AMERICAN ACADEMY of ACTUARIES

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Request for Information: Assessing How Common Practices and Methods Used by Health Actuaries and Health Plans Affect Health Disparities

October 29, 2021
Updated: January 11, 2022 (Deadline Extended to February 15, 2022)

Summary:

The American Academy of Actuaries[1] Health Equity Work Group (HEWG) is issuing this request for information (RFI) to solicit input for its work assessing whether and how health actuarial practices and methods affect health disparities. Health actuaries often partner with other professionals in many different aspects of the health care and health insurance systems, including those related to administration, financing, and care management. The HEWG has identified four areas in which health actuaries are involved that may affect health disparities, either by contributing to disparities or by mitigating disparities: (1) health insurance benefit design, (2) provider contracting and network development, (3) premium pricing, and (4) managing population risk. The work group is also exploring data collection issues.

The HEWG seeks articles, links to resources, and other input, information, and existing or ongoing research in these identified areas from anyone with relevant information or perspectives, including but not limited to: health economists and health services researchers, actuaries, health plans and other payers, health care providers, health care consumers, policymakers, and other health policy experts or stakeholders. This information will be used by the HEWG to better understand the effects of actuarial practices on health equity and to identify gaps in knowledge.

The HEWG will use what it learns from this RFI to inform future papers on this topic and research proposal requests to further explore the areas of interest. Respondents will be recognized as contributors to this work. In addition, the HEWG plans to hold a health equity symposium, and respondents may be invited to attend and/or to present their work or perspectives.

Dates:

Comments should be submitted prior to February 15, 2022.

Addresses:

The HEWG will accept comments by either electronic or conventional mail. If you wish to use email, please send a message to healthequityRFI@actuary.org. Please do not password-protect any attachments. Please include the phrase "HEWG Request for Information" in the subject line of your message.

[1] The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

If you wish to use conventional mail, please send your response to the following address:

Health Equity Work Group
American Academy of Actuaries
1850 M Street, NW, Suite 300
Washington, DC 20036-5805

For Further Information Contact:

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The HEWG is interested in all of the questions below, but respondents are welcome to address as many or as few as they choose, and also to address issues that are not listed. In addition, although the HEWG is interested in considering each question independent of others, we are also interested in the interactions of multiple factors. (For instance, how the equity effects of pricing methods interact with other pricing elements such as premium subsidies.)

Please ensure it is clear which question(s) you are responding to. You may also include attachments to articles or other materials or links to online material or interactive presentations (please indicate which materials are publicly available). Each response should include:

- The name(s) of the individual(s) and/or organization responding.
- The area(s) (1, 2, 3, 4, and/or 5) that your submission and materials address.
- A brief description of the responding individual(s) or organization's mission and/or areas of expertise.
- A contact for questions or other follow-up on your response.
- An indication if you or your organization would be willing to collaborate with the American Academy of Actuaries in undertaking future research—and, if so, what areas you may be interested in exploring.

Background:

The American Academy of Actuaries Health Practice Council formed the Health Equity Work Group to contribute to efforts to reduce health disparities and improve health equity. The work group is examining health actuarial practices and methods to assess the extent to which they may affect health disparities and recommend changes when appropriate, educating actuaries and other stakeholders on health equity issues, and applying an equity lens to the Academy's health policy work.

As a first step, the work group identified areas in which health actuaries are involved that may affect health equity and developed 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 work group broadened its scope to include non-financial outcomes, such as health outcomes and health disparities, when considering the effects of actuarial practices.

The HEWG first released a broad overview of the questions it is exploring, *Health Equity from an Actuarial Perspective—Questions to Explore*. More detailed information regarding these questions is available for each topic area under investigation:

- Health Plan Benefit Design
- Provider Contracting and Network Development
- Health Plan Pricing
- Managing Population Health

The HEWG now turns to seeking answers to the questions it has posed. To that end, this request seeks information on existing analysis and research that can inform the questions under consideration. Information provided will be used by the HEWG to better understand the effects of actuarial practices on health disparities, draw conclusions when sufficient evidence is available, and identify gaps in the literature. Any information that is submitted may be referenced by HEWG issue briefs summarizing the available evidence, with attribution. Depending on what information gaps exist, the HEWG may consider new research to fill those gaps.

Request for Information

The Health Equity Work Group requests information on the following questions.

1. Health Plan Benefit Design: The HEWG is requesting information regarding the ways in which benefit designs, formularies, or cost-sharing structures can affect health disparities. Questions of interest include:

    a) Does the complexity of benefit designs lead to a consumer focus on particular cost-sharing features or other design features and cause people to under- or over-insure? How do suboptimal choices vary by demographic and socioeconomic characteristics? How do insurance broker incentives, insurance navigators, insurance choice architecture, and employer communications affect plan choice?

    b) Do benefit design features that aim to manage utilization and spending (e.g., high deductibles and other cost-sharing features, reference pricing, tiered formularies, utilization management protocols) lead to under-utilization of necessary services, particularly among under-resourced or underserved populations?

    c) How does the utilization of new and expensive advanced treatments vary by demographic and socioeconomic characteristics? How does the utilization of preventive services and wellness benefits vary by these characteristics? How does the inclusion of nontraditional benefits (e.g., after-hours care, transportation benefits, navigation assistance, nutritional benefits) affect utilization among under-resourced or underserved populations?

    d) How does the availability and accessibility of network providers vary across geography and populations? Do tiered networks and narrow networks increase barriers to care in underserved or under-resourced communities? How does telehealth affect the availability and accessibility of providers across geography and populations?

