

# Health Equity From an Actuarial Perspective— Provider Contracting and Network Development

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# About the Academy



- 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.

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[www.actuary.org](http://www.actuary.org)

# Why actuaries care about health equity

- Key health decision-makers rely on actuaries for advice
- Unique skillset to quantify costs of health disparities to the health care system
- Commitment to identifying and addressing issues on behalf of the public interest
- Desire to explore and understand whether any actuarial practices inadvertently lead to or exacerbate health disparities and inefficient use of health care dollars
- Potential to use actuarial principles to reduce health disparities and improve health outcomes

# American Academy of Actuaries Health Equity Committee

- Created to contribute actuarial perspective to health equity
- Focus:
  - Evaluate actuarial practices in the context of health equity
  - Educate actuaries and other stakeholders on health equity issues
  - Apply an equity lens when considering the impact of current or proposed health care policies

# Definitions used by the Health Equity Committee

Health Equity: 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: 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: 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, which 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, N.J.: Robert Wood Johnson Foundation, 2017.

# Initial phase—Discussion brief developed a list of questions and topics to explore further



- Comprehensive list served as starting point for further analysis
- Four areas of focus:
  - Health plan pricing
  - Health plan benefit design
  - Provider contracting and network development
  - Population health management

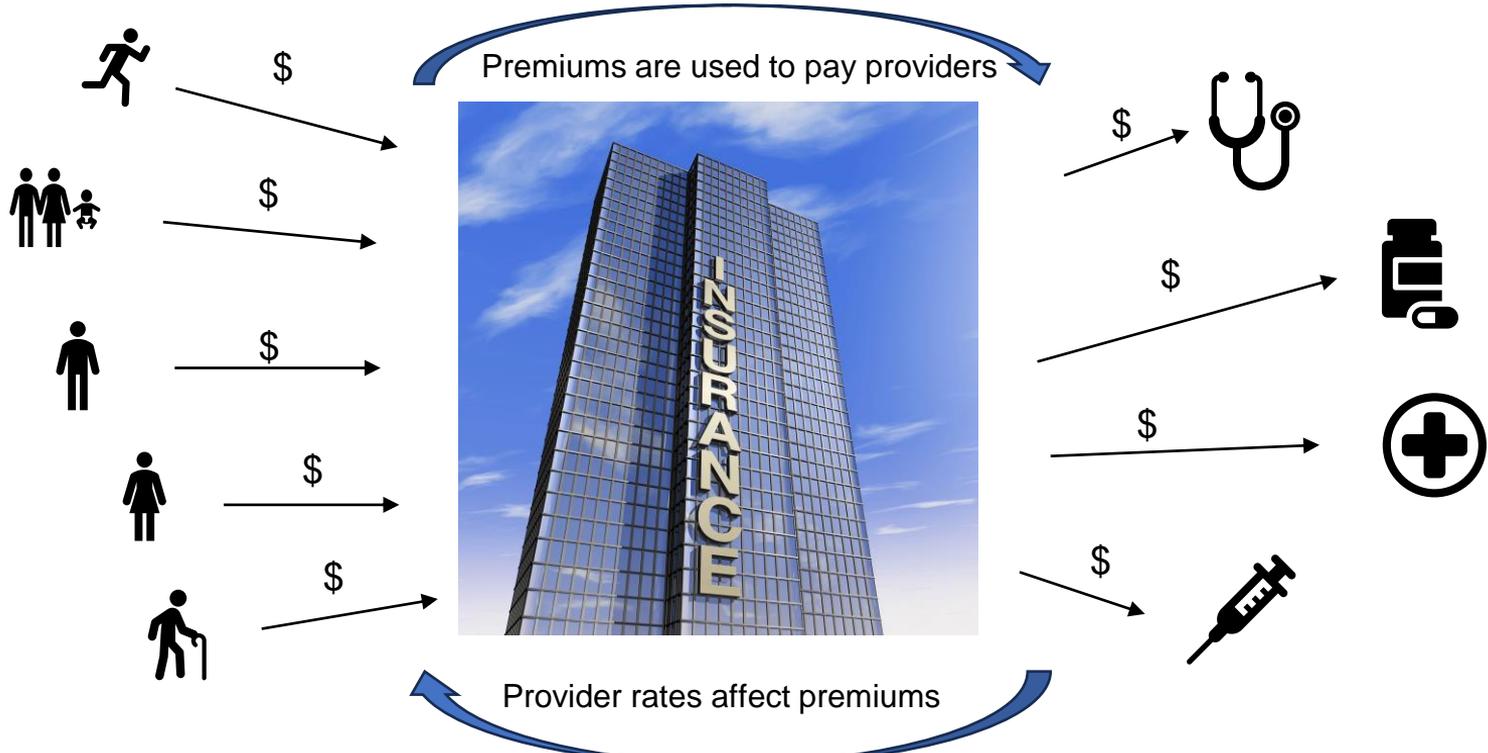


# Health equity and provider contracting and network development

In what ways might the incentives embedded in health care provider network development and provider payment methods affect health disparities?

