Smarter Health Care Coalition

THE INTERSECTION OF BENEFIT DESIGN, SOCIAL DETERMINANTS OF HEALTH, AND COVID-19 RESPONSE

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About Us – Smarter Health Care Coalition

The Smarter Health Care Coalition represents a broad-based and diverse group of health care innovators, including patients, employer groups, consumer organizations, health plans, life science companies, provider-related organizations, trade associations, academia centers and professors. Our goal is to leverage our combined perspectives and experiences to achieve smarter health care that improves the patient experience, particularly through integrating benefit design innovations and consumer/patient engagement within broader delivery system reform.

For comments and questions, contact: Michael Budros (mbudros@healthsperien.com).

Executive Summary

Policymakers, health plans, and other stakeholders are increasingly interested in the role that social determinants of health (SDOH) play in building healthy communities. Robust literature has linked the conditions and environments in which people live, and the unmet social needs such as adequate housing and nutrition that result, to health outcomes. Health plans, providers, and industry stakeholders broadly are increasingly investing in programs to address social needs. One additional mechanism through which health plans and policymakers could explore improving SDOH is through benefit design. Taking principles from "value-based insurance design," we define what high-value SDOH services could mean, and we outline the opportunities or challenges present in the current system for addressing SDOH through benefit design. In particular, industry leaders in Medicare Advantage and Medicaid managed care offer innovative examples and opportunities. Notably, the policy recommendations provided herein are not meant to serve as comprehensive solutions to address SDOH, nor the health inequities born of SDOH. The topic of social determinants encompasses several distinct aspects of both medical and non-medical factors. As such, issues related to SDOH cannot be solely addressed within a medical scope—let alone through the scope of benefit design.

SDOH and COVID-19 Response

The ongoing COVID-19 pandemic underscores the importance of multi-stakeholder engagement in the social determinants of health.

The pandemic will widen existing SDOH-related health disparities as the crisis continues. Studies show that people with chronic illnesses such as diabetes, obesity, and heart disease, are more likely to develop severe symptoms associated with COVID-19. Unfortunately, chronic disease is more prevalent in low-income communities and communities of color. The same communities are simultaneously more likely to suffer economically during the COVID-19 pandemic, all of which will exacerbate pre-existing unmet social needs. Minority and low-income communities are therefore at higher risk of contracting COVID-19, facing serious illness, and dying. [1]

The incentives and flexibilities to encourage investment in social determinants through benefit design, as described in this paper, are options to improve population health through existing tools in the health care system. The recommendations herein could be one part of a larger set of tools to mitigate the deleterious effects of the virus on SDOH.

[1] https://www.ajmc.com/focus-of-the-week/medicare-claims-data-further-highlight-pandemics-toll-on-racial-minorities

Contents

Introduction

Social determinants of health (SDOH) are commonly defined as the "conditions in the places where people live, learn, work, and play" that affect health outcomes.[2] SDOH can include income, neighborhood safety, housing, and education, which broadly capture the "social and physical environments" that influence health outcomes. The importance of SDOH can be highlighted in the expansive literature linking poverty, race, education, and where people live to health.[3] SDOH can create unmet social needs, some of which can be addressed through benefit designs that encourage utilization of social service organizations -- food, transportation, or other goods or services the individual lacks due to underlying economic, physical, and environmental conditions.[4]

Researchers estimate that social determinants and health behaviors, as opposed to direct medical care, influence the vast majority of health outcomes.[5] However, the United States underinvests in the social services and support systems designed to address these social determinants and behaviors relative to medical care services, meaning that for many communities the infrastructure and resources necessary to meaningfully intervene on social determinants is limited outside of the medical system.

[2] https://www.cdc.gov/socialdeterminants/index.htm
[3] https://www.ncbi.nlm.nih.gov/pubmed/27513279
[4] https://www.healthaffairs.org/do/10.1377/hblog20191025.776011/full/
[5] https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/

The converging trend of 1) increased health insurance coverage for the previously uninsured in the last decade and 2) an increased interest in population health in the health care industry represents an opportunity to think creatively about how to cover social needs through benefit design. In the last decade, a substantial number of Americans gained access to health insurance coverage that were previously ineligible or that otherwise could not afford coverage. At the same time, the health care industry has offered some innovation and initiatives around integration and use of non-health related services to address population health – with the goal of improving outcomes.

As the health care industry expands the use and integration of traditionally non-health related services, lawmakers on the federal and state level continue to navigate how the current policy landscape may be amended to better accelerate the adoption of service approaches that address social determinants of health (SDOH) under government health insurance programs. Notably, in 2019 alone, Congress saw the introduction of several standalone bills aimed at improving the focus on SDOH within Medicare, Medicaid and the Children's Health Insurance Program (CHIP) (e.g., H.R. 4004, *Social Determinants Accelerators Act of 2019*; S. 1323, *UNDERSTAND Act of 2019*; and, H.R. 4621, *Collecting and Analyzing Resources Integral and Necessary for Guidance for Social Determinants Act of 2019*, among others), while several other bills included efforts to address SDOH within the larger scope of their respective proposals (e.g., S. 2721, *Healthy Communities through Health Care Act*; H.R. 4334, *Supporting Older Americans Act of 2020*; and S. 1895, *Lower Health Care Costs Act of 2019*, among others).

