

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

Overcoming Constraints to Implementation

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 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. The incorporation of more equity-enhancing design elements has the potential to improve health outcomes and use health care dollars more effectively and efficiently. 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 Health Equity Committee held focused workshops and other conversations with a variety of thought leaders and decision-makers. 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. This issue brief in particular broadened the lens somewhat to incorporate relevant information from the individual and small group markets, which have different decision-making processes for changing plan benefits than the large group market.

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.

Point solutions address health care needs when the employer or insurance carrier doesn't have the required expertise. Point solutions can address specific conditions or social needs and can be used to improve care, reduce health care costs, or both.

*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 [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.



AMERICAN ACADEMY
of ACTUARIES

AMERICAN ACADEMY OF ACTUARIES
1850 M STREET NW, SUITE 300
WASHINGTON, D.C. 20036
202-223-8196

ACTUARY.ORG

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. The [third issue brief](#) explored how to better understand unmet needs and incorporate input from employees and plan members into the benefit design decision making process.

This issue brief discusses some of the challenges of implementing equity-enhancing benefit plans and possible solutions that were shared in the fourth and final workshop as well as during other conversations with additional experts and decision-makers. Actuaries may be involved in numerous aspects of the implementation process, such as collecting and analyzing data, provider contracting, pricing the benefits, and ensuring that laws and regulations are adhered to. These and other aspects of implementation need to be considered when incorporating benefit design features aiming to reduce health disparities.

Employers often work with limited budgets and other financial pressures, which may complicate implementing equity-enhanced benefits. The lack of complete and comprehensive data can also impede health equity efforts. However, these challenges need not stall efforts to reduce health disparities. Data sources, while not perfect, are available and may help to reveal unmet health needs. Once identified, those needs can be addressed through benefit changes or other interventions. At the same time, there are opportunities to improve data collection efforts by employers, insurers, data scientists, and others. Other factors that can contribute to successful health equity plan design initiatives include having a health equity champion(s) in an organization's leadership, tailoring communications to the populations being served, including culturally competent health care providers who are aware of their patients' unique circumstances in provider networks, and cooperation from state and federal authorities to eliminate regulatory barriers that may be inadvertently inhibiting health equity initiatives.

In the absence of “perfect” data, employers and insurers can start with the information they have and build from there

As noted in prior issue briefs, data is the cornerstone to understanding the needs of plan participants and developing benefit plans to meet those needs. Otherwise, it's difficult to direct resources optimally. There are many challenges to collecting and using data. Claims and enrollment data may be limited and lack information about the need for care. In addition, privacy laws and regulations limit the sharing of health care information. Survey data can be informative, but often are limited in terms of what individuals are willing to share and how employers can use the information. Even when data is available, a lack of uniformity and consistency can make the data hard to analyze and inform decision-making. However, employers and insurers don't need to wait for the perfect data to begin addressing disparities through equity-based benefit plans. Working with the current information available, action can be taken while data collection efforts continue to improve and expand, offering additional insights and the ability to respond accordingly. Simultaneously, more immediate solutions can be implemented, such as pilot initiatives that focus on unmet needs that are already identified or diagnoses that disproportionately affect employees or plan participants.

There are numerous options to improve data collection and use, including:

- *Standardizing data collection questions and categories.* The lack of uniform collection standards of race and ethnicity in the commercial market hinders efforts to collect and use data effectively. Health plans, employers, and providers differ in terms of the ability to and methods for collecting race and ethnicity data. The Office of Management and Budget (OMB) sets standards for collecting and reporting race and ethnicity data across federal agencies. Revisions to the OMB standards are currently under review. Federal, or other widely accepted, standards could be used by commercial organizations when collecting race and ethnicity data. Any standards need enough granularity to be meaningful and allow for individuals to indicate multiple categories.
- *Sharing information on best practices.* Particular states or organizations may have had greater success when implementing data collection questions or methods. Sharing this information to develop best practices can help other organizations and states in their own data collection efforts. Sharing lessons learned when methods lead to disappointing results can be equally illuminating.
- *Surveying employees on satisfaction and health care outcomes, including barriers to care.* Reaching out directly to employees for benefit plan and health outcomes feedback can provide employers important and actionable information. For instance, questions on whether employees delayed care due to worries around costs, or whether finding a mental health or physical health care provider was challenging, or whether they have a usual source of care can indicate unmet needs. Survey results can then be compared to national survey responses to identical questions, helping an employer better gauge the relative needs of their employees and plan participants. When interpreting the results, it is important for employers to be aware that respondents may be hesitant to provide honest feedback if they do not trust their employer or understand how the survey responses will be used.
- *Combining available information with area-level social risk indices.* Overlaying information on where employees live with an area-level social risk index—which reflects the relative socioeconomic characteristics for a geographic area—can highlight needs for additional services around social determinants of health. For instance, such analyses can reveal that some employees live in food deserts and therefore might need nutritional assistance. It can also highlight areas with limited public transportation, which translates into a need for transportation services for doctor appointments. Such data can also reveal which areas have few to no primary care providers or pharmacies to access, which can create access to care issues that are not easily solved by an employer, insurer, or employee. As with imputed data, it's important to avoid ascribing information from area deprivation indices to any particular person. Rather, these indices can be used to better understand the characteristics of a population within a specific geographic area.

- *Building trust with workers and plan members.* As highlighted in the third issue brief in this series, building trust is essential for outreach and data collection efforts. Sharing with participants what the data will be used for, working through trusted advisers and respected community groups, partnering with employee resource groups and affinity groups, and communicating in ways that are inclusive, accessible, and understandable, can all help improve trust and increase participation.
- *Creating data hubs using third parties.* Rather than building unique data hubs with race/ethnicity, other personal characteristics, and social risk information, insurers, providers, and employers could work with a trusted external entity—such as a state department of health, health insurance association, or business services company—to create a single data hub. Information could then be collected and shared among the different data hub members, which when combined with claims information could be used to analyze and develop equity-enhancing benefits.
- *Standardizing quality measures.* Another data-related challenge is the lack of uniformity in the quality measures that employers use in the commercial space. Different employers may have different priorities, depending on the composition of their plan participants. However, creating uniform measures could help facilitate an evaluation of health outcomes and the effects of equity-based interventions. Uniformity is especially important when being used to hold providers accountable for health care outcomes.
- *Coordinating different data systems.* In the current environment, employers and insurers incorporate data across their own IT systems, as well as from distinct systems and platforms of various partners, vendors, and providers. Different systems within and across organizations increases the level of complexity when sharing, ingesting, and analyzing data, even more so when addressing privacy concerns. Making whole-system changes, which requires significant momentum and leadership support, can help eliminate inconsistencies across systems and facilitate better collection and analysis of data. Nevertheless, the ability to manage data effectively can be especially difficult for those employers with limited budgets.
- *Abiding by gag clause prohibitions.* The *No Surprises Act*, enacted as part of the *Consolidated Appropriations Act, 2021*, prohibits gag clauses on price and quality information in group health plan contracts with providers and third-party administrators. The elimination of gag clauses is intended to increase the availability of cost and quality information to health plans as well as consumers. Employers and data scientists may also be able to use this information to help shed light on patterns of utilization, costs, and unmet needs.

Organizations need a health equity champion(s) to overcome reluctance acknowledging health disparities and to help lead efforts to address them

Data are needed not only to explore where health care disparities and unmet needs exist in the workforce, but also to provide evidence that disparities exist at all. Some employers may not realize that health disparities can affect employees or may assume that any such disparities reflect income differences rather than other factors, such as race and ethnicity. Acknowledging areas where an employer may be falling short can be difficult. Building an evidence base of workforce disparities can help initiate conversations among leadership and catalyze the development of initiatives to reduce known disparities. Having a champion of health equity efforts, with the authority and budget to implement necessary changes, can be the difference between making such initiatives a priority and letting obstacles get in the way.

