

# Health Benefit Design Innovations for Advancing Health Equity: Removing the Barriers to Successful Implementation

## Overcoming Challenges to the Way Potential Benefit Changes Are Evaluated

**Many factors contribute to health disparities, which are differences in health or its key determinants that adversely affect marginalized or excluded groups.** 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 (as opposed to through premiums). In this series of issue briefs, the Health Equity Committee of the American Academy of Actuaries explores potential strategies for incorporating more equity-enhancing features into health insurance benefit designs. Actuaries are one part of multi-disciplinary 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 American Academy of Actuaries Health Equity Committee is holding focused workshops and other conversations with a variety of thought leaders and decisionmakers. Workshop participants include human resources benefit directors, medical directors, benefit consultants, health equity officers, health services researchers, actuaries, and others. In terms of equity-enhancing features, the conversations are focusing on changing cost-sharing features, such as using 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 the scope of this project, as were initiatives outside of plan design that employers might incorporate to make health care more accessible (e.g., more flexible time off policies). The goal of these conversations is not only to highlight the challenges of incorporating equity-enhancing benefit design elements, but also to offer ways to address those challenges.

### 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.



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\*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.

The investigation focuses on benefits in the employer-sponsored insurance market, both because it is the dominant source of coverage for Americans younger than 65 and because employers, especially large employers, may have more flexibility and tools available than in other insurance markets regarding their health benefit offerings. Employers can test different initiatives and the resulting lessons learned may be applicable in other markets.

The [first issue brief in the series](#) provided an overview of issues related to designing health benefits to improve health equity that were discussed in the first workshop. It outlined aspects of the decision-making process with respect to adding benefits and the challenges of incorporating more equity-improving elements into health insurance plan designs. Although employers have started to use benefit design to reduce health disparities, progress has been slow, incremental, and focused primarily on cost-sharing features rather than benefits that aim to address social needs.

This second issue brief examines in more detail how potential benefit changes are evaluated and how those evaluations could facilitate the incorporation of equity-enhancing benefit design features. The summary below highlights the insights shared in the conversations in the second workshop and in other conversations on this topic with additional experts and decision makers. It also discusses several areas for further exploration.

### **Both quantitative and qualitative data are needed to identify benefit needs and build solutions**

Insurers and employers often use quantitative data to assess health plan performance and identify areas where targeted solutions can be used to narrow gaps between goals and actual experience. Although numerous metrics are examined, much of the focus has typically been on costs, with some consideration for efficiency and clinical outcomes as well. More recently, some organizations have been incorporating information on members' social risks into their analyses, to determine whether there are gaps in benefit utilization, accessibility, or clinical outcomes by race, ethnicity, language, age, income, gender, sexual orientation, or other social risk categories. If disparities are identified, potential solutions to prevent or narrow those gaps can be crafted. Employers may already have some information on social risks for their employees (e.g., income, job type, geography), and other data on social risks can be collected directly from employees and other plan participants, for instance during a health care encounter. Alternatively, area-level factors or indices can be used to impute the social risks of area-level populations. However, such area-level metrics may not be appropriate to estimate the social risks of particular individuals.

Qualitative data can be just as important as quantitative data but might be under-collected. In addition, robust methods may be needed to facilitate the analysis of qualitative data, which can enhance the understanding of the needs of underserved and under-resourced populations. Such data can be collected through surveys, focus groups, and other outreach efforts to employees. Employee resource groups can be used to engage particular employee populations and can alert employers to other trusted advisors. Many insurers and employers also compare their benefit offerings to those offered by peer organizations to help identify any gaps in their benefits.

### **There are opportunities to improve health equity by leveraging the employer-employee relationship**

Often there is a misperception that health disparities are experienced solely by economically disadvantaged populations and that it's an issue only for the Medicaid program. However, many workers have low to moderate incomes, limited educational attainment, or other characteristics that can create challenges to achieving good health and result in health disparities. Understanding the experience and prevalence of such disparities within their own employee and community population is particularly critical for employers.

