [mp=title, subject heading word, abstract, instrumentation] (93409)
11. 9 and 10 (17)
12. 1 or 4 or 11 (17)
13. limit 12 to (english language and yr=1975-2004) (17)
14. from 13 keep 9 (1)

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

1. TS=premium tax* OR TS=((solvency or bankruptcy) AND (regulation or statute or restriction or limitation)) OR TS=(state AND health insurance AND (regulation or statute or restriction or limit*))
   DocType=All document types; Language=English; Databases=SCI-EXPANDED, SSCI, A&HCI; Timespan=1978-2004 (201)
2. Of these, 21 selected for detailed review

Database: Lexis-Nexis <1975 to July Week 4 2004>
Search Strategy #1: ALL

-----------------------------------------------------------------
1 (premium tax AND health insurance) (at least 3) OR ((solvency or bankruptcy) AND health insurance) (at least 3) (239)
2 Of these, 10 selected for detailed review

**Database: PAIS <1975 to July Week 4 2004>**
Search Strategy #1: ALL

1 (((premium tax*) and (health insurance)) or ((solvency or bankruptcy) and (health insurance)) or (state and health insurance) and (regulation or statute or restriction or limit*)) and (LA:PAIS = ENGLISH) and (PY:PAIS = 1975-2004)(69)
2 Of these, 11 selected for detailed review

**Database: Dissertation Abstracts <1975 to July Week 4 2004>**
Search Strategy #1: ALL

1 (((kw: premium and kw: tax*)) and ((kw: health and kw: insurance))) or ((kw: solvency or kw: bankruptcy) and ((kw: health and kw: insurance))) or ((kw: state and (kw: health and kw: insurance)) and (kw: regulation or kw: statute or kw: restriction or kw: limit*)) and yr: 1975-2004 and ln= "english" (116)
2 Of these, 9 selected for detailed review

**Database: Books in Print <1975 to July Week 4 2004>**
Search Strategy #1: ALL

1 (((kw: premium and kw: tax*)) and ((kw: health and kw: insurance))) or ((kw: solvency or kw: bankruptcy) and ((kw: health and kw: insurance))) or ((kw: state and (kw: health and kw: insurance)) and (kw: regulation or kw: statute or kw: restriction or kw: limit*)) and yr: 1975-2004 and ln= "english" (44)
2 Of these, 10 selected for detailed review

**Database: Health Affairs <1981 to July Week 4 2004>**
Search Strategy #1: premiumtax

1 premium tax  (exact phrase anywhere in article) (18)
2 Of these, 1 selected for detailed review

Search Strategy #1: solvency

1 solvency bankruptcy regulation  (all words anywhere in article) (16)
2 Of these, 8 selected for detailed review

Search Strategy #1: regulation

1 state insurance regulation  (all words in title or abstract) (5)
2 Of these, 0 selected for detailed review
Appendix C. Web Sites Used in I-16 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/ (no documents found)
- Findlaw.com—health law
  http://www.findlaw.com/01topics/19health/index.html (no documents found)
- Health Care Compliance Association
  http://www.hcca-info.org/ (no documents found)
- HealthHippo
  http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=gao&docid=f:he97122.txt
- National Health Care Anti-fraud Association (NHCAA)
  http://www.nhcaa.org/ (no documents found – 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)
  http://www.aahp.org/ (no documents found)
- Health Insurance Association of America (HIAA)
  http://www.hiaa.org/index_flash.cfm (no documents found)
- Blue Cross and Blue Shield Association (BCBSA)
  http://www.bluecares.com/ (no documents found)
- National Committee for Quality Assurance (NCQA)
  http://www.ncqa.org/ (no documents found)
- National Association of Insurance Commissioners (NAIC)
  http://www.naic.org/ (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/ (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/  (no documents found)
• State Health Policy Web Portal Group  
  http://www.hpolicy.duke.edu/cyberexchange/Whatstat.htm#States
  Rather than search 50 individual sites, we queried by e-mail the directors of all  
  centers included in this group for relevant reports/studies their centers had  
  conducted or that had been conducted by agencies in their states

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://www.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)
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.academyhealth.org/index.html (no documents found)
- 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.heritage.org/ (no documents found)
- Institute of Medicine (IOM)
  http://www.iom.edu/ (no documents found)
- Lewin Group
  http://www.Quintiles.com/Specialty_Consulting/The_Lewin_Group/default.htm (no documents found)
- Mathematica Policy Research (MPR)
  http://www.mathematica-mpr.com/HEALTH.HTM (no documents found)
- National Bureau of Economic Research (NBER)
  http://papers.nber.org/papers/w8917
• National Health Policy Forum  
  http://www.nhpf.org/ (no documents found)
• RAND Health  
  http://www.rand.org/health_area/ (no documents found)
• 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/index.jsp (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)