Culturally competent providers are central to improving health equity

Reducing health disparities requires the availability of providers who speak the language of patients, are located in convenient locations, have accessible hours, and are accepting new patients. It's understood that most patients are more likely to trust providers who look like them. This means not only on a gender or race/ethnicity basis, but also if there is a shared language. Moving toward a provider profile that is aligned with the patient profile within a specific geographic area could help improve equity. However, much like individual data, provider data at this level is often limited and suffers from the same challenges as collecting individual-level data. To more completely assess the needs of employees and plan participants, employers and insurers need more complete data on provider characteristics and availability. For employees and plan participants, having such information within a provider directory or other easily accessible tool could be helpful. While some data collection efforts have focused on race and ethnicity, broader characteristics have been challenging to collect. Provider credentialing information may be a source of some information, but providers may be reluctant to share additional personal information, perhaps echoing the concerns around trust and use of data among plan participants.

Provider shortages must be addressed to improve access

Offering additional benefits to address unmet needs and improve health outcomes may be a positive step toward equity, but it would prove ineffective without a provider workforce to handle the demand. As the nation continues to experience a shortage of health care providers, particularly within primary care, behavioral health, obstetrics/gynecology, pediatrics, and certain other specialties, these shortages are often felt more acutely in urban areas with higher levels of social needs and in rural areas. In areas with provider deserts, where there are few providers, it is difficult to address health care disparities. In urban areas, building and zoning rules may challenge the ability to open new office space.

Several solutions to address the workforce gaps have recently emerged. Some health plans are partnering with startups that focus on treating specific geographies or demographic groups or those with particular conditions. Telemedicine has been found to be helpful in closing provider gaps, although it is not a solution for all populations or conditions.

Longer-term solutions include increasing the pipeline of physicians, especially from traditionally underserved populations. While this is an obvious solution to the provider shortage, it does require significant time and investment from many stakeholders, including the educational system and hospital and health systems. Adjusting laws and regulations that would empower providers to practice at the top of their license has also been suggested as a longer-term solution, particularly in those geographic areas where it can be challenging to find a provider. Given the multiple federal, state, and local regulations that influence the delivery of health care, a careful review and revision of existing and proposed laws and rules could ensure there are no unintended restrictions to access of care or access of providers.

Tailoring communications to the population being served can improve the effectiveness of outreach

Employees and plan participants need to be aware of, understand, and know how to use their health benefits. Outreach to ensure this basic understanding starts with verifying that employers and health benefit providers have the correct contact information for those they serve. Once correct contact information is in hand, further action includes active outreach and tailoring messages for different populations. Communications provided in multiple languages, reflecting the nuances of language among different cultures, could be effective in communicating benefit information to different ethnic groups. Terms such as “financial assistance” may have negative connotations, whereas “lower premiums” may resonate better with individuals eligible for premium tax credits. Additional engagement with plan members, through community events and town halls, can improve awareness and increase take-up of equity-based benefits. Efforts are also being made to address regulatory restrictions on the use of email and text communications, recognizing that these communication tools may help increase engagement while avoiding overburdening plan participants.

Improving one-way communication is not the only solution. Offering benefits-related information in a consumer-friendly format that is accessible at any hour of the day, such as through accessible websites, allows employees and plan participants to gather information they need at the time they need it. Reminding employees and plan participants of the availability of consumer relations representatives or professional navigators or care coordinators can offer one-on-one opportunities to help explain benefit information, facilitate access to care, and offer support when navigating the health system. Using trusted advisers to disseminate benefit information can also amplify and improve engagement efforts.

Provider engagement can help optimize communications outreach and benefit access

Health care providers directly meet and engage with employees and plan participants. Ideally, providers would be aware of a patient's benefits and help them access those benefits. While the information is shared by health plans, with most providers accepting multiple insurance plans and working with multiple insurers, such specificity with an individual patient is challenging. Nevertheless, it has been suggested that providers are an untapped resource to help patients optimize the use of their benefits, especially those geared to addressing unmet needs. It may be worth exploring how best to incorporate health plan information into the electronic medical record system that the provider accesses. One of the challenges is sharing the most vital information with providers, such as cost share for different treatment options or availability of nontraditional assistance, without overwhelming providers with information.

Some health plans have aimed to increase provider engagement by partnering with providers more directly, for instance through a capitated or salaried arrangement for onsite clinics or through a point solution offered by a vendor to meet a specific need. Onsite providers become more familiar with the employees and the employer's full suite of services, including the employee assistance program, and may be able to enhance the programs' effectiveness. Such arrangements, while not addressing the problem completely, can help improve provider engagement.

