

# Health Equity from an Actuarial Perspective

## Health Plan Benefit Design

The American Academy of Actuaries Health Practice Council created the Health Equity Work Group with a goal of contributing to efforts to reduce health disparities and improve health equity among racial and ethnic minority populations and underserved or under-resourced communities. The work group is examining actuarial practices and methods in the health area 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.

An initial discussion brief, [Health Equity from an Actuarial Perspective: Questions to Explore](#), introduced the first phase of the work group's work—an identification of areas in which health actuaries are involved that may affect health equity and development of a list of questions and topics to explore further. This discussion brief is part of a follow-up series providing more context and details on these questions. This discussion brief focuses on questions related to health plan benefit design. Another brief, [Health Plan Pricing](#), and forthcoming briefs on provider contracting and network development, and population health are part of this series.

Taken together, the series forms the foundation for the next phase of the group's work—investigation and analysis to answer the questions. By sharing an actuarial perspective through this series, the work group hopes to actively engage not only the actuarial profession, but also policymakers and the health policy community, to help advance the public discourse on health equity 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.



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Health plan “benefit design” refers to the set of provisions that determine which services will be covered, which providers will provide covered services, the cost-sharing structure (e.g., deductibles, copayments, or coinsurance), as well as the utilization and medical management protocols (e.g., precertification, preauthorization, and continued stay review) used to manage access to and the cost of covered services. Actuaries work with teams of other professionals, such as those involved with product development and regulatory compliance, to create and evaluate benefit designs. Many different and sometimes conflicting goals need to be considered when setting benefit designs. These can include fulfilling regulatory requirements, attracting plan membership, for employer-sponsored coverage retaining employees, and steering plan members to use the most appropriate type of care for a given condition. When considering the impact of benefit design on health care outcomes and disparities, issues arise around two key areas: access to care and affordability of care. Access and affordability are affected by the services covered, sites of care, network structure (tiered, narrow, broad network), and the out-of-pocket costs, including both cost-sharing and premiums, for which the insureds are responsible.

This paper discusses in more detail the questions that the Health Equity Work Group will explore regarding whether the methods of creating and valuing benefit designs contribute to health disparities among populations that are underserved or under-resourced, such as communities of color, or whether they might be helping to mitigate disparities. The questions outlined below are applicable across markets, including the individual market, employer-sponsored coverage, Medicaid, and Medicare.

*How is benefit design used to attract and maintain health plan members? Are there barriers to individuals in choosing the plan that best fits their needs, and if so, do they contribute to health inequities?*

Actuaries are often called upon to design health plans that meet many, often competing criteria. From the health plan perspective, stable membership representing a broad cross-section of risks is desirable to keep premiums predictable and as affordable as possible. Attracting and retaining health plan members are important considerations when designing and valuing health benefits. In addition to premiums, the attractiveness of a plan to consumers is commonly focused around a few key cost-sharing features such as deductibles, primary care provider (PCP) copays, and out-of-pocket maximums. The importance of these features can vary by individual, as can non-financial factors, such as access to specific providers and coverage of certain services. However, in order to choose an optimal plan, individuals need to understand the overall expected cost of coverage, including premiums and cost-sharing, as well as other non-financial factors, such as access to current providers. Focusing on one aspect of benefit design could lead plan members to make suboptimal plan choices. And even if individuals could choose the plan that best meets their expected future health needs, individuals also need to consider how plans would meet health needs that could arise unexpectedly.

For example, high-deductible plans can be attractive to plan members with lower incomes due to lower premiums, but may limit access to care for those with limited ability to pay high out-of-pocket costs and lead to underutilization of needed services. On the opposite end of the spectrum, plans that provide very rich benefits have high premiums (unless subsidies are available), limiting access to those who might need the more generous coverage but cannot afford to buy the insurance.

Plan options need to appeal to consumers, be attractively priced for the benefits offered, and meet regulatory guidelines. Benefit designs can also be used to attract particular populations with chronic conditions that the insurance company believes it can manage effectively, such as diabetes. This confluence of factors over time has led to complex benefit design options where the difference between options may be difficult to discern even for knowledgeable individuals. In addition, insurance brokers—used extensively in the small group market and somewhat in the individual market—are typically compensated through premium-based commissions, which could lead to plan recommendations that don't align with consumer needs.

