Health Equity from an Actuarial Perspective
QUESTIONS TO EXPLORE

Actuaries are adding their voices to the national conversation on health equity. The American Academy of Actuaries Health Practice Council has formed the Health Equity Work Group, whose goal is to contribute to efforts to reduce health disparities and improve health equity. The work group will examine health actuarial practices and methods to assess the extent to which they may affect health disparities and recommend changes when appropriate, educate actuaries and other stakeholders on health equity issues, and apply an equity lens to the Academy's health policy work.

This discussion brief acts as a framework to introduce the first phase of the work group's work—identifying areas in which health actuaries are involved that may affect health equity, and developing a list of questions and topics to explore further. While through its exploration and analysis the work group may find that some actuarial methods and practices help mitigate health disparities, it may find that others —no matter how well-intentioned —could be perpetuating long-standing health inequities and inadvertently leading to poor health outcomes and an inefficient use of health care dollars. In general, actuaries focus primarily on identifying and managing financial risk. The questions below help broaden the scope of the work group's considerations to include non-financial outcomes, such as health outcomes and health disparities, when considering the effects of actuarial practices. By sharing information on the work group's process, including on these initial questions and the efforts to start to answer them, the aim is to initiate a more focused health equity dialogue from an actuarial perspective, and deepen the understanding of this complex issue, which could eventually lead to effective solutions.

The Health Equity Work Group has found it instructive to refer to the following definitions in its work:

Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.

Health disparities are differences in health or its key determinants that adversely affect marginalized or excluded groups. Disparities in health and in the key determinants of health are the metric for assessing progress toward health equity.

Social determinants of health are nonmedical factors such as employment, income, housing, transportation, child care, education, discrimination, and the quality of the places where people live, work, learn, and play that influence health.

Source: Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. What Is Health Equity? And What Difference Does a Definition Make? Princeton, NJ: Robert Wood Johnson Foundation, 2017.

Actuaries are involved, either directly or indirectly, in various aspects of health benefit programs, including designing benefit packages, developing provider networks and negotiating provider contracts, pricing health benefit plans, and managing the health of plan members. The Health Equity Work Group has developed questions relative to these areas that it will be exploring further—to examine whether and how different actuarial practices can affect health disparities, either positively or negatively, and then to explore the potential for using actuarial principles to help reduce disparities.

HEALTH INSURANCE BENEFIT DESIGN

In what ways can benefit designs, formularies, or cost-sharing structures contribute to health disparities, and in what ways can they mitigate disparities?

- How is plan design used to attract and maintain health plan members? Does the inclusion or exclusion of particular benefits, services, or prescription drugs mitigate or exacerbate disparities?
- Can plan design features that aim to control utilization and spending affect health disparities?
- Does benefit coverage standardization, such as essential health benefit requirements, or a lack thereof mitigate or exacerbate disparities?
- Are there barriers to individuals choosing the plan that best fits their needs, and if so, do those barriers contribute to health inequities?
- Does benefit design exacerbate or mitigate inequities in availability and accessibility of certain provider specialties, technologies, or treatments that may differ across geography or population?

PROVIDER CONTRACTING AND NETWORK DEVELOPMENT

In what ways can the incentives embedded in health care provider network development and provider payment methods contribute to health disparities? In what ways can they promote health equity?

- How do overall health plan spending goals or other outcome goals and considerations affect network development and provider contracting, and do these have effects on access to care and health disparities?
- Can risk-bearing provider contracts affect disparities in access to care and health outcomes? Are incentives aligned with desired health outcomes?
- How do alternative payment models and cost targets calculated for risk-bearing provider contracts affect provider incentives and disparities in health care access and outcomes?

- Are quality provisions and outcome measures in value-based purchasing contracts aligned with achieving equitable health outcomes?

- How do the risk adjustment methods used in provider contracting and network development affect access to care and health outcomes?

PREMIUM PRICING

In what ways can the methods of pricing plan benefits, developing premiums, and paying plans contribute to health disparities related to access to coverage, coverage affordability, and health outcomes? In what ways can they help mitigate disparities?

- Does the use of historical experience data and traditional methods for trending data forward to project future spending reflect true health care needs of underserved populations? What are the implications for premiums and plan incentives to better meet the health needs of underserved populations?