2. Provider Contracting and Network Development: The HEWG is requesting information regarding how the incentives embedded in health care provider network development and provider payment methods affect disparities. Questions of interest include:

a) How does relative provider market power affect a provider's inclusion in an insurer's network, provider prices, and access to providers, especially to those serving patients with lower socioeconomic status or racial and ethnic minority groups who experience social disadvantages that negatively impact their health?

b) Do algorithms or other methods of identifying cost-efficient and high-quality providers for network inclusion reflect the different medical and social needs of different populations? Do these methods distinguish between low-cost providers who are more efficient from those who are providing substandard levels of care? How do cost and quality metrics affect provider willingness to serve populations with unmet medical/social needs or challenges complying with care plans?

c) How do provider payments under alternative payment models (APMs) and cost targets for risk-bearing provider contracts vary across populations? Do barriers to care in underserved and under-resourced communities result in lower payments and cost targets—and, if so, are access problems exacerbated?

d) Are quality provisions and outcome measures in APM contracts aligned with achieving equitable health outcomes? For instance, are the quality metrics relevant to the types of conditions and care received by populations experiencing disparate health outcomes? Are any quality metrics specifically geared toward measuring health disparities? Do adjustments to outcome measures promote fairness to providers without disregarding poor quality? How do the methods of quality measurement (e.g., whether provider performance is compared to a benchmark or against performance of other providers; whether metrics apply to particular conditions/procedures or applicable to all) affect incentives to improve outcomes for populations with unmet medical/social needs or challenges complying with care plans?

3. Health Plan Pricing: The HEWG is requesting information regarding how the methods of pricing plan benefits, developing premiums, and paying plans affect health disparities related to access to coverage, coverage affordability, and health outcomes. Questions of interest include:

a) Do historical data on health care utilization and spending accurately reflect underlying health care needs? How does the correlation differ for different demographic and socioeconomic groups? To what extent do barriers to care suppress health care utilization among populations that are under-resourced or underserved?

b) Within risk pools, do health care utilization and spending vary among demographic and socioeconomic subgroups? Do medical prices vary within a geographic rating area, and do different subgroups use providers charging different prices? In large group insurance plans or self-funded health plans, to what extent do health care utilization and spending vary within industry groupings by sociodemographic and -economic factors? Do geographic or industry factors in effect reflect variations by race or other characteristics?

c) How do risk adjustment program methodologies affect plan payments for populations that are under-resourced or underserved?

d) What are the offsetting cost reductions, if any, of including additional health benefits such as prescription drugs or telehealth services? What is the timing of those cost reductions—do they accrue the same year the benefit is added or over a longer term?

4. Managing Population Health: The HEWG is requesting information regarding how efforts to assess health risks and address those risks affect health disparities. Questions of interest include:

    a) How are algorithms to identify enrollees for disease management, care management, or wellness programs designed, and do they accurately identify those who would most benefit?
    b) Do care management programs address needs beyond those directly related to health care, such as the social determinants of health? Do requirements that the same rules and methods apply to different populations affect disparities?
    c) How do program costs and benefits accrue over time? Does the focus on a one-year time horizon for program costs and benefits lead to not pursuing programs that could provide benefits over a longer time frame?
    d) How does a focus on financial metrics, such as return on investment (ROI)—commonly used to quantify the impact of disease management, care management, or wellness programs—affect implementation of such programs and health outcomes, especially in underserved or under-resourced groups?
    e) How are clinical algorithms that are used in clinical practice, health systems, or payment systems designed and structured? Does their inclusion of information on race/ethnicity, social determinants of health, or other sociodemographic or -economic factors, or lack thereof, bias decision-making and lead to increased disparities?

5. Data collection: The HEWG is requesting information regarding data availability and collection for use in testing and measuring impacts described in items 1-4. Questions of interest include:

    a) What data are available to actuaries to indicate sociodemographic or -economic characteristics such as race, ethnicity, income, disability, geography, gender, and sexual orientation? Are self-reported data on this information available?
    b) When self-reported data are unavailable, what methods are used to impute race, ethnicity, income, and other demographic data, and what are the benefits and risks of using these methods in the absence of self-reported data?
    c) How does the lack of consistent race and ethnicity data collection requirements—and the lack of agreed-upon categories for race, ethnicity, and other characteristics—affect the ability to analyze and address health disparities?
    d) How does the lack of widely accepted and applied mechanisms to test for bias in actuarial practices affect disparities in health outcomes?