Many questions related to benefit design and consumers' plan decisions should be considered in the context of health equity, including: Does the complexity of benefit designs cause people to under- or over-insure due to the level of health literacy needed to effectively choose a plan? Can the focus on certain cost-sharing features or other design features to simplify the plan choice decision lead to suboptimal decisions, especially among groups that have been economically or socially marginalized? Does premium-based compensation or other broker incentives lead to suboptimal plan choice and overspending on health insurance by groups experiencing disadvantage?

### *Can benefit design features that aim to manage utilization and spending affect health disparities?*

Benefit design is commonly used as a method to manage utilization and cost, and therefore premiums. Plan features such as the cost-sharing structure, provider network design, and preauthorization requirements are intended to create financial incentives for plan members to be more price-sensitive and to use lower-cost, higher-quality services. But a key consideration is whether these features reduce costs because of underutilization of necessary services, especially among people with fewer resources or face other barriers to care, rather than elimination of unnecessary services.

One way to limit health utilization and spending is to require patients to bear some of the cost of care themselves through cost-sharing features such as deductibles, copayments, coinsurance, and dollar maximums on benefits for specific services. The goal is to reduce or eliminate unnecessary utilization of services and maintain the affordability of the plan by transferring some of the cost of care to the patient. Notably, there can be trade-offs between premiums, which spread spending over all enrollees, and out-of-pocket costs, which levy higher costs on those with health care utilization.

In theory, cost-sharing can influence consumer behavior by encouraging higher-value or more appropriate care and discouraging low-value care. Cost-sharing can also be structured to create incentives to choose a more cost-efficient site of care, such as urgent care rather than the emergency room. But the effective use of cost-sharing differentials for services or providers/sites of care assumes members receive adequate, culturally appropriate information to distinguish between high-value and low-value care. Questions to explore in a health equity context include how actuaries reflect expected utilization changes under different cost-sharing structures and whether higher cost-sharing leads to underutilization of necessary services in underserved or under-resourced communities.

Another example of a cost-sharing benefit design is “reference pricing,” which is used in some plans for a limited set of services. With reference pricing, a standard price is established for a drug, procedure, service, or bundle of services and requires that the health plan member pay any allowable charges above this price. The effective use of this feature calls for the patient to access time-sensitive information, usually via the internet. Again, effective use of this feature is reliant on members accessing information, which may not be readily accessible to people experiencing language, cultural, or technological barriers. A further question to consider is whether the use of complex and nuanced cost-sharing design structures impacts health disparities.

Health plans also use utilization management protocols such as pre-certification or pre-authorization to prevent unnecessary services. Out-of-pocket costs can vary depending on whether certification/authorization is obtained before receiving care. Requiring prior authorization for services or drugs that are high-cost or that provide limited clinical benefits ensures protocols are in place to manage utilization of these services. In addition, they can have significant financial implications for consumers. If the service is not authorized, the consumer may face severely reduced coverage or no coverage at all for service, resulting in higher out-of-pocket costs or uncompensated care. Again, consumers with lower health care literacy, or those experiencing language or cultural barriers, may find it difficult to navigate these complex processes. Another question to consider is whether the use of utilization management protocols result in underutilization or deferral of needed services in underserved or under-resourced communities, thereby leading to health disparities.

*Does benefit coverage standardization or a lack thereof exacerbate disparities? Does the inclusion or exclusion of particular services mitigate or exacerbate disparities?*

Benefits can be standardized, at varying levels of detail, across a market, a product line, or a portfolio of products within a product line. Full standardization typically means that the services covered and the cost-sharing elements for these plans are uniform across carriers. This type of standardization occurs for Medicare Supplement policies which have a defined set of included services and cost-sharing that is set by the federal government. Standardization can also occur to a lesser extent where guidelines or parameters are created for coverage, but the design is not uniform. This type of standardization occurs in the Affordable Care Act (ACA) individual and small group markets. These plans must cover Essential Health Benefits (EHBs) and must have actuarial values that meet with metal-level (i.e., platinum, gold, silver, bronze) requirements, but

the exact cost-sharing features can vary by plan. Health insurers may also create a portfolio of products with standard benefits included but with varying cost-sharing elements to offer to their employer groups. This method provides some choice to the employer group, within limits, to help reduce the administrative cost of the plan. Actuaries are involved in designing standardized benefits to meet specific plan and public policy goals and assist in the evaluation of the trade-offs between simplicity and effectiveness.

