

# Advancing health equity in commercial benefit plans by addressing social determinants of health

*Terminology and strategies for commercial plan sponsors*

Andrew Hiles, F.S.A., M.A.A.A, Aetna VP for Plan Sponsor Insights & Commercial Health Equity Solutions

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Commercial health plans provide insurance coverage for nearly 50% of Americans. That means they represent the largest source of health care in the country.<sup>1</sup> And for years, benefit plan managers and their consultants have done great work. They've supported their organizations' talent and financial goals while helping workers and their families get the care they need to lead healthy and productive lives.

The current drive for health equity has been building for years. But it's only in the past couple of years that the lens of health equity is being strongly applied to commercial health plan results. In fact, the COVID-19 pandemic and associated actions for social change have shined a bright light on all parts of the health care system. It's time for commercial plan sponsors to take ownership of the health equity outcomes of their program. And for them to add this focus to the traditional measures of plan efficiency and effectiveness.

This paper introduces benefit managers to the terminology of diversity, equity and inclusion (DE&I). It gives you a brief overview of how Aetna® applies these important concepts to help improve outcomes in commercial health plans.

## **How we got here**

Workers who make lower wages have been dealing with slow wage growth in the face of rapidly rising point-of-care health costs.<sup>2</sup> We know the argument for high deductibles is that they're necessary to prevent moral hazard — the theory that people who are protected from risk will act differently than people who aren't. And when paired with cost/quality tools, they allow and encourage workers to act as informed *consumers* of health care services.

The Commonwealth Fund study<sup>3</sup> shows that over one-quarter of the approximately 160 million Americans insured by a commercial employer-sponsored health plan are “underinsured.” This is their term for someone who technically has health insurance coverage but can't afford to use it. The result is that their health outcomes mirror those of the completely uninsured.

## **Understanding the terminology<sup>4</sup>**

Applying health equity thinking to an employer-sponsored health plan begins with learning the terminology. Most benefit managers are new to the concepts that are foundational to

long-time experts working in the diversity, equity and inclusion (DE&I) space. Our goal in this paper is to give you solid working definitions that will help you understand what's possible right away or what's more long-term thinking. And how to start taking action as health equity leaders in your organization.

Starting at the highest level, DE&I covers a wide range of organizational efforts. These efforts are to create a more welcoming environment for people of historically underrepresented identities. For example, DE&I focuses on activities like ensuring company leadership is not comprised entirely of white men. Or helping to create learning and promotional opportunities for young professionals of color.

Breaking DE&I into its three parts can be helpful for those new to the topic:

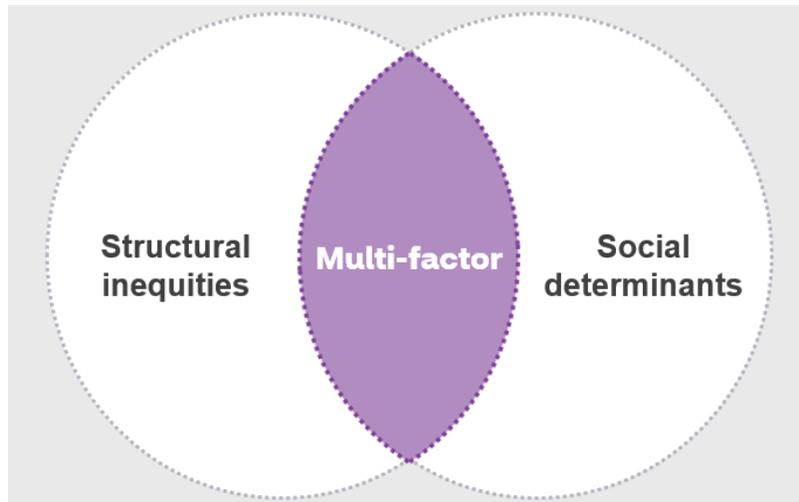
- **Diversity:** Includes all the ways in which people differ, involving the different characteristics that make one individual or group different from another, like identity markers such as race, ethnicity, gender, disability, sexual orientation, religion, etc.
- **Equity:** The fair treatment, access, opportunity and advancement for all people, while at the same time striving to identify and remove barriers that have prevented the full participation of some groups. Improving equity involves increasing justice and fairness within the procedures and processes of institutions or systems, as well as in their distribution of resources. This category is most immediately relevant to the role of the benefit manager.
- **Inclusion:** The act of creating environments in which any individual or group can be and feel welcomed, respected, supported and valued to fully participate. An inclusive and welcoming climate embraces differences and offers respect in words and actions for all people.

