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

How to Better Understand the Needs of the People We're Trying to Serve

Many factors contribute to health disparities, which are differences in health or its key determinants that adversely affect historically 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 out of pocket for using these services (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 explore options for facilitating increased adoption of these features, the Health Equity Committee held focused workshops and other conversations with a variety of thought leaders and decisionmakers. Although the investigation focused primarily on benefits in the employer-sponsored insurance market, the resulting lessons learned may be applicable in other markets, and vice versa.

The first issue brief in the series provided an overview of issues related to designing health benefits to improve health equity. 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. The second issue brief examined in more detail how potential benefit changes are evaluated and how those evaluations could facilitate the incorporation of equity-enhancing benefit design features, including a shift in focus from costs to cost-effectiveness.

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.

In the context of benefit design changes, **cost savings** are the reduction in health spending (or total spending) that result from a new or changed benefit design feature. Such savings ignore any non-financial changes in health outcomes.

Cost effectiveness reflects an improvement in health care outcomes per health dollar spent, resulting from a new or changed benefit design feature.

*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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This third issue brief explores how to better understand unmet needs and incorporate input from employees and plan members into the benefit design decision-making process. Actuaries typically focus on quantitative data, including that from claims data and enrollment data, to identify unmet needs and develop solutions to address them. However, addressing health disparities requires moving beyond the typical quantitative data sources. Gathering information directly from employees and other plan participants (e.g., through focus group sessions and surveys), along with tools such as individual assessments, can provide additional insights into unmet needs, especially when followed up with questions about what needs respondents want prioritized. By supplementing quantitative data, qualitative input helps invoke data empathy among actuaries, data scientists, and others analyzing the data—the recognition that data represents real people, not lines of numbers, and facilitating the development of approaches that are tailored to meet the needs of particular groups. Collecting information from plan participants requires having their trust. Sharing what the data will be used for, as well as what it won't be used for, along with communicating in ways that are inclusive, accessible, and understandable, can lead to the collection of information that helps address unmet needs and improve health outcomes.

The discussion below reflects the insights shared in the conversations in the third workshop and in other conversations on this topic with additional experts and decision-makers. It also discusses several areas for further exploration.

Information from claims data and enrollment data is useful, but doesn't necessarily tell the whole story

Employers with health equity initiatives typically use the information available to them and which they, working in conjunction with benefit partners and other third-party experts, have the capability to analyze. Some employers may only have surveys of employees to indicate health-related social needs. Other employers may be able to obtain and analyze claims data from their insurance administrators and vendors, with the opportunity to place precedence on those analyses over information collected from surveys.

Although claims data can be used to compare how health care utilization patterns differ among different subgroups, exposing potential health care disparities and unmet needs, it may not include patient demographic information beyond age, geographic location and gender. Claims data may also be useful in identifying access to care based on ZIP codes, which can provide further insight into related social determinants of health (SDOH). However, without more complete data sources, employers and insurers may be limited in their ability to explore utilization across multiple characteristics and identify disparities by household income, race, ethnicity, language, sexual orientation and gender identity (SOGI), disability status, or other social risk categories. Gathering and analyzing information across the multiple employee characteristics can also be challenging depending upon the employer's characteristics—whether they a large or small employer, a national or local company, federal contractor or public corporation. Although claims data can include new ICD-10 diagnosis Z codes to indicate SDOH information, these codes are not consistently used and may not be a good reflection of unmet needs, even if used. Moreover, not everyone covered has a claim, regardless of their health care needs, so claims data will not be a complete reflection of health care needs.

Demographic information from enrollment data, especially when combined with area-level social risk indices, can give insights on the risks and needs of the plan member population. For instance, it can highlight the share of workers living in areas with a lack of health care providers, in food deserts, or in areas of high poverty and low educational attainment. Such information can indicate social risks that may need to be addressed. There has been an emergence of community-based organizations (CBOs) that members can be referred to once social needs are confirmed. However, it can be difficult to implement interventions for a variety of reasons, including a lack of knowledge by a patient's care team about CBOs and a CBO's lack of capacity to render services. These challenges can be exacerbated by a lack of follow-up communication between the provider and the CBO.

Vendors specializing in health care can offer point solutions to address needs when the insurance carrier doesn't have the required expertise. For instance, point solutions can address specific conditions or social needs (e.g., diabetes care management, nutritional support), and employers may have different goals and priorities, including cost reductions or simplifying benefit administration for plan participants. Employers may choose to directly contract with only a limited number of point solutions vendors due to the administrative burden. Point solutions focused on niche activities likely can't be used to address a broad range of needs, and the use of multiple point solutions to address different components of the same problem could be an inefficient approach. In some instances, there might not be solutions currently available.

