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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The committee's exploration focuses on benefits in the employer-sponsored insurance market, both because it is the dominant source of coverage for Americans younger than age 65 and because employers, especially large employers, may have more flexibility than in other insurance markets regarding their health benefit offerings. Lessons from the employer market may be able to be applied to other markets and vice versa.

This first issue brief in the series provides an overview of issues related to designing health benefits to improve health equity that were discussed in the first workshop. In particular, it outlines some of the decision-making process with respect to adding benefits and the challenges of incorporating more equity-improving elements into health insurance plan designs. The summary below highlights the insights shared in the conversations. Many of these issues will be explored in greater depth in subsequent issue briefs in the series.

Different employers have different legal and strategic levers to affect health disparities through benefit design

Generally, employers have three ways to sponsor health insurance benefits for their employees, and the challenges and solutions to implementing equity-enhancing benefit design elements differ among these options. One option is to subsidize the purchase of coverage in the individual market through an individual coverage health reimbursement arrangement (ICHRA). State and federal laws and regulations govern the design of individual market plans. Employers have no control over benefit design decisions but can vary their contribution amounts by employee age, family size, and employee class (e.g., full time, part time, salary, hourly).

Another option for employers is to offer fully insured coverage, which can be more popular among small and mid-sized firms. Fully insured small group coverage (e.g., for those with up to 50 employees in most states) is highly regulated, and employers' decisions on benefit design may be limited to choosing which available plans to offer. There are less restrictive regulations on fully insured plans for larger employers, and employers may have more input into benefit design decisions. In the fully insured group market, plan design is driven primarily by insurance carriers, who are trying to be competitive in the market, and by larger fully insured groups, which are able to make group-specific modifications to carriers' off-the-shelf benefit design.

As group size increases, employers often move toward self-insurance—the third option. Jumbo employers (e.g., with 5,000+ employees) are more likely to self-insure, which gives them the most flexibility to design their health benefit package while also avoiding many of the regulations that govern fully insured coverage.

In all three options, employers can use contribution amounts (the part of premium funded by employer versus what the employee pays) as a lever in impacting health equity.

Health disparities can be experienced along many employee characteristics

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 employees have low or moderate incomes and limited educational attainment, which can result in increased challenges to achieving good health. In addition, disparities can also occur by age, gender, race/ethnicity, occupation, urban/rural status, and other characteristics, even among privately insured individuals with high incomes and high educational attainment. Employers have a closer relationship with their employees than insurers do with enrollees, as well as a vested interest in keeping them healthy and productive. Employers can leverage this relationship to gather more relevant and timely information about their employees' diverse needs.

There is pressure to identify cost savings in order to add new or innovative benefits

Insurer and employer decisions on whether to add or change benefits usually reflect input by a multi-disciplinary team, including medical and pharmacy directors, finance, sales and marketing, human resources, actuaries, operations, market research, health equity officers, and others. Employers with unionized workers also need to negotiate any benefit changes with the union(s) and may face pressure to add particular benefits while also keeping cost sharing requirements low. Different team members may have different priorities. And although many factors are considered—including whether the benefit would improve health outcomes—often the decision comes down to whether the benefit will add costs and whether there are savings that can offset those costs. For instance, insurer finance and sales departments have a goal of keeping premiums low, otherwise employers will go elsewhere for coverage. That said, sometimes benefits are added even if they increase costs.

Employers may recognize that savings can result from outside of the health program (e.g., reduced absenteeism, improved worker retention, lower disability costs, improved productivity), but even large, self-insured employers may focus on achieving savings within the health program itself. On the one hand, savings can be attained by reducing spending on low-value health care services. Doing so can improve outcomes by reducing spending on health care services that at best don't improve health outcomes and at worst cause harm. Savings may also be available through reducing "waste" in the system. Reducing such costs can be difficult, however, because those who rely on that revenue may not have readily available alternatives.

To more comprehensively address health disparities, the goal needs to switch from cost savings to value, quality, and cost-effectiveness

While there is a desire to spend health care dollars more effectively and efficiently, the path to achieving a cost-effective health system with high-quality and equitable outcomes is not an easy one. The term "value" itself can mean different things to different people and organizations. There is no lack of quality metrics, but it's unclear to what extent they improve health outcomes and reduce disparities. Although the Centers for Medicare & Medicaid Services (CMS) has pivoted to a focus on achieving quality care, this work has been primarily with the Medicare and Medicaid programs. It has not been standardized in the commercial market, and without standardization across health insurance and health care providers, it is difficult to operationalize. Some limited

work is being done to tie performance guarantees to closing gaps in the commercial market. With more than half of Americans obtaining health insurance coverage through the commercial market, mostly through employer coverage as a worker or dependent, a holistic health equity strategy must include the commercial market.