### **Root causes of health inequities**

When it comes to employer-sponsored health coverage, DE&I focuses on equity as a primary goal. It's what benefit professionals are seeking to measure through their health plan data. And what they look to deliver for their organization. Having a diverse and inclusive environment is helpful to achieving higher levels of equity. But equity — as measured by the health outcomes of workers and their dependents — is the primary goal.

According to the National Academy of Sciences, Engineering and Medicine,<sup>5</sup> “*Health inequities* are systematic differences in the opportunities groups have to achieve optimal health, leading to unfair and avoidable differences in health outcomes.”

There are two primary sources of inequities in health care: structural inequities and social determinants of health.



“*Structural inequities* are the personal, interpersonal, institutional, and systemic drivers — such as, racism, sexism, classism, able-ism, xenophobia, and homophobia — that make those identities salient to the fair distribution of health opportunities and outcomes.” We see these show up in health disparities impacting certain groups as a result of systemic bias.

Some examples of this include:

- Physician practice patterns relative to Black or African American patients
- Lack of comprehensive coverage for gender confirmation services
- Health plan algorithms that direct resources away from certain underrepresented groups

“*Social, environmental, economic, and cultural determinants of health* (social determinants of health) are the terrain on which structural inequities produce health inequities. These multiple determinants are the conditions in which people live, including access to good food, water, and housing; the quality of schools, workplaces, and neighborhoods; and the composition of social networks and nature of social relations.”

In commercial health plans, we see social determinants in these examples:

- Inflexible job scheduling for call center employees that prevent workers from getting needed physical therapy
- A deductible that is so high, workers are underinsured and unable to afford needed basic and preventive care
- Awareness challenges that result in members using the emergency room when an urgent care center would provide the same care at lower cost

Social determinants of health are usually seen as not belonging to subgroups. For example, let’s say retail workers who make lower wages in three ZIP codes in downtown Atlanta can’t find convenient and affordable transportation to urgent care centers. This likely impacts workers across multiple underrepresented groups, although we know that certain groups

are disproportionately subject to both systemic bias **and** social determinants of health. We've found this through our pilot studies. This can be because of structural inequities or social determinants. Workers who are affected by systemic bias and social/financial risk have the greatest need for commercial plan sponsors to make changes based on health equity.

### **Addressing structural inequities**

Although not the focus on this article, there is important work being done to address these inequities. This work will partly depend on how fast the commercial market is willing to share member-level race and ethnicity data, and then report those results. Temporary solutions like imputing or indirectly determining race and ethnicity at the cohort level are available (like the RAND Bayesian Indirect Surname Geocoding or BISG, etc.).<sup>6</sup> These could offer an initial look at high-level results.

There's also potential complications coming from the broad racial/ethnic categories generally in use today (like Black or African American, Asian, Hispanic and White). These categories are at such a high level that they may hide important underlying health differences in various subgroups.

For example, a recent law passed in New York state requires that all data collection by the state in two prior categories under Asian (Asian and Pacific Islander) is now subdivided further into approximately 20 different groups. These groups are based on language, country of origin and other key variables.<sup>7</sup> It's not hard to see this same logic being applied to other groups to recognize important differences that drive health outcomes. These could include things like country of origin, preferred language and number of years in the U.S.

To quote a recent study, "the lack of detailed characterization of this population ultimately creates roadblocks in translating evidence into practice when providing care to the large and increasingly diverse Hispanic population in the U.S."<sup>8</sup> It concluded that "we believe that increasing the precision of the racial variable will only help to increase the reliability of the information provided by study participants, which will in turn ensure the accuracy of the research findings and ultimately assist practitioners in better implementing the scientific evidence produced by the research." As this helpful scrutiny of racial/ethnic categories plays out, plan sponsors and health plans must find ways to capture and organize all this data into sufficiently detailed and actionable cohorts.

There's something else that slows progress in addressing structural inequities in employer-sponsored commercial health plans. These plans are generally not built to recognize race and ethnicity. There aren't different plan options or contribution levels for different racial or ethnic groups. So many of the racial/ethnic disparities that the data will show may lead to interventions around social determinants that aren't specific to a group. This leads us back to the immediate opportunity we all share. To tackle a significant part of the problem of health disparities directly through the lens of social risk.

## **Action planning for the benefits and HR executive**

In a word: **lead**. That's the role for the benefits and HR team on the issue of health equity. They have the expertise and access to information that will allow timely and material progress on the challenges to health equity.

Taking action begins with educating the executive team on the health equity overall. And what's currently happening within the plan sponsors' own program. Even with the current challenges around addressing structural inequities, plan sponsors should begin an internal dialogue. They can talk about collecting member-level data on underrepresented groups and submitting it to health plan partners. Significant progress toward identifying and eliminating the impact of systemic bias in commercial health plans is not possible until the marketplace crosses this data threshold.