Getting information directly from plan members and medical providers can be more useful and actionable

Information from plan members can add more context to claims data and indicate what needs and solutions should be prioritized. Such information can be collected through proactive focus group sessions with employee resource groups or affinity groups, town halls, text message campaigns, and surveys. Patterns of complaints from historically marginalized populations can also highlight areas for improvement. Formal health screenings and assessments can indicate the needs of particular individuals, especially when follow-ups to those assessments gather information on what assistance, if any, is desired. Due to limited resources, the number of plan members who can get personalized assessments is limited. Plans can leverage technology, including member self-service portals, to conduct screenings on a wider basis.

Providers have clinical data, which can be used to more directly meet the needs of patients. Provider organizations may also have relationships with patient groups, which may lead to information on patient needs. These organizations may partner with CBOs to better meet the identified needs. Although legal restrictions may preclude the sharing of an individual's clinical data with employers, there may be ways to share aggregated information.

Information can be available from other sources as well, including public health data, the behavioral risk factor surveillance system, social vulnerability indices, and organizations that set requirements for coverage inclusivity (e.g., Human Rights Campaign). Working with different stakeholders can offer providers, employers, insurers, vendors, and community-based organizations a broader perspective on unmet needs and how best to address them. As noted previously, however, to be useful the information needs to be actionable. Ideally, direct input from plan members will help prioritize initiatives that address what the members want.

The larger the employer, coupled with the more time and financial resources it is willing to dedicate to these efforts, the more the root causes can be established and addressed, should it be desired. Even small employers, however, can do work to identify areas of concern and find solutions.

Building trust is essential to outreach efforts

Lack of trust is a significant barrier to collecting information from plan members, and building trust is hard to shortcut. Workers can be concerned about divulging personal information (e.g., demographics such as race, ethnicity, and sexual orientation) in fear that employers or insurers could use it against them. Many communities have a history of uneasy relationships with those in positions of authority. Historically, and even currently, many have experienced poor treatment by health care providers and health care systems. Therefore, building trust is difficult.

To help establish a threshold of trust, plan participants must be told by those collecting their information what the data will be used for and, likely even more importantly, how it *won't* be used. This may help assuage participant fears that the information collected will be used against them; instead, the data is being collected in order to reach the goal of overall health improvement and health equity for them and their community. In addition, partnering with respected community groups and trusted advisers, insurers, employers, and medical professionals may build bridges with disadvantaged populations and can be the gateway to open dialogues with employee resource groups and affinity groups. Leaders of historically marginalized and underrepresented communities have suggested that compensating participants for their time participating on advisory councils can help diversify participation, adding the perspective of those who may be most impacted by health disparities. In addition, building long-term relationships may help build trust and generate more candid feedback.

It's also important that communication with employees and others is inclusive, accessible, and understandable. This may be achieved by adopting inclusive language guidelines and establishing a reading grade level for all communication initiatives. It is also important to have inclusive images (e.g., same-sex couples, wheelchair users, etc.) in the communication materials, and ensure that any forms of communication are accessible, such as addressing needs for those with hearing loss, vision loss, color blindness, or limited English proficiency. Questions should be asked in culturally sensitive ways, and when asking for demographic data, the language used should align with nationally recognized standards of categorization, including an opt-out category. Workers who feel seen and included generally feel empowered, making them more likely to provide candid input.

There are barriers beyond trust as well. As people grow more reluctant to answer phone calls from unknown entities, other means of communication are becoming more important, including emails and text messages. Moreover, texting can be the preferred mode of communication among some cultures. However, regulatory consent requirements for emails and texts are greater than those for phone calls. Efforts are being made to allow the increased use of different communication modalities. However, any outreach should be deliberate and measured, as too much communication can become overly burdensome and result in poor response rates and engagement.

Under the *Employee Retirement Income Security Act of 1974* (ERISA), a health plan's fiduciary responsibility is to ensure that plan assets are used to benefit the plan participants. This seemingly implies that should employers covered under ERISA identify health disparities in their plan participant population, they might be obligated to address them. Those employers advancing health equity initiatives could benefit from integrated partnerships between third-party administrators and other benefit vendors who can help identify health disparities and implement initiatives. This includes partners who are actively involved in evaluating the progress and status of these health equity initiatives.

A sample of a population doesn't explain the whole story

An aspect of building trust is the need to ensure that individual participants aren't treated as representative of their entire group. Each individual is unique, and those individuals within a population may share certain identifying characteristics but face different risks and have different needs. People are more than just one identity; an employee may be Black, gay, and a wheelchair user, resulting in an array of health challenges. This multi-aspect perspective makes it important to examine data across different combinations of identities. It is critical that intersectionality and inclusivity be considered, especially when conducting data analytics and implementing health equity initiatives.

The use of employee resource groups can be useful in getting qualitative information from a diverse group of people. This may also occur in town hall and webinar events, as long as every employee feels comfortable speaking up. Employers and their benefit vendors may also conduct research on the clinical evidence for health care services. Information from claims, electronic health records, and surveys may be used to better understand the challenges and opportunities in achieving health equity for all covered employees.