Adoption of equity-enhancing benefit designs has been incremental

Major changes are difficult to implement in the fragmented U.S. health system. But even without incorporating equity-improving benefit design elements in a comprehensive and coordinated way, progress is being made. Over time, these developments can combine to result in significant improvements. In the meantime, employers and insurers are making use of point solutions within the health benefit (and among employers, also outside of it) geared toward addressing gaps in their ability to meet particular needs (e.g., to improve behavioral health).

Many employers, especially those that are self-insured, are piloting programs to generate their own evidence and expanding those that are successful. Measuring the impact of these pilots is based in part on feedback from employees, which can become available more quickly than clinical evidence. Metrics can include outcomes beyond health care costs, such as reduced absenteeism. In addition, the feedback can include whether employees are aware of the benefit and whether they are using it. Such feedback may lead to additional outreach by employers.

Focus has been primarily on cost-sharing elements rather than coverage of nontraditional benefits

When considering adding or changing benefits to address health disparities, employers and insurers have primarily focused on cost-sharing elements—for instance, reducing cost-sharing for certain services or allowing select services to be covered before the deductible is met. This is a goal of value-based insurance design—reducing or eliminating cost-sharing for high-value services. Even focusing on cost-sharing elements faces some challenges, given health savings account (HSA) restrictions on what services can be covered by the plan prior to a plan participant reaching the deductible.

There may be some hesitance among employers to incorporate nontraditional benefits, especially if those benefits could be perceived to be geared toward lower-paid workers. For example, a transportation benefit could be added to help members get to doctor appointments. There could be concerns of creating a stigma related to such benefits and about being too paternalistic. In addition, there may be push back from those who may not be eligible for the benefits. Employers may be more comfortable when looking to expand or change benefits more broadly.

Data is crucial to reducing health disparities

Data is needed for numerous aspects of benefit design and for incorporating more equity-enhancing design elements. First, data is needed to help identify health disparities. To be most helpful, the data needs to include information on race/ethnicity, income, and other social risks. However, there may be legal and other barriers to employers obtaining and using data.

Data on employees can help employers better identify needs, and that data can be quantitative as well as qualitative. For instance, demographic data combined with area level social risk measures can provide insights on employee needs. Qualitative data obtained from surveys, focus groups, and other direct interaction with employees—as well as information from unions—can provide valuable additional information. Both quantitative and qualitative data, including employee feedback, are also needed to evaluate new benefits and pilot programs.

Even when data is available, different people can interpret the data differently, depending on their perspectives. These differences can make it difficult to reach agreement that a program is successful. As a result, performance metrics should be clearly defined at the outset.

There are also practical issues regarding data. In particular, data on race/ethnicity and social risks is both highly sensitive and requires employees to trust it will be used properly. Regulations on how to handle and share this information is ambiguous at this time.

Data questions include:

- Who owns the data?
- How are the data used and shared—just for benefit design development, or for other purposes such as for improving access to care?
- Can data be shared with providers so they have a clearer picture of who their patients are?
- Are the data-related incentives aligned between health plans and employers so that each can understand where the disparities are and can share data between them?
- Does the data accurately and sufficiently represent the entire population?

Designing benefits to address disparities is not enough; employees need to be aware of and understand benefits, and navigate the system

Incorporating benefits that aim to improve health equity and reduce health disparities is for naught if those benefits aren't used. A communications strategy is needed to make sure that workers and other plan participants know about the benefit. Additional educational materials are needed so that workers understand what the benefit is and how it can be helpful to them. Employees may also need assistance navigating the health system to be able to then use the benefit. Each of these steps may need to be tailored for a particular population.

Employers and carriers may also need to address factors beyond the benefit design itself to consider how the plan may be affecting access to care. For instance, what the benefit eligibility requirements are and whether those are exacerbating disparities among particular populations (e.g., hourly vs. salaried, part-time vs. full-time workers). In addition, whether the benefits are affordable to the workers, considering both the employee premium contributions and out-of-pocket requirements. Employers may wish to revise the way they determine contribution requirements (subject to laws and regulations).

Summary and next steps

The challenges to incorporating more equity-enhancing benefit design features and options for addressing them can vary among employers. Although employers have moved to use benefit design to close gaps in health care disparities, progress has been slow, incremental, and focused primarily on cost-sharing features rather than benefits that aim to address social needs.

For actuaries, there is a need to think beyond the numbers and gain a better understanding of the complex health ecosystem and all the different levers that can be manipulated to alter the system. Insurers and employers may need to realize that making changes to improve the lives of workers won't necessarily lead to gains in their bottom lines. And bringing in employees to the process requires intentional outreach.

The subsequent issue briefs in this series will explore these topics more deeply, with the aim of offering strategies to address these challenges.

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