Reasons for benefit standardization include: ensuring that benefits are comprehensive and cover major types of health care services, including mental health and prescription drug coverage; ensuring that certain benefits, such as preventive care, are available without any cost-sharing; simplifying the consumer purchasing decision by allowing an “apples-to-apples” comparison of premiums or cost-sharing elements; and reducing the administrative costs of the plan. Benefit standardization can reduce risk selection among plans, which can occur if some plans are more attractive to individuals expecting to consume health care services for particular conditions and limited benefit plans are more attractive to individuals without conditions requiring specialized care or innovative treatment plans.

On the other hand, standardizing benefits can reduce consumer choice, hinder innovations that could ultimately help consumers, and limit the ability for insurers to tailor benefits to meet the needs of particular enrollees. In addition, even a standardized plan design can treat different individuals differently. For instance, a plan design tailored for people with diabetes that has lower upfront cost-sharing for diabetes treatment and maintenance supplies but a higher overall out-of-pocket maximum would be beneficial for members with a well-controlled condition but more costly if that member has a health episode requiring hospital care.

Benefits advertised as being “free” (i.e., not requiring cost-sharing), including annual preventive care and wellness benefits, such as fitness trackers or gym memberships, may be underutilized by plan members for whom these benefits are not as easily accessible, for instance due to limited time availability or inconvenient locations. Similarly, costs of new advanced treatments may require cost-sharing that is prohibitive to price-sensitive populations. In both of these situations, the costs to the plan of these services are borne across the entire population through premiums. A question to consider is whether the inclusion of particular benefits leads to under-resourced communities either being priced out of the market or subsidizing the premiums of well-resourced communities.

Another aspect of benefit standardization to be considered is how the “standard plan” is determined. For instance, to what extent are health disparities considered when determining statutorily/regulator-mandated benefits? What are the health equity effects from the inclusion or exclusion of nontraditional benefits such as after-hours care, transportation benefits, navigation assistance, or food as medicine in a standard benefit package?

A more fundamental consideration is whether a standard set of included services preclude the use of features which recognize different needs for different populations. For example, whether food assistance could be offered, but only to populations experiencing food insecurity. This would be an unequal offering of benefits, but if allowed could address underlying disparities contributing to inequitable health outcomes.

The emphasis on equal benefits for all is a public policy concern that focuses on ensuring that underserved and under-resourced groups do not experience further disadvantage by having access only to a lesser set of benefits. Some health insurance programs, such as Medicaid, encourage targeted programs for those parts of the population with socioeconomic factors or other challenges that contribute to inequity of health outcomes. A question to consider is whether and how successfully such programs address disparities. In addition, it is important to explore whether and how other insurance markets, such as the individual and employer-group markets, can scale benefits up or down based on an individual's level of need or whether there are barriers to doing so.

*Are health disparities affected by differences in availability and accessibility of providers across geography or population?*

Access to health care is affected by the availability and accessibility of health care providers. The number and type of providers varies by geographic area and the accessibility (including location, hours of service, and languages spoken) varies by provider. Insurance benefits add an additional layer of complexity to health care access. Often benefit levels for services are dependent on whether the provider is contracted with the payer/insurer. Providers that are considered “in-network” typically negotiate discounted prices for services. In exchange, members are encouraged to use these providers because they get higher benefit levels for using providers on the preferred list. This is often the case with narrow networks, prescription drug formularies, and step-up case management programs where benefits are not approved until other treatment options are exhausted. Actuaries are involved in designing and valuing benefit features, such as tiered networks and narrow networks, that impact access to providers. A question to consider is whether these types of design features achieve cost savings because of restricted access to care that is biased against certain populations.