data  
access to care  
plan spending goals  
cost targets  
risk-bearing contracts  
alternative payment model  
fee-for-service  
value-based purchasing  
quality provisions  
outcomes measures  
risk adjustment

# Health plan spending goals can affect network development and provider contracting



# Relationship between health plan spending targets, provider reimbursement rates, network size, and premiums

- Negotiated reimbursements reflect discount from provider billed charges
- The narrower the provider network, the deeper the discounts providers are willing to accept (and the lower the premiums)
- Higher health plan spending targets can support broader provider networks and higher provider prices
- Lower targets can require more limited networks that do not include some higher-cost providers

# Do resulting provider networks allow access for all segments of the enrolled population?

- Does network development consider health care access issues faced by people living in underserved or under-resourced communities or who belong to groups that have been economically or socially marginalized?
- Access issues can arise from:
  - Too few providers
  - Inconvenient provider locations or office hours
  - Lack of culturally competent providers

# Provider size and negotiating leverage

- Large providers with infrastructure and capital often have leverage to get better pricing terms with plans
  - More likely to be in communities with greater social and economic resources
- Smaller providers and those with less negotiating leverage might be more likely to serve communities with fewer social and economic resources
  - May face choice between accepting prices offered or opting out of the network
  - If agree to offered prices, may have fewer resources to meet patient needs
  - If opt out, may reduce access to care in these communities

# Shift from fee-for-service to alternative payment models and risk-bearing arrangements can affect provider incentives

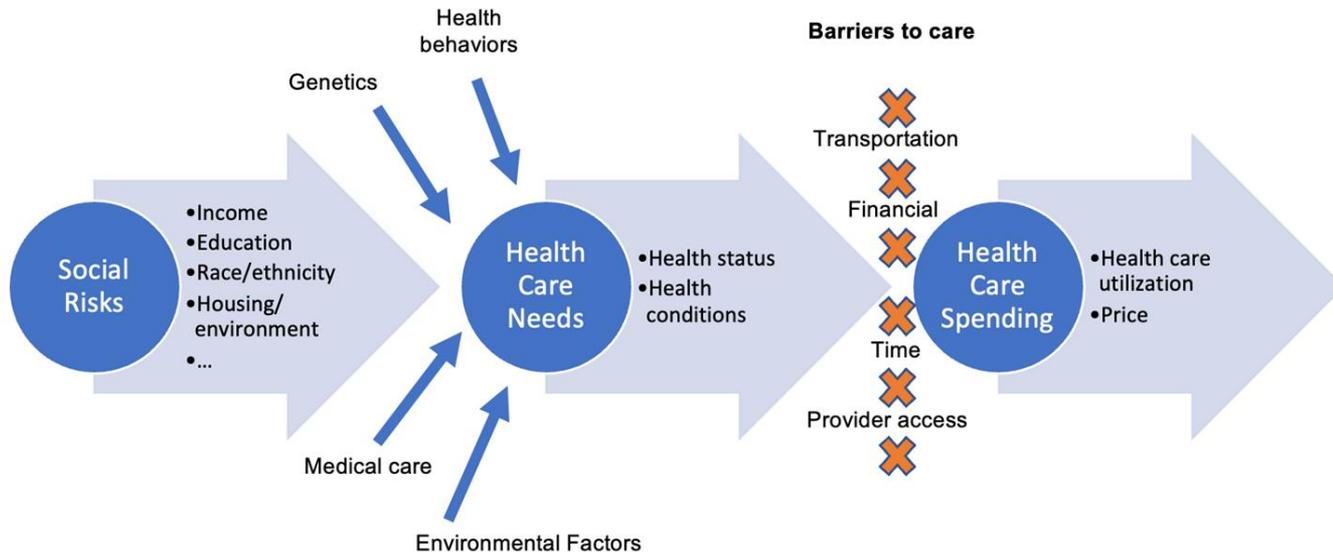


Incentives to:

- Provide care more efficiently
- Reduce unnecessary medical services
- Shift care to similar but less costly services or sites of care
- Improve health care quality
- Improve general health of the population

# Historical data are used to develop capitation rates or cost targets for APMs or risk-bearing entities

- Analyses typically don't consider socioeconomic factors and barriers to care
- Health care spending can understate health care needs for marginalized populations



# What are other potential implications for health equity of incentives in capitation or cost targets?

- Do incentives cause providers to limit or improve access for certain members via office hours, location convenience, or telehealth availability?
- Do incentives lead providers to heighten their focus on certain conditions or populations and lessen focus on others?
- To meet cost targets, do providers limit care in ways that disproportionately and adversely affect members who may need care the most?

# Capitation rates could understate health care needs of underserved populations

- Provider groups that historically care for high utilizers of health care will be able to negotiate a higher capitation rate compared with provider groups caring for lower utilizers, even if their needs are higher
- Does using historical data to develop cost or other outcome targets, without adjustment for socioeconomic or other factors, embed existing disparities into provider payments and contribute to continued disparities?

# Quality and outcome measures in APM contracts

- Quality and outcome measures can be used to adjust payments to providers
  - Recognize that positive health outcomes rely on quality care
  - Guard against the reduction of necessary care
- Types of measures include:
  - Clinical processes
  - Patient safety
  - Utilization
  - Clinical outcomes
  - Patient experience
  - Costs

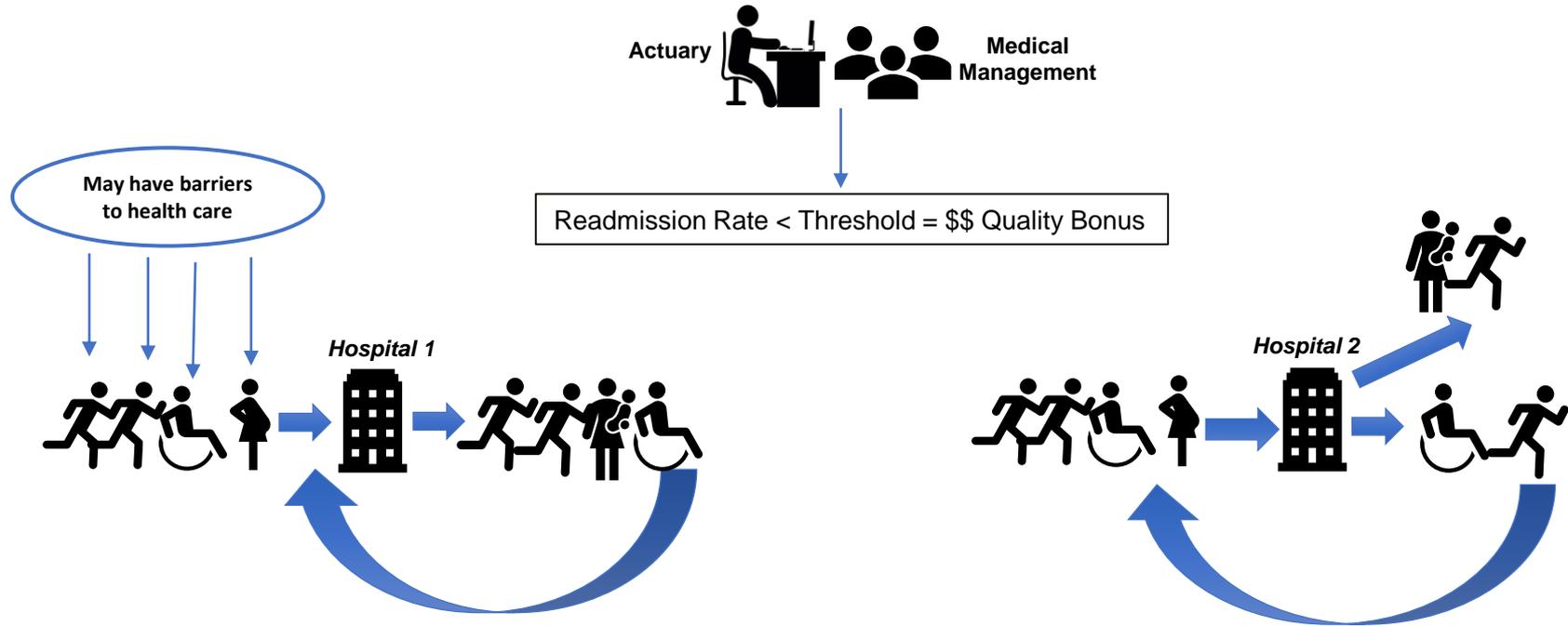
# Are quality metrics aligned with provider financial incentives to improve health equity?