Within the context of health insurance, a handful of SDOH initiatives are currently underway within commercial settings. As policy makers push for changes that expand more widespread utilization and provision of services that address SDOH, changes to benefit designs and insurer incentives may play a significant role in improving the overall adoption of such services throughout the health care industry. While benefit design is not the definitive route to fully mitigate social and physical environments that lead to poor health, higher-value benefit designs should nonetheless align with the importance of addressing social determinants and social needs.

In the context of the ongoing pandemic, SDOH initiatives are generating additional attention. Research has demonstrated the close connection between social risk factors to severe illness.[6] Policymakers should consider ways to expand health plan SDOH initiatives as part of the COVID-19 response.

Disclaimer and Limitations

Notably, the policy recommendations provided herein are not meant to serve as comprehensive solutions to address SDOH, nor the health inequities born of SDOH. The topic of social determinants encompasses several distinct aspects of broad medical and non-medical factors. As such, issues related to SDOH cannot be solely addressed within a medical scope—let alone through the scope of benefit design.

[6] https://www.ajmc.com/focus-of-the-week/medicare-claims-data-further-highlight-pandemics-toll-on-racial-minorities

Further, an overarching challenge with a growing focus on social determinants and additional health plan benefits to address social needs is cost and capacity —how to pay for them, who should pay for them, what services are already available and will need to be available in a given community, and how does the addition of such services affect premiums and health plan costs. Below we describe in more detail specific challenges within the current statutory and regulatory framework, and opportunities for incentives, some of which addresses financing and capacity. However, the methods to comprehensively finance social determinants of health services are outside the scope of this paper.

Defining "Value" for SDOH Services in the Context of Benefit Design

As payers and health care providers transition to a more value-based medical system, stakeholders are increasingly interested in how to address social determinants given their greater impact on health outcomes than medical services alone. A challenge will be incorporating these initiatives that address SDOH into the "benefit design" without increasing premiums. Otherwise persons who do not use these services will see less value in their health care coverage. Like medical services, determining the "value" of a SDOH service is a complex process dependent on a myriad of factors – who receives it, when, how, and from whom. Notably, what may be considered "high-value" will oftentimes differ between individuals of the same target population, regardless of disease state – *SDOH services are both highly personal and local*.[7]

In order to improve the uptake of meaningful and impactful SDOH services, health plans must have the flexibility to adjust benefits on an individual level as well as on a group basis. Laws or regulations to promote SDOH services, therefore need to be both flexible and address the possibility of adverse selection and benign discrimination that could result from rich SDOH-targeted benefits. Otherwise, these entities may be discouraged from investing in SDOH benefits.

Value-based insurance design (V-BID) — built on the concept of clinical nuance —is an example of design flexibility which has positive effects on the uptake of "high-value" medical services.[8] Lessons and challenges from these initiatives (namely, the challenge in defining, communicating, and adjudicating value among enrollees) will be instructive to how high-value SDOH services can be promoted through benefit design, while avoiding the promotion of services that provide less to little health benefit to an enrollee.

Regarding current research, the evidence base assessing the "value" of certain SDOH services is still evolving. Research has not significantly stratified the value of SDOH services on a population-specific level. In fact, policymakers should expand the federal research agenda to further define the "value" of different SDOH services for different population groups. Research has, however, extensively highlighted health disparities and social inequities experienced by varying communities in the United States.

[7] http://vbidcenter.org/initiatives/v-bid-clinical-nuance/
[8] http://vbidcenter.org/initiatives/medicare-and-medicare-advantage/

Families USA, for example, has publicly released numerous analyses, studies, and white papers.[9] This research can serve as a proxy for discussing what SDOH services are of "high value" for relevant target populations. In the clinical community, variation in service utilization with similar health outcomes across geographic locations has been used to infer that there is some level of unnecessary utilization (and underutilization of necessary services). Similar approaches could be applied to SDOH services.

We propose a framework for evaluating which SDOH services to include within a benefit design. Below are the basic criteria that should be considered, irrespective of policy barriers that will be discussed later, to determine if a SDOH service is of "high-value" to both the patient and the health plan. Determining the value of a given SDOH service is important for targeting benefits appropriately, and creating a proper balance of incentives, similar to V-BID cost-sharing changes for medical services.

Criterion 1: Services must Improve Patient-Reported Quality of Life.
Any initiative to address SDOH should aim to improve beneficiary-reported quality of life. From an industry perspective, return on investment (ROI) and other financial metrics are secondary to, and dependent on, this basic principle.