- Can actuarial methods of pricing benefits foster inequity? How are offsetting cost reductions considered when rating additional benefits? Does using a one-year time frame limit the ability to consider longer-term cost reductions?

- Can the methods used to develop geographic rating factors and other rating factors (e.g., industry factors) affect health disparities?

- How does risk pooling affect cross-subsidization and the impacts of pricing on disadvantaged populations?

- How do risk adjustment program methodologies, in conjunction with risk pooling, affect plan payments for disadvantaged populations, and thereby plan incentives to enroll these populations? How might access to coverage and care be affected?

MANAGING POPULATION HEALTH

In what ways can efforts to assess health risks and address those risks affect health disparities? In what ways can they mitigate health disparities?

- Are financial metrics such as return on investment (ROI) aligned with improved health? To what extent are non-financial metrics incorporated into population health decisions?

- Does the focus on a one-year time horizon for program costs and benefits perpetuate disparities?

- How does applying the same rules and methods to different populations and markets affect disparities?

- How do algorithms that are designed to identify enrollees for disease management, care management, or wellness programs—and the proxy data underlying the algorithms—affect disparities?

- Do the metrics used to quantify the impact of disease management, care management, or wellness programs widen or narrow disparities?

- When designing care management programs for specific populations, how are factors other than those directly related to health care, such as the social determinants of health, considered?

This is not an exhaustive list of questions the Health Equity Work Group will be exploring; the work group plans to provide more detail on these questions and add to the list over time. In addition, there is overlap among these broad categories. For instance, data issues, including what historical data—including third-party data—are used, whether there are underlying biases in the data, whether the data are used appropriately for the given task, and the appropriateness of proxy data when the actual data of interest are not available, are common across several areas. Similarly, issues concerning risk adjustment and predictive modeling arise in each of the categories including whether models are predicting what they are intended to predict. It's also important to consider not just each of these questions in isolation, but also the combined effects of multiple factors—for instance, the interactions between risk pooling, risk adjustment, and premium rating factors. Importantly, throughout this work, the intention is not just to look at averages, even within demographic or other categories of interest, but also at the distribution of impacts.

And finally, the Health Equity Work Group is approaching this work introspectively, with openness and without any presuppositions. It will be undertaking a fresh re-examination of all aspects of health actuarial practice to identify areas where change is needed to help address health inequities. The important thing is to begin, so that we can all better understand if and how activities actuaries are involved with may affect disparities and health equity, and then help bring awareness and work to make changes where needed.

Members of the Health Equity Work Group, which produced this discussion brief, include; Annette James, MAAA, FSA, FCA—*Chairperson*; Bela Gorman, MAAA, FSA—*Vice Chairperson*; Stacey Lampkin, MAAA, FSA—*Vice Chairperson*; Corryn Brown, MAAA, FSA; April Choi, MAAA, FSA; Andrea Christopherson, MAAA, FSA, FCA; Catherine Jo Erwin, MAAA, FSA; Audrey Halvorson, MAAA, FSA; Barbara Klever, MAAA, FSA; Johann Leida, MAAA, FSA; Julia Lerche, MAAA, FSA; Yi-Ling Lin, MAAA, FSA; Ian McCulla, MAAA, FSA; Mitchell Momanyi, MAAA, FSA; Donna Novak, MAAA, ASA, FCA; Ugo Okpewho, MAAA, FSA; Rebecca Owen, MAAA, FSA, FCA; Susan Pantely, MAAA, FSA; Anthony Pistilli, MAAA, FSA; Daniel Pribe, MAAA, FSA; Erica Rode, MAAA, FSA; Christopher Schmidt, MAAA, FSA; Enrique Schulz-Figueroa, MAAA, ASA, FCA; Rebecca Sheppard, MAAA, FSA; Derek Skoog, MAAA, FSA; Yixuan Song, MAAA, FSA; Martin Staehlin, MAAA, FSA; Sara Teppema, MAAA, FSA; Michael Thompson, MAAA, FSA; Tammy Tomczyk, MAAA, FSA, FCA; Jim Toole, MAAA, FSA; Cori Uccello, MAAA, FSA, FCA.