Health Equity From an Actuarial Perspective—Benefit Design

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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.

For more information, please visit:

www.actuary.org

What is an actuary?

- Actuaries put a price tag on risk. They are experts in:
  - Evaluating the likelihood of future events
  - Reducing the impact of undesirable events
  - Designing ways to reduce the likelihood of undesirable events
- Health actuaries are trained in all aspects of the finance and delivery of health benefits. Their responsibilities can include:
  - Projecting future health care utilization and spending
  - Designing health benefit packages
  - Developing premiums

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

Series of discussion briefs to explore health equity issues from an actuarial perspective

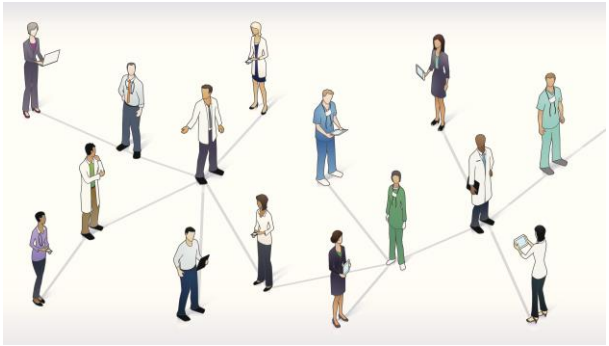
- Areas of focus:
  - Health plan pricing
  - Health plan benefit design
  - Provider contracting and network development
  - Population health management