Unlike insurance coverage through Medicaid, Medicare, or the individual commercial health insurance market, employers often consider health benefits within the broader context of the employer-employee relationship. That relationship can be leveraged more broadly to improve health outcomes. Self-funded employers in particular have tremendous latitude in identifying and implementing health benefits that make sense for their employees and their dependents. Employers often think beyond the impact of health benefits to the health plan itself to consider the effect the benefits have on productivity, absenteeism, the ability to attract and retain workers, as well as other non-medical benefits.

Although employers frequently measure employee productivity and may often launch employee satisfaction surveys, it can be difficult to measure the direct impacts of particular health-related benefits on non-medical outcomes or attribute any changes in non-medical outcomes to any particular benefit. Nevertheless, using quantitative and qualitative data, employers can shift from a one-size-fits-all paradigm to one that tailors benefit design and interventions that meet the needs of particular subgroups. Different solutions are needed for people with different risks and employers are well situated to meet the needs of their unique workforce.

When these methods are more fully developed in the employer space, a potential area for further exploration would be to consider how to replicate the employee-employer relationship while considering how to evaluate outcomes more holistically in non-employer health insurance markets.

### **Employers with high employee retention rates have more incentive and flexibility to consider benefits with long-term impacts**

Employers in industries with a high rate of worker turnover may focus more on the short-term impacts of benefit changes on health plan costs and worker well-being. In contrast, employers with high retention rates and long-tenured employees may consider longer-term effects in their decision-making process. For instance, new weight-loss prescription drugs are expensive, but can be effective at reducing obesity. They also have the potential to reduce future spending on medical and non-medical benefits. Firms with higher retention rates can accrue those savings, whereas firms with shorter tenured workers are less likely to realize such savings. As noted above, however, it can be difficult to estimate long-term savings and to allocate any savings to a particular health benefit.

### **Cost is a significant factor when determining whether to add equity-enhancing benefits**

Although other factors are considered, including whether a benefit can improve clinical outcomes, employers and insurers are often hesitant to make a benefit change that could increase short-term medical costs. Those costs can lead to increases in overall benefit costs, premium increases, and increases in patient cost-sharing.

Some benefit changes that improve health equity can result in savings and a positive return on investment (ROI), even in the short term. One such example is greater advocacy and navigation support, which helps members navigate the complexities of the health care system to more efficient sites of care, improve their self-care resources, or remain adherent to prescribed treatment. Benefit consultants may focus on these benefits, showing how improving equity can not only improve the health among particular groups, but also lower their medical costs. For instance, interventions that shift high utilizers of emergency departments for non-urgent care to use primary care can reduce spending for both the employer and the plan participant, while also improving clinical outcomes.

Many equity-enhancing changes, especially those with long-term impact, are likely to increase medical costs within the plan sponsor's planning horizon. Although employers can measure employee satisfaction and retention, it can be challenging to quantify non-medical savings, such as improvements in productivity and well-being. This is also true of longer-term savings that can arise after short-term costs. Additionally, it can be difficult to attribute costs or savings solely or primarily to particular benefit changes. Research may be available regarding the effects of different cost-sharing requirements, but details regarding the cost and clinical impacts of benefits intended to address health-related social needs is only just emerging. Ultimately, if positive non-financial medical outcomes, positive financial outcomes outside the medical program, or longer-term savings aren't incorporated into the analysis, ROI measures can be biased against benefits that increase health care costs, regardless of their impact on medical and non-medical outcomes.

### **Shifting the focus from cost savings to cost effectiveness can facilitate the incorporation of equity-enhancing benefits**

Focusing on health plan cost savings can be at odds with a goal of spending health dollars optimally. Focusing instead on cost effectiveness, which reflects not only health costs but also desired health outcomes, as well as the impact on total benefits, can help reframe the evaluation to prioritize high-value care that improves health outcomes. Focusing on cost effectiveness may also better align with a plan fiduciary's responsibility to ensure that plan assets are used to benefit the plan participants.