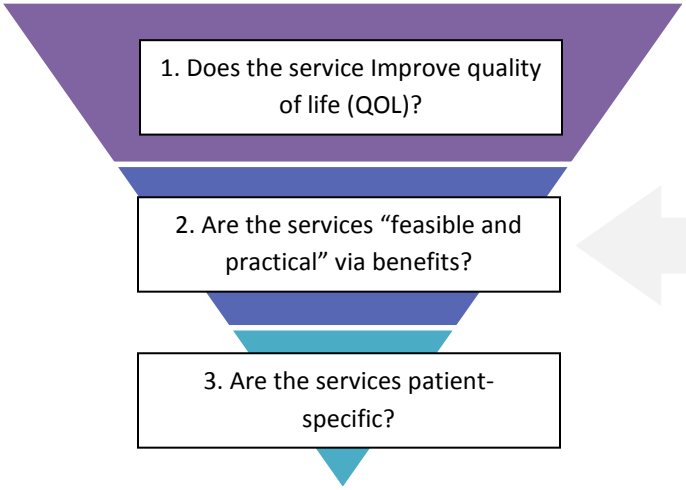
Criterion 2: Services Must Be Feasible, Cost-Effective, and Practical to Address Through Benefit Design:
Social determinants can be addressed through various settings and mechanisms. It is important to note, however, that initiatives and services "feasible and practical"—from a capacity and financial

perspective—to implement through *benefit design* may be limited. Realistically, in the current environment, benefit designs can best influence the uptake and utilization of SDOH services through innovative cost-sharing incentives and supplemental benefits.

Furthermore, we define services that are "feasible and practical" as services that are achievable within the community/environment of the covered beneficiary. Targeted communities must have a general capacity and infrastructure to provide SDOH services at a quality level. It is important that policy makers acknowledge this requirement (and solve for it) when contemplating any policy change or proposal to improve the uptake of SDOH services through the vehicle of benefit design.

Criterion 3: Services Should Address Patient-Specific Non-Medical Needs.
For the purpose of SDOH and benefit design, plans should consider how the SDOH service will address non-medical needs for the *individual* patient. To do so, plans will likely utilize a health risk assessment tool for collecting information on social determinants. Through this assessment, which would allow the plan to identify specific risk factors in which SDOH exist, the plan can identify social services that might be needed. For example, the inclusion of transportation into covered benefits for people with depression could address an identified risk factor of social isolation and remove a barrier to accessing mental health services.

[9] https://www.familiesusa.org/



High-Value SDOH services, are services that:

1) Improve patient-reported quality of life (PR-QOL);
2) Are feasible, practical, and cost effective to address through benefit design; and
3) Are patient specific.

Current Opportunities

Health plans are already active in addressing social determinants of health. In the sections below, we highlight programs and models that are making, or have the potential to be, inroads into social determinants of health service delivery through benefit design.

Medicaid Expansion and Medicaid Managed Care Organizations

Some Medicaid expansion states have incorporated cost-sharing into their expansion population coverage, and in doing so, there may be opportunities to improve access to or incentives for SDOH services through benefit designs. Although cost-sharing for the Medicaid expansion population, in general, presents a barrier to medical services for low-income enrollees, incentives for targeted use of SDOH services can be a positive addition and opportunity to mitigate beneficiary cost-sharing burden.

For example, Indiana *"POWER Accounts"* are a part of the "Healthy Indiana Plan" (HIP) - Indiana's Medicaid expansion.[10] These accounts are special savings accounts that Medicaid expansion members use to pay for the first $2,500 of health care spending. Members have an income-based monthly contribution between $1-20, which gives the member access to additional coverage (e.g. vision, dental, chiropractic benefits). Otherwise, without POWER contributions, members pay point-of-service copayments. Ostensibly, the copayments would equal more than the monthly contributions, especially for those below federal poverty line. If members were able to purchase social services (or achieve better alignment with or additional social services beyond those to which they are already eligible for from

[10] https://www.in.gov/fssa/hip/2590.htm

other government programs) through these accounts, they could be used to incentivize the use of SDOH services in an important population. Alternatively, Medicaid managed care organizations (MCOs) could encourage targeted services (e.g. health literacy) by reducing required POWER account contributions for participation.

Other states, including Kentucky and Michigan, which have cost-sharing requirements for Medicaid expansion enrollees could look to remove premium surcharges or reduce cost-sharing for using SDOH services. Additionally, states that intend to implement community engagement requirements could include uptake of SDOH services as part of these programs. However, these strategies are a mixed opportunity. Although incentives for targeted use of SDOH services in such environments could mitigate potential harm, Medicaid programs that incorporate community engagement requirements or cost-sharing could introduce barriers to enrollment or medical services for low-income enrollees.

Some state Medicaid agencies have started to integrate coverage for interventions focused on SDOH into new value-based payment models.[11,12,13] In addition, MCOs are also developing interventions that address SDOH by linking clinical and non-clinical service delivery to improve health outcomes and cost efficiencies.[14] Notably, North Carolina's Healthy Opportunities pilot—which aims to support and strengthen managed care efforts that address housing and food insecurities, transportation barriers, employment issues, and interpersonal safety issues, among other factors—is one of the cutting-edge federally approved state initiatives to pilot such comprehensive SDOH-focused programs and supports.[15]

At the federal level, the Center for Medicare and Medicaid Innovation (CMMI) is testing whether Accountable Health