- Are the specific measures used relevant to the types of conditions and care received by populations experiencing disparate health outcomes?
- Are there any quality metrics specifically geared toward measuring health disparities?
- If provider performance is compared to a benchmark or to other providers, do those comparisons reflect the population being served?
- Do provider comparisons recognize differences in patient characteristics or health care needs?

# Should outcomes metrics be adjusted for population characteristics that influence successful achievement?

- Providers serving populations experiencing social or economic advantage may face special challenges
- Unless outcomes measures are adjusted to reflect those challenges, providers serving such populations may be disadvantaged in their ability to provide high-quality of care.
- Any adjustments need to promote equitable treatment without introducing excuses for poor quality that can exacerbate disparities

# Illustrative Provider Contracting Example: Evaluating Metrics Used in Value-Based Purchasing



# Using Risk Adjustment to Evaluate Provider Performance



Goal:

- To avoid advantaging or disadvantaging providers based solely on their patient profile

# Reasons to Evaluate Provider Performance

- Identify providers for network inclusion
  - Providers may be subject to performance requirements related to costs, outcomes, and quality
- Assess payments/rewards under value-based payment arrangements
  - Provider payments adjusted for quality, resource use, and patient experience measures
- Develop quality ratings
  - Quality ratings can help consumers make informed decisions

# Risk Adjusting Provider Performance Measures

- Provider performance can be risk adjusted to account for differences in patient characteristics that can affect outcomes
- Risk adjustment can improve provider comparisons and facilitate the identification of high-quality providers
- In the absence of risk adjustment, providers treating higher-risk patients could be at a disadvantage, potentially leading to providers avoiding these patients
- Social risk factors are not typically included in risk adjustment

# Appropriateness of Adjusting Outcomes for Social Risk

Incorporate social risk factors to avoid penalizing or rewarding providers for factors outside of their control

Vs.

Rather than adjusting outcomes by social risk, provide additional resources to providers treating patients with more social risk



# On the horizon

- December 12: Presentation on health equity and population health management
- Ongoing work to focus on strategies to incorporate more equity-enhancing features in health insurance benefit design
  - Series of issue briefs
  - Symposium on November 15



# Additional Resources

## American Academy of Actuaries Health Equity Committee

- *Health Equity from an Actuarial Perspective: Questions to Explore*  
[https://www.actuary.org/sites/default/files/2021-03/Health\\_Equity\\_Discussion\\_Brief\\_3.21.pdf](https://www.actuary.org/sites/default/files/2021-03/Health_Equity_Discussion_Brief_3.21.pdf)
- *Health Equity from an Actuarial Perspective: Provider Contracting and Network Development* [https://www.actuary.org/sites/default/files/2021-09/Health\\_Equity\\_Provider\\_Contract\\_Network\\_Develop\\_09.2021.pdf](https://www.actuary.org/sites/default/files/2021-09/Health_Equity_Provider_Contract_Network_Develop_09.2021.pdf)
- *Health Risk Assessment and Risk Adjustment in the Context of Health Equity*  
<https://www.actuary.org/sites/default/files/2022-08/RiskAdjust.8.22.pdf>
- *Health Benefit Design Innovations for Advancing Health Equity: Removing the Barriers to Successful Implementation: Issue Brief 1—Overview*  
<https://www.actuary.org/sites/default/files/2023-08/health-brief-benefit-design-overview.pdf>
- Additional issue briefs and other materials available at:  
<https://www.actuary.org/committees/dynamic/HEALTHEQUITY>

# Additional Resources

## External resources on incorporating social risks into risk adjustment

- Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors (National Quality Forum)  
[https://www.qualityforum.org/Publications/2014/08/Risk\\_Adjustment\\_for\\_Socioeconomic\\_Status\\_or\\_Other\\_Sociodemographic\\_Factors.aspx](https://www.qualityforum.org/Publications/2014/08/Risk_Adjustment_for_Socioeconomic_Status_or_Other_Sociodemographic_Factors.aspx)
- Second Report to Congress on Social Risk and Medicare's Value-Based Purchasing Program (ASPE)  
<https://aspe.hhs.gov/reports/second-report-congress-social-risk-medicares-value-based-purchasing-programs>

# Questions?

# Thank You

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