Health care disparities arise in part because of the underutilization of services among underserved and under-resourced populations. Closing those gaps can increase spending, but can also improve health and clinical outcomes. A challenge is how to measure health and outcomes. Data on health plan costs are readily available and easily assessed, which encourages the emphasis on costs. But while there are numerous metrics to assess health and clinical outcomes, no universally agreed upon or available metrics currently exist. Increased standardization of metrics, along with additional research on the multiyear impacts of benefits designed to address health-related social needs, is needed to facilitate a focus on cost effectiveness.

### Reducing low-value benefits can also improve equity

Underserved and under-resourced populations often use less *high-value* care and more *low-value* care compared to other populations.<sup>1</sup> The term “value” can mean different things to different people, and there is not necessarily agreement on what services are considered high-value or low-value. Nevertheless, there has been progress to identify and cover high-value care. For instance, the Affordable Care Act requires that health plans include coverage with no cost-sharing for certain preventive care services, including services with a U.S. Preventive Services Task Force “A” or “B” rating.<sup>2</sup> The District of Columbia’s Health Benefit Exchange chose to go beyond the federal requirements, mandating that plans also include coverage for certain diabetes-related services with no cost-sharing. Less information is available regarding the value of benefits that aim to address health-related social needs.

Efforts have also been made to identify low-value care. For instance, the *Choosing Wisely*<sup>®</sup> campaign worked with provider specialty societies to identify tests and treatments that provide little to no benefit or could even be harmful. Examples identified in the campaign include routine tests of vitamin D levels, routine imaging for uncomplicated lower back pain, and prescribing antibiotics in the absence of a bacterial infection. Eliminating coverage of low-value care, or reducing such coverage by increasing cost-sharing or prior authorization requirements, is likely to improve health outcomes and reduce health disparities. Reducing the utilization of low-value care also can produce cost savings, which could be used to offset increased use of high-value care.

However, eliminating coverage for benefits can be difficult, even if those benefits aren’t beneficial. Plan participants, relying on their health care provider recommendations, are likely to view such reductions negatively and providers may experience revenue losses. Effective communications with both plan participants and providers regarding overused, unnecessary, and low-value treatments are key, as is aligning provider compensation to the delivery of high-value care. As noted below, however, communicating directly to providers can be difficult.

<sup>1</sup> “For Selected Services, Blacks And Hispanics More Likely To Receive Low-Value Care Than Whites”; *Health Affairs*, Vol. 36, No. 6; June 2017.

<sup>2</sup> The ACA preventive services mandate is currently under litigation.

### **Addressing inconsistencies in coverage for different conditions could create synergies that improve cost effectiveness**

Health conditions are often interrelated and inconsistent treatment coverage may be counterproductive. For example, obesity increases the risk of diabetes, and diabetics are at higher risk of heart disease. Limiting coverage of obesity treatment options could be inconsistent with a more comprehensive coverage of treatments for diabetes and heart disease. Increasing consistency between the approaches to address obesity with that of conditions for which obesity is a contributing factor could improve health and health care outcomes.

### **Health care needs to be affordable—assessing affordability needs to consider factors beyond premiums and cost-sharing requirements**

Health insurance is not meaningful if plan participants can't afford to access the benefits. Increasingly, lower-wage workers have been unable to afford medical care, due to ever-increasing health care costs, high deductibles, limits on pre-deductible coverage of services, and other cost-sharing requirements. Employers and insurers have begun acknowledging some flaws of consumerism in health care—the idea that consumers can take a more active role in their own health care decision-making process. Plan designs were developed with cost-sharing features, including large deductibles, aimed to incent plan participants to choose more cost-effective care. Although these types of arrangements can lead to lower premiums and benefit those with the required health literacy, time, and financial and other resources to shop for and optimally use health care, they can be harmful to those who don't. This is true even for those individuals with health savings accounts (HSAs) or other health accounts that can be a source of funds to pay out-of-pocket costs. Some employers are rethinking their cost-sharing design, including moving from uncapped co-insurance to flat copays. Such approaches are seen as a way to spread the costs of those needing care across the entire group through higher premiums, rather than levying the costs disproportionately on those who need care.

