



# Policy Research Perspectives

Center for  
Health Policy  
Research

## **Review of “Actuarial Methodology of the Analysis of Dingell-Ganske-Norwood ‘Patients’ Bill of Rights’ (H.R. 526),” by Health Insurance Association of America**

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The Health Insurance Association of America (HIAA) report “Actuarial Methodology of The Analysis of Dingell-Ganske-Norwood ‘Patients’ Bill Of Rights’ (H.R. 526)” utilizes projections of the number of individuals with employer-based health insurance (EBHI) and the number of uninsured to examine two effects of patient protection legislation -- increases in employee costs resulting from employers increasing cost sharing with employees and the employer dropping health coverage altogether. An American Academy of Actuaries *Issue Brief* (American Academy of Actuaries, 2001) is cited by HIAA as though it were a source of quantitative information on these impacts. However, in fact, the *Issue Brief* contains no quantitative analyses of the effect of these five possible responses on employers’ or employees’ shares of premiums, employment based offers or coverage, or any other outcome variable. The primary focus of the *Issue Brief* is health plan liability and notes that there “... is not sufficient data available at this time to accurately determine the direct and indirect costs of allowing lawsuits against health plans in state court. Most actuaries who have reviewed proposed legislation believe costs will increase, but the amount of that increase is uncertain.”

There are numerous methodological flaws, and erroneous and unsupportable assumptions in the HIAA estimates of the changes in national and state-level numbers of individuals with EBHI and the number of uninsured. Two major shortcomings in the analysis, however, provide enough grounds to conclude that none of the impact estimates presented are defensible.

First, the HIAA analysis fails to cite any quantitative evidence to account for the effect of increases in premiums on employers “trying to offset rising costs by increasing cost sharing with employees” or the relationship between changes in employee cost sharing and the probability of employees accepting offers of health coverage from his or her employer. Regarding higher employee costs, the HIAA study claims to have “...looked at the historical increase in the percentage of employees who are offered health coverage and decline it...to predict the increase in the number of uninsured from an increase in the declination rate.” None of the studies cited report empirical findings that might be used to assess the impact of changes in employees’ cost sharing on accepting employer coverage offers. In fact, in one HIAA commissioned study (Custer and Ketsche, 2000), the authors notes that in previous studies “...the cost of health insurance is cited as a major unmeasured contributor to declining insurance rates.”

The second major shortcoming in the HIAA estimates is that they include the effect of employers dropping coverage due to perceived expanded liability. The study cites the results from a Hewitt Associates survey (Hewitt Associates, 2001), that 46 percent of the survey respondents would likely get out of the business of providing health care coverage. HIAA assumes that 1 in 10 of these employers would actually drop coverage in first year under the legislation. The question used by HIAA in their analysis is not specific to the context of liability under Dingell-Ganske-Norwood. It is in fact, much broader in its construct. The question asks, "Would your organization be likely to get out of the business of providing health care coverage if legislative changes made employer plan sponsors subject to malpractice lawsuits?"

This clearly is in sharp contrast to Dingell-Ganske-Norwood which explicitly excludes employers and other plan sponsors from causes of action unless they have direct participation in medical decisions. Only when employers make medical treatment decisions, in essence, practice medicine, they would be held accountable. On the other hand, with no increase in employer liability, the effect the proposed legislation on the number of individuals with EBHI or the number of uninsured would be zero. Because the HIAA study does separate the two effects in their estimates of the number of individuals with EBHI or the number of uninsured, it is impossible to determine the size of the error in the impact estimates caused by the shortcoming.

## **References**

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