Elements of Benefit Design

Cost sharing

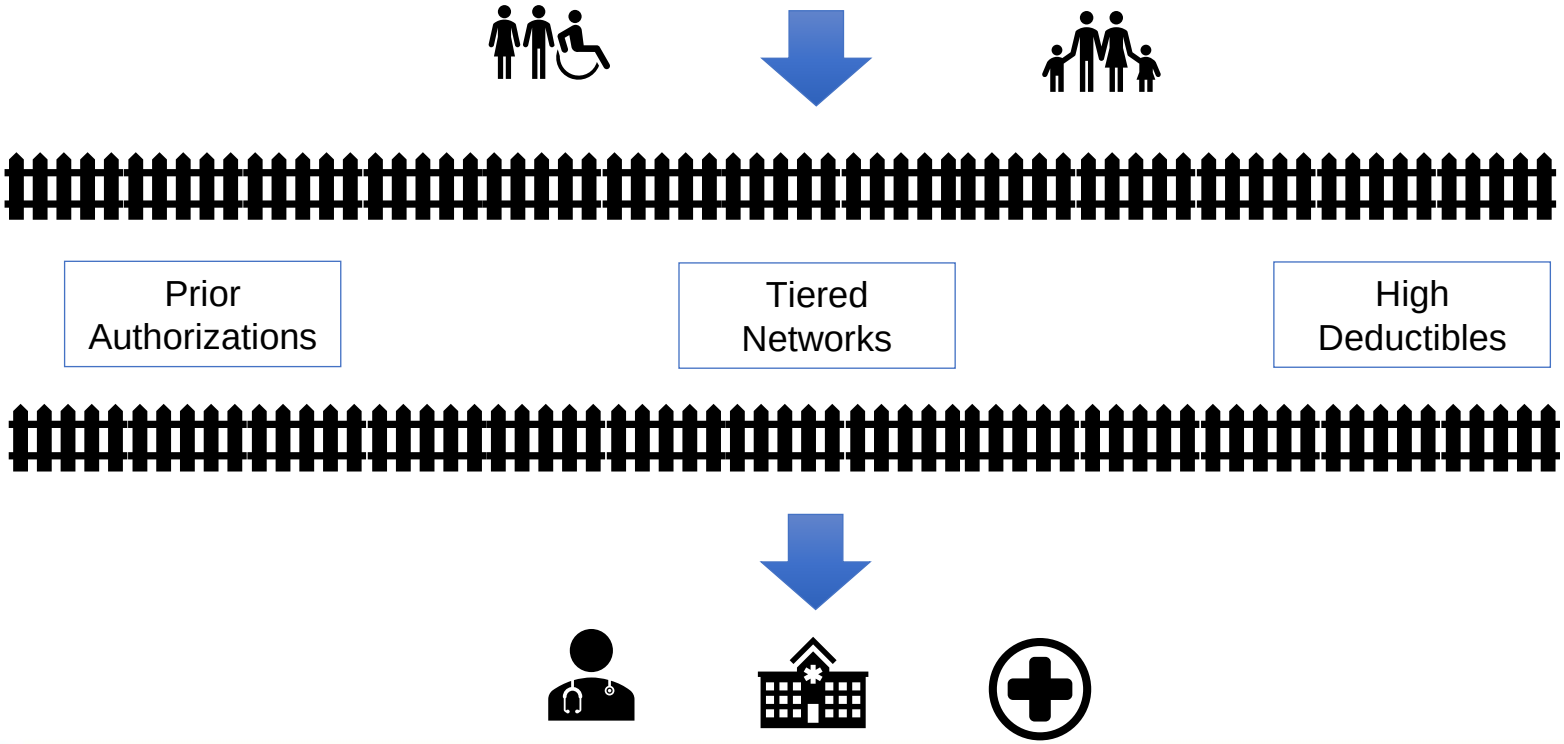
Covered Services

Provider Network



Utilization Management

Benefit Design Example: Impact on Equity



Patient cost-sharing

- Goal of the payer: Reduce or eliminate unnecessary utilization of services by transferring some of the cost of care to the enrollee
- Trade-offs between premiums and out-of-pocket costs
- Cost-sharing can be a blunt instrument
  - ➢ It can lower utilization of both highly effective and less-effective services and can lead to worse outcomes for poorer and sicker patients (RAND Health Insurance Experiment)
  - ➢ High-deductible health plans and HSAs can lower premiums, but can be harmful to those without the required health literacy, time, and other resources to shop for and optimize use of their care

Patient cost-sharing (cont.)

- Value-based insurance design (VBID) varies patient cost-sharing to align with the value of health care services
- Example: The ACA requires coverage of certain preventive services with no cost-sharing
- Gaps in the availability of first-dollar coverage:
  - Diagnostic (vs. screening) tests may require cost-sharing
  - Chronic care management may require cost-sharing and be subject to the deductible
  - Even with zero cost-sharing, other barriers can affect access to care (e.g., transportation)

Services covered

- Goal of the payer: Comply with federal/state requirements and attract customers while keeping premiums affordable
- The Affordable Care Act (ACA) requires coverage of a set of essential health benefits (EHBs) for fully insured individual and small group market plans
  - Allows for some variability by state and health plan
- Considerations regarding equitable coverage
  - Are prescription drugs used to treat conditions disproportionately affecting communities of color included in the formulary? In what tier?
  - Are nontraditional services covered? (e.g., transportation services, nutrition assistance)

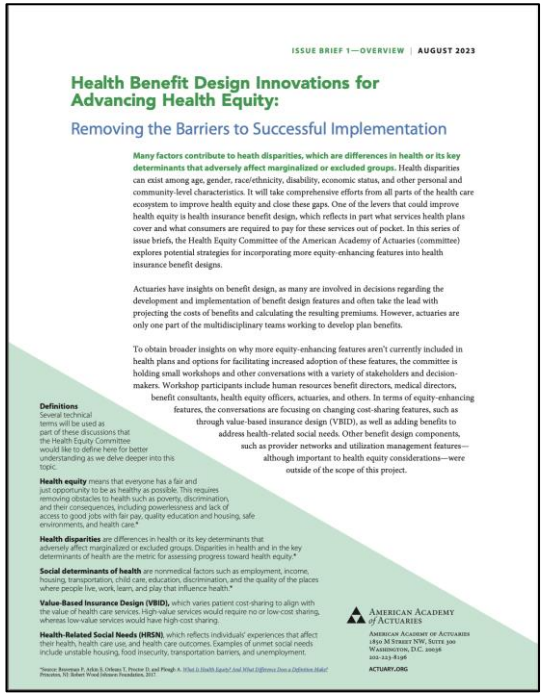
Provider Networks

- Goal of the payer: Provider networks are used to negotiate more favorable payment rates and identify high-quality providers
- Considerations regarding equitable access
  - Are tiered networks and narrow networks adequate to ensure primary and specialty care access among underserved populations?
  - Are there sufficient culturally competent providers?
  - Are nontraditional providers included? (e.g., doulas)
  - Are providers available in convenient locations with after-hours availability?