Bottom-up rather than top-down approaches better incorporate the priorities of those being served

Part of the process of building trust with historically marginalized populations and working to improve their health outcomes is asking them where they want assistance. Employers, insurers, and providers need to work directly with the individuals and groups that are impacted by demographic or social risks. This includes establishing whether members of these groups think particular issues are actually a problem and, if so, whether they want something done. Trusted peers could be enlisted to help gather this information. The next step is to work with the individuals and groups to address the problem and measure the impact of the intervention. The key to this process is assessing the information objectively, without making assumptions.

A benefit of bottom-up approaches is that they can be better tailored to meet the needs of particular groups, as opposed to generic one-size-fits-all approaches. For instance, benefit solutions that focus on weight management and diabetes through nutritional interventions need to recognize cultural food traditions, as well as the challenges faced by individuals who live in food deserts where accessing healthy and nutritious food is very challenging. Wellness programs need to consider how to incorporate CBOs connected to historically disadvantaged populations, not just those frequented by more advantaged populations.

In many, if not most, cases, data is used to inform top-down solutions. Employers determine what services are available to address specific needs, make sure the contracted organization has capacity to meet the needs, and engage a vendor to help patients navigate the system. That said, employers and insurers are using some bottom-up processes to address needs. For instance, discussions that bubble up from a complaint process or town halls can help flag particular problems. Employers can then connect with resource groups to discuss solutions. Larger employers sometimes have worksite clinics, which they use to help address needs. Requiring that the providers working in those worksite clinics have ongoing training on cultural competency, empathy, and responsiveness can help ensure that all employees will be treated respectfully. Those clinics can collect information on other needs, and that information can go back to the employer, which can then work with others to address those needs. When an individual health assessment reveals a specific need, rather than simply moving ahead to meet the need, there can be follow-up conversations with the individual to determine what is driving the need and what assistance the individual wants or needs.

There are also growing efforts to organize CBOs to work with health care organizations through networks to create a community care hub. Beyond providing additional resources to address unmet needs, such efforts can facilitate interactive feedback and discussions between the various stakeholders and the individuals being served.

Feedback on benefit changes is needed to assess outcomes and make any necessary changes

To assess the results of any subsequent benefit changes that stem from the initial surveying of employees, a follow-up survey of the same initial population is usually conducted. The results of the survey are then compared to findings in the benchmark year. Information on engagement rates, patient-reported metrics, and clinical outcomes can be compared with predetermined goals, with an analysis capturing the degree of success any changes have made for the groups that the changes are intended to benefit and overall health of the organization. When evaluating outcomes, it is important to look beyond the simple averages, which can mask variation. The range of responses, including how outcomes and feedback differ among and between different populations and different geographies, can better inform the success of the program and the likely long-term impact the changes will have on inequity and disparities. Successful outcomes can be built upon, and disappointing results can be identified and addressed. Employers may also use the analysis to determine whether the program should be eliminated or continued.

Beyond surveys, employee resource groups can also provide feedback. As noted in prior issue briefs in this series, employers have to balance health outcomes and patient satisfaction with costs. Costs are part of the evaluation process, but they should not be the sole consideration. If the benefit changes increase costs, savings could be found elsewhere. Ideally, medical benefits would be approached in a total rewards context, not as a cost center but as a source of employee retention, satisfaction, and well-being.

Summary and next steps

Addressing unmet health care needs and improving health equity means looking beyond using claims data to identify health disparities. While actuaries, data scientists, and others may traditionally focus solely on quantitative data, it is evident that addressing health disparities requires going beyond traditional data sources. Qualitative input helps invoke data empathy and can lead to more tailored responses for employees and plan participants. Claims data may be incomplete and lacking in reliable information about patient characteristics. Information gathered directly from employees through focus group sessions with employee resource groups, town halls, text message campaigns, surveys, and individual assessments can be more actionable and provide context to claims data. To be willing to share information on personal characteristics and health care needs, however, individuals need to trust that such information won't be used inappropriately. Building trust by sharing with participants what the data will be used for, and what it *won't* be used for, along with communicating in ways that are inclusive, accessible, and understandable, can lead to the collection of information that helps address unmet needs and improve health outcomes.

Collecting information on unmet needs is most effective when it includes follow-up inquiries to participants on what needs they want prioritized. Such input can facilitate bottom-up approaches that can be better tailored to meet the needs of particular groups, as opposed to top-down approaches. Feedback on any benefit changes can also be used to make adjustments as needed.

Beyond trust issues, barriers to data collection can impede the identification of unmet needs and the implementation of initiatives to meet those needs. The final issue brief in this series will explore data constraints as well as other challenges to implementation, such as IT systems limitations, legal and regulatory requirements, and the challenges in engaging plan members in the rollout of new benefits.

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