In addition to the cost-sharing requirements, other factors can affect affordability and access. These include transportation costs associated with traveling to the provider, provider capacity to see the person in a timely manner, the need to take time off from work to seek care and other factors. Such barriers also influence how people are able to use their coverage. In some instances, including transportation or telehealth benefits in combination with the ability to use sick time for in-person or virtual doctor visits could prove helpful. However, while office workers may be able to take time out during the day for a virtual or in-person health care visits, others may not, including for instance front-line workers, retail workers, and construction workers. Furthermore, telehealth benefits could exacerbate disparities for those without broadband access or those who may be less technically savvy, especially if audio-only telehealth visits are not available.

### **A marketing and communications strategy is needed for both employees and providers**

It can be difficult for employees to understand what their health plan covers and how best to use the coverage available. Benefit administrators should develop and implement a marketing and communications strategy to make sure that employees and other plan participants are aware of and understand their benefits and benefit options. This is particularly important when new offerings are introduced or when participants need specific services. Without this baseline understanding, high-value benefits often go unused. Educational materials are needed to build employees' understanding regarding their benefits and how those benefits can help improve health and well-being. Employees may also need assistance navigating the healthcare system to access and use their benefits more effectively. Each of these steps may need to be tailored for particular populations and should involve two-way communications between employers and employees.

### **Defining success in terms of cost effectiveness and health equity can improve the use of health care dollars**

Different stakeholders have different ways of defining whether a benefit change has been successful. For instance, financial officers may view success in terms of costs, whereas human resource officers may view success in terms of employee satisfaction and utilization metrics. Success can be defined and measured in a myriad of ways. By analyzing plan performance in terms of cost effectiveness and health equity, the focus can be placed on whether health care dollars are being spent optimally.

Plan administrators can also aim to compress the timeframe for testing and implementing plan design changes. Depending on the benefit, it can take two or more years to design and implement a new benefit in large companies, and even longer to evaluate the impacts of the change. By that time, new innovations may make the change outdated. Implementing changes more quickly, such as using a pilot, followed by an expedited review, might provide more timely feedback. Any disappointing or unclear results could then be analyzed to identify causes or gaps, offer the opportunity to make appropriate refinements, or determine the need to abandon the change. On the other hand, successful results and outcomes could lead to an expanded rollout.

### **Summary and next steps**

Shifting the benefit design decision-making process from one focused primarily on costs to one that emphasizes cost effectiveness and equity may facilitate the better use of health care dollars. But that may be easier said than done. Costs are easy to measure, and research is available regarding the effects of cost-sharing on health care utilization and health spending. Measuring health outcomes and cost effectiveness on a uniform basis is more difficult and may require a longer time horizon to achieve the desired results. Additional research is needed to understand the impacts of benefit features, including benefits to address health-related social needs, on non-medical outcomes (e.g., worker productivity) and on long-term costs and health outcomes. Both quantitative and qualitative data should be better leveraged to identify benefit needs and develop targeted solutions. Employers may consider taking an active part in building the body of evidence by experimenting with different benefit features.

Effective communications are also needed to ensure that plan participants and providers are aware of, understand, and know how to access the benefits available. Requesting feedback from employees is one tool to assess whether a benefit change met the goals of the employer. Gathering input from employees is needed not only when evaluating plan performance, but also to provide more direct insight on benefit needs prior to deciding on any benefit changes. The next issue brief will explore in more detail how insurers and employers incorporate the voices of the employees they are trying to serve, especially those facing higher social risks.

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