Increasingly payers are using narrow networks to control costs and apply downward pressure on premiums. Narrow networks are created by using cost and quality criteria to select health care providers from a broader network and then establishing strong incentives for consumers to seek care from that more limited set of providers. While this approach may achieve desired cost efficiencies, a narrow network may create access issues to certain specialists or subspecialists, which could affect certain populations disproportionately. For instance, networks with insufficient hematologists could adversely affect African Americans, who are at higher risk for sickle cell disease. In addition, narrow networks may increase wait times for appointments or impose heavy cost-sharing on members who need to access providers that are outside of the network for rare forms of illnesses.

A plan's accessibility is evaluated based on network adequacy standards, which generally consider time and distance criteria. Typically, these standards don't consider lack of access to transportation or the lack of extended hours of operation or languages spoken as barriers to an adequate network for groups experiencing disadvantage. Furthermore, each geographic area may have unique issues related to accessing providers and plans may not account for this impact across a diverse population. For instance, health care needs and provider availability in rural areas can differ from those in urban areas.

Further questions to consider regarding whether these issues affect health disparities include: Does the use of design features that control access to providers disadvantage racial and ethnic minority groups? Do the methods of determining the cost impact of different benefit designs account for cost savings due to underutilization caused by increased barriers to care in underserved or under-resourced communities? How does the increased use of telehealth impact racial and ethnic minority groups and underserved or under-resourced communities?

## NEXT STEPS

The questions raised in this discussion brief provide a context and framework for considering the impact of benefit design on health disparities. A thorough examination of these questions can help actuaries, public policymakers, health care consumers, and others better understand whether and how current methods used to create and value benefit designs are inherently biased in ways that contribute to disparities and whether actuarial methods could be used to help reduce disparities. By taking a holistic approach to reviewing benefit design practices, the aim is to comprehensively capture aspects of benefit design that may directly or indirectly be increasing or decreasing healthcare disparities.

The work of the American Academy of Actuaries Health Equity Work Group involves a further investigation of many of these questions to analyze how actuarial practices may affect health disparities, either positively or negatively. Each of these questions is being considered independent of others, but the interactions of multiple factors will also be considered. If the analysis suggests that certain practices contribute to disparities, options for making changes—including the potential for application of actuarial principles to help reduce disparities—will be explored.

Members of the Health Equity Work Group's Benefit Design Subgroup, which produced this discussion brief, include Andrea Christopherson, MAAA, FSA—*Subgroup Leader*; Yi-Ling Lin, MAAA, FSA—*Subgroup Leader*; April Choi, MAAA, FSA; Jennifer Elwood, MAAA, FSA, FCA; Catherine Jo Erwin, MAAA, FSA; Craig Huval, MAAA, ASA; Annette James, MAAA, FSA, FCA; Michael Thompson, MAAA, FSA; Susan Pantely, MAAA, FSA; and Rebecca Sheppard, MAAA, FSA.

Members of the Health Equity Work Group 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; Jennifer Elwood, MAAA, FSA, FCA; Catherine Jo Erwin, MAAA, FSA; Craig Huval, MAAA, ASA; Barbara Klever, MAAA, FSA; Jennifer Lazio, MAAA, FSA; Johann Leida, MAAA, FSA; Julia Lerche, MAAA, FSA; Yi-Ling Lin, MAAA, FSA; Ian McCulla, MAAA, FSA; Mitchell Momanyi, MAAA, FSA; Tim Murray, MAAA, FSA; Donna Novak, MAAA, ASA, FCA; Ugo Okpewho, MAAA, FSA; George Omondi, MAAA, FCA, ASA; Rebecca Owen, MAAA, FSA, FCA; Susan Pantely, MAAA, FSA; Anthony Pistilli, MAAA, FSA; Daniel Pribe, MAAA, FSA; Lee Resnick, MAAA, ASA; Erica Rode, MAAA, FSA; Christopher Schmidt, MAAA, FSA; Enrique Schulz-Figueroa, MAAA, ASA, FCA; Rebecca Sheppard, MAAA, FSA; Derek Skoog, MAAA, FSA; David Sky, MAAA, FSA; Yixuan Song, MAAA, FSA; Martin Staehlin, MAAA, FSA; Sheree Swanson, MAAA, ASA; Sara Teppema, MAAA, FSA; Michael Thompson, MAAA, FSA; Tammy Tomczyk, MAAA, FSA, FCA; Jim Toole, MAAA, FSA; and Cori Uccello, MAAA, FSA, FCA.

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