Utilization management (UM) protocols

- Goal of the payer: Manage costs
- Types of UM protocols
  - Prior authorization
  - Step therapy
  - Concurrent review
  - Retroactive review
- In marginalized communities, UM protocols can result in underutilization or deferral of needed services
- Lack of awareness of and difficulty with navigating appeals process can especially harm individuals from marginalized communities

Focus on strategies to incorporate more equity-enhancing features in health insurance benefit design



ISSUE BRIEF 1—OVERVIEW | AUGUST 2023

Health Benefit Design Innovations for Advancing Health Equity:

Removing the Barriers to Successful Implementation

Many factors contribute to heath disparities, which are differences in health or its key determinants that adversely affect marginalized or excluded groups. Health disparities can exist among age, gender, race/ethnicity, disability, economic status, and other personal and community-level characteristics. It will take comprehensive efforts from all parts of the health care ecosystem to improve health equity and close these gaps. One of the levers that could improve health equity is health insurance benefit design, which reflects in part what services health plans cover and what consumers are required to pay for these services out of pocket. In this series of issue briefs, the Health Equity Committee of the American Academy of Actuaries (committee) explores potential strategies for incorporating more equity-enhancing features into health insurance benefit designs.

Actuaries have insights on benefit design, as many are involved in decisions regarding the development and implementation of benefit design features and often take the lead with projecting the costs of benefits and calculating the resulting premiums. However, actuaries are only one part of the multidisciplinary teams working to develop plan benefits.

To obtain broader insights on why more equity-enhancing features aren't currently included in health plans and options for facilitating increased adoption of these features, the committee is holding small workshops and other conversations with a variety of stakeholders and decision-makers. Workshop participants include human resources benefit directors, medical directors, benefit consultants, health equity officers, actuaries, and others. In terms of equity-enhancing features, the conversations are focusing on changing cost-sharing features, such as through value-based insurance design (VBID), as well as adding benefits to address health-related social needs. Other benefit design components, such as provider networks and utilization management features—although important to health equity considerations—were outside of the scope of this project.

Definitions
Several technical terms will be used as part of these discussions that the Health Equity Committee would like to define here for better understanding as we delve deeper into this topic.

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.*

Value-Based Insurance Design (VBID), which varies patient cost-sharing to align with the value of health care services. High-value services would require no or low-cost sharing, whereas low-value services would have high-cost sharing.

Health-Related Social Needs (HRSN), which reflects individuals' experiences that affect their health, health care use, and health care outcomes. Examples of unmet social needs include unstable housing, food insecurity, transportation barriers, and unemployment.

*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.

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- Areas of exploration:
  - Process and challenges to incorporating equity-enhancing features
  - How benefit changes are evaluated
  - How to incorporate the voices of plan participants
  - Addressing implementation challenges
- Nov. 15 symposium

Why aren't more equity-enhancing features included in benefit designs?

- There is pressure to identify cost savings in order to add new or innovative benefits
  - Estimates of new benefits costs may ignore related reductions in other spending
  - One-year health insurance term discourages benefits if offsetting benefits would not be realized until future years
- Adoption of equity-enhancing elements has been incremental
- The focus has been primarily on cost-sharing elements rather than coverage of nontraditional benefits
- Large employers may have more flexibility to incorporate new benefits and more ability to consider long-term and non-medical effects than individual and small group markets

How to overcome the challenges to how new benefits are evaluated

- Shift the focus from cost savings to cost effectiveness
  - Cost effectiveness incorporates changes to health outcomes, not just changes to costs
- Increase use of high-value benefits and reduce use of low-value benefits
- Examine inconsistencies in treatments for interrelated conditions and address as appropriate
- Consider the total impact of the new benefit over its lifetime and not in isolation from other benefits

Other considerations

- Quantitative and qualitative data are needed to identify unmet needs
- More research is needed to understand the cost effectiveness of new benefit features, especially nontraditional benefits aiming to address health-related social needs (e.g., transportation, nutritional support)
- Standardized measures of health care outcomes can facilitate the shift to cost effectiveness in the private health insurance markets
- Benefit design is not enough; plan participants need to be aware of the benefits, understand their value, and be able to use them

Questions?

Thank You

For more information contact:

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