There are sufficient data and analytics available to plan sponsors to help them develop a solid business case showing the costs and returns associated with targeted interventions to address social determinants. Some executive teams will be motivated to action by the social justice perspective of health equity. At these companies, demonstrating a return on investment is less important.

That said, every organization owes its stakeholders an operational model that is as efficient as possible. The good news is that with the right analytics toolkit, plan sponsors can show that reaching higher levels of health equity is compatible with a health insurance program delivering cost management and worker productivity. It can even show skeptical leaders that it's a necessary component of them.

## **The ART of the possible**

For customers here at Aetna, building the business case is straightforward. Our proprietary ART analytics tool makes the impact of social determinants in a commercial health plan:

- **Identifiable:** We assign a behind-the-scenes multidimensional social risk score. It doesn't require additional information from a plan sponsor since it's embedded in our systems. Our underlying 18 indices provide deep-dive insight into the primary causes of social risk. Our tools review hundreds of health plan metrics to determine which aspects of worker health are impacted by social determinants.
- **Quantifiable:** Our account teams, clinical consultants and analytic experts partner with plan sponsors to measure the cost associated with each health disparity. Savings opportunities exist for all employers — more for plan sponsors in a high-deductible environment and those with concentrations of low-wage workers. Our internal studies show that on average, unaddressed social determinants add approximately 5% to total plan costs.<sup>9</sup>

- **Addressable:** We have developed strategies that go directly to the root cause of each disparity, creating a short- and long-term action plan to help improve worker health and lower plan costs.

Once the most important disparities are agreed-upon and a plan is in place, our teams apply many data-driven interventions. These include those that are highly targeted as well as “one size fits many.” They help create opportunities for savings, health improvement and greater equity across the organization.

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<sup>1</sup> KFF. Health insurance coverage of the total population (CPS). 2020. Available at: [KFF.org/other/state-indicator/health-insurance-coverage-of-the-total-population-cps](https://www.kff.org/other/state-indicator/health-insurance-coverage-of-the-total-population-cps). Accessed February 7, 2022.

<sup>2</sup> Horowitz JM, Igielnik R, Kochhar R. Most American say there is too much economic inequality in the U.S., but fewer than half call it a top priority. Pew Research Center. January 9, 2020. Available at: [PewResearch.org/social-trends/2020/01/09/trends-in-income-and-wealth-inequality](https://www.pewresearch.org/social-trends/2020/01/09/trends-in-income-and-wealth-inequality). Accessed February 7, 2022.

<sup>3</sup> Collins SR, Gunja MZ, Aboulafia GN. U.S. health insurance coverage in 2020: a looming crisis in affordability. The Commonwealth Fund. August 19, 2020. Available at: [CommonwealthFund.org/publications/issue-briefs/2020/aug/looming-crisis-health-coverage-2020-biennial](https://www.commonwealthfund.org/publications/issue-briefs/2020/aug/looming-crisis-health-coverage-2020-biennial). Accessed February 7, 2022.

<sup>4</sup> YW Boston Blog. Beyond the DE&I acronym: what are diversity, equity, and inclusion? March 26, 2019. Available at: [YWBoston.org/2019/03/beyond-the-acronym-dei](https://www.ywboston.org/2019/03/beyond-the-acronym-dei). Accessed February 7, 2022.

<sup>5</sup> Baciu A, Negussie Y, Geller A, et al. Communities in Action: Pathways to Health Equity. The root causes of health inequity. National Center for Biotechnology Information. January 11, 2017. Available at: [NCBI.nlm.nih.gov/books/NBK425845](https://ncbi.nlm.nih.gov/books/NBK425845). Accessed February 7, 2022.

<sup>6</sup> Fremont A, Weissman JS, Hoch E, et al. When race/ethnicity data are lacking: using advanced indirect estimation methods to measure disparities. RAND Corporation. 2016. Available at: [RAND.org/pubs/research\\_reports/RR1162.html](https://www.rand.org/pubs/research_reports/RR1162.html). Accessed February 7, 2022.

<sup>7</sup> The New York State Senate. Senate Bill S6639A. 2021–2022 Legislative Session. May 10, 2021. Available at: [NYSenate.gov/legislation/bills/2021/S6639](https://www.nysenate.gov/legislation/bills/2021/S6639). Accessed February 7, 2022.

<sup>8</sup> Aragonés A, Hayes SL, Chen MH, et al. Journal of Immigrant and Minority Health. Characterization of the Hispanic or Latino population in health research: a systematic review. U.S. National Library of Medicine, National Institutes of Health. July 29, 2015. Available at: [NCBI.nlm.nih.gov/pmc/articles/PMC4518558](https://pubmed.ncbi.nlm.nih.gov/26118558/).

<sup>9</sup> Aetna 2021 internal study of 440 million member months over three-year time period.

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