American Academy of Actuaries Health Equity Committee

Presentation to the National Association of Insurance Commissioners (NAIC) Special (EX) Committee on Race and Insurance, Workstream Five

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Academy Health Equity Committee

- Primary goal:
  - Seek solutions to health equity and health disparities by first evaluating current actuarial practices in the context of health equity
- Health equity focus is broader than race and ethnicity
- Five issue briefs published to date
  https://www.actuary.org/committees/dynamic/HEALTHEQUITY
- Two publications in process
- Several research projects planned

Elements of Benefit Design

Cost-sharing structure

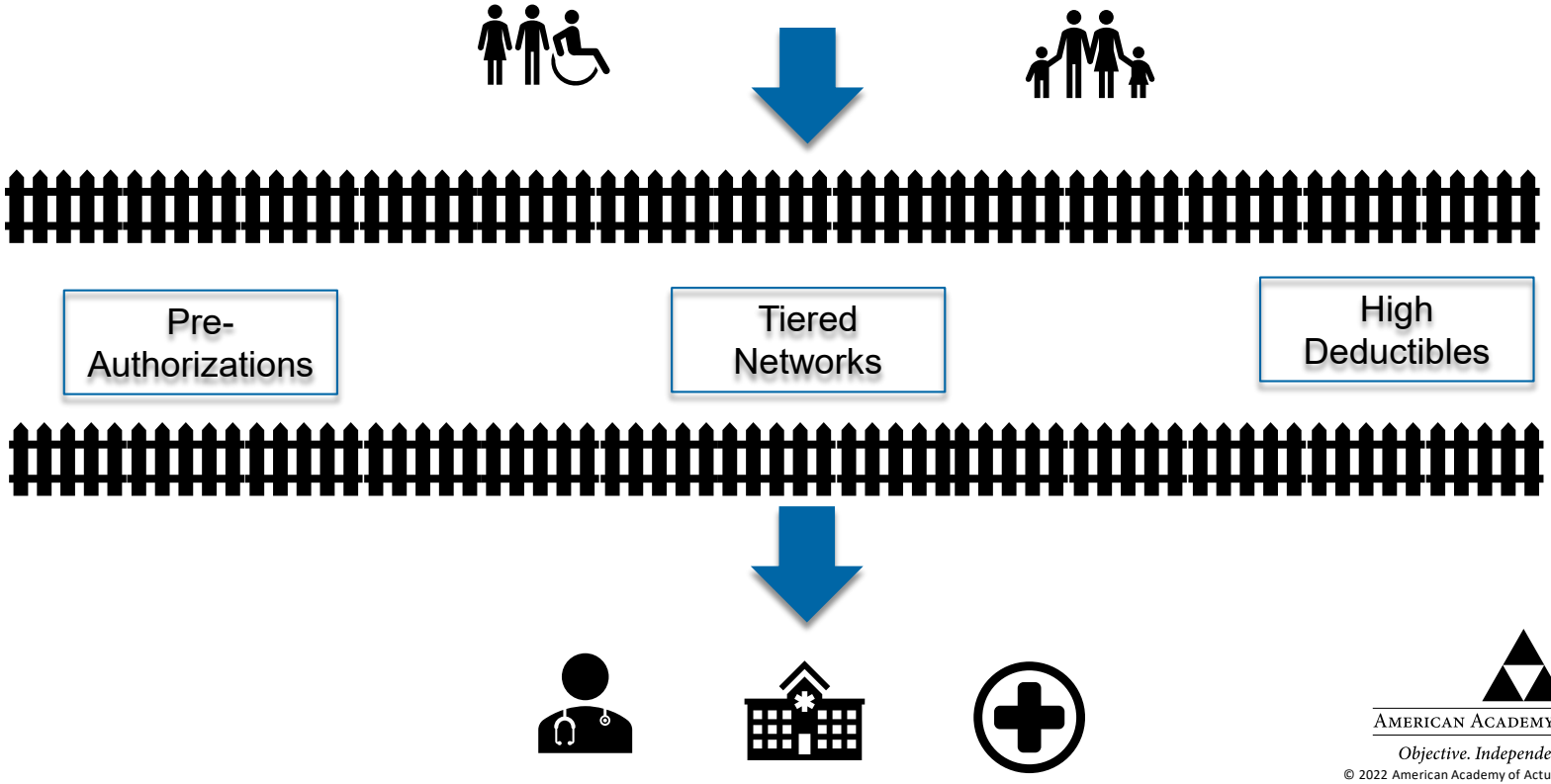
Services covered

Provider network

Utilization management

How do these features impact health disparities?

Benefit Design Example: Impact on Equity



Cost Sharing

- The goal: 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
- Studies have shown:
  - Cost sharing reduced the utilization of both highly effective and less effective services and was associated with worse health outcomes for poorer and sicker individuals[1]
  - High-deductible health plans may widen health disparities in cancer patients[2]
  - Individuals of low socioeconomic status who were enrolled in high-deductible plans reduced ER visits and hospitalizations in their first enrollment year, increasing subsequent high-acuity care[3]
- In high-deductible plans with Health Savings Accounts (HSAs) , how do HSA contributions vary by race and ethnicity?
- For conditions experienced disproportionately among communities of color, what are cost-sharing requirements for health care providers, services, and prescription drugs?

[1] Source: Center for Health Studies, Group Health Cooperative of Puget Sound, Seattle, WA 98112.

[2] Source: Cole MB, Ellison JE, Trivedi AN. Association Between High-Deductible Health Plans and Disparities in Access to Care Among Cancer Survivors *JAMA* 2020;3(6):e208965.https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2767589

[3] Source: https://www.healthaffairs.org/doi/10.1377/hlthaff.2012.1426

Services Covered

- 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.
- Are prescription drugs used to treat conditions disproportionately affecting communities of color included in the formulary? In what tier?
- Are covered services equally accessible in all communities? (e.g., behavioral health)
- Are nontraditional services covered? (e.g., transportation services, food assistance)

Providers Covered

- Do tiered networks and narrow networks disproportionately affect access to care among communities of color?
- Do narrow networks include sufficient specialists to care for conditions more prevalent among communities of color?
- Are there differences in number/% of providers accepting new patients by ZIP code?
- Are the risk-sharing provider incentives aligned with providing care in marginalized communities?
- Are nontraditional providers covered? (e.g., Doulas for maternal health)

Utilization Management (U/M) Protocols

- Goal: Manage costs
- Types of U/M Protocols
  - Prior authorization
  - Step therapy
  - Concurrent review
  - Retroactive review
- In marginalized communities:
  - Lower utilization of health services, including preventive care
  - Does the use of U/M protocols result in underutilization or deferral of needed services?
  - Do prior authorization requirements exacerbate the effects of unconscious bias among providers, reducing access to care?
  - Does retroactive denial of services have a dampening impact?

Other Considerations

- For groups that have been socially or economically marginalized:
  - Does the complexity of benefit designs cause people to under- or over-insure due to the level of health care literacy needed to effectively choose a plan?
  - Can the focus on simplifying the plan choice decision lead to suboptimal decisions?
  - Does premium-based compensation or other broker incentives lead to suboptimal plan choice and overspending on health insurance?

Regulatory Considerations

- Changes in benefit design over time
- Differences in benefit design by geography
- Data
  - Discrepancies in utilization
  - Prior authorization, retroactive denials
  - Narrow networks
  - Cost-sharing patterns
    - Formularies, especially for specialty drugs
- Cost implications of changes in benefit design

Thank You – Questions?

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