External expertise may be needed to help identify clinically appropriate care

When developing equity-enhancing benefits, it is important to consider evidence and guidance on what is deemed clinically appropriate care. Such expertise may not be available within an employer organization. When it is not, employers and their benefit consultants may need to rely on outside experts, including generally accepted clinical care practices as determined by national medical organizations, federal guidelines on standards of practice, or health plan chief medical and pharmacy officers. Understanding current standards of care can be used to guide benefit design and facilitate access to treatments for conditions disproportionately affecting underserved communities.

Affordable Care Act requirements can affect equity-enhancing plan flexibility

The learnings from the large group health benefit market may be applied to other markets, such as the individual and small group markets. The *Affordable Care Act* (ACA) and its affiliated regulations include requirements that may inadvertently make it difficult to incorporate equity-enhancing benefits, especially in the individual and small group markets. The actuarial value provisions include a de minimis range of acceptable values, which means reducing cost-sharing for high-value benefits can cause the actuarial value to exceed the allowed range. As a result, incorporating such cost-sharing reductions, or other benefits intended to address unmet needs, may need to be balanced by reductions in benefit generosity elsewhere, which could also reduce equity (e.g., increased deductible or out-of-pocket maximum). The limits on how rich a benefit plan can be in the ACA market should be considered when analyzing the impact of an equity-enhancing benefit change.

Another related challenge is the limitation of how much of the premium can be devoted to non-essential health benefits, which could restrict the addition of nontraditional benefits intended to address health-related social needs. The template used to indicate benefit design features doesn't necessarily allow for the nuances and granularity of coverage provisions. Similarly, standardized plan materials, including member benefit cards, may not capture equity-based plan nuances. Such requirements wouldn't affect large employers, but can make it difficult for plans in the individual and small group markets to make significant equity-enhancing plan design changes.

Additional clarity may be needed on whether nontraditional benefits to address health-related social needs would qualify as excepted benefits under the ACA. If they are not, services such as non-emergency transportation or meal support after surgery might be subject to the deductible, which could put such benefits out of reach for many plan participants. If they are excepted benefits, employers could offer them to all employees at no cost. Some carriers are already using this approach with "value-added services and benefits." However, because they are not true "benefits" under the plan, they are not allowed to be included in the plan document and summary of benefits and coverage. A clearer regulatory framework could resolve this question.

Summary

Actuaries may be involved in numerous aspects of the implementation process, such as collecting and analyzing data, provider contracting, pricing the benefits, and ensuring that laws and regulations are adhered to. Although there are numerous challenges to implementing equity-enhancing health benefits, these challenges do not need to stall efforts to reduce health disparities. Data sources, while not perfect, are available to reveal unmet health needs that can be addressed through benefit changes or other interventions. Employers can work to improve data collection by standardizing data collection questions and categories, creating data hubs, and combining available information with area deprivation indices. Surveying employees may provide additional insights on what groups are experiencing health disparities, what their unmet needs are, and where to prioritize efforts to narrow gaps. Data collection efforts should not be limited to individuals, but also include health care providers to facilitate access to culturally competent providers.

Data on its own cannot reduce health disparities. Ideally, employers would have a champion(s) advocating for health equity and ensuring that it remains a priority. In addition, involving appropriate experts in the discussions related to proposed equity-enhancing benefits would help to ensure those proposals are clinically appropriate.

Implementing benefit changes isn't enough; employees and dependents need to know what benefits exist. Communications tailored to the populations being served, as well as engaging the provider community, would amplify outreach efforts and help plan participants be aware of and use the benefits available to them. This level of personalized engagement could improve the likelihood of reducing disparities. Consumers need to have access to culturally competent providers, which can be difficult where shortages exist.

Some barriers are outside the direct control of employers and insurers. These include laws and regulations that set benefit standards, which may inadvertently restrict the ability to adopt particular plan features, whether they are intended to reduce cost-sharing for high-value services or add benefits to address health-related social needs. Reviewing such provisions and making changes when appropriate could help enable efforts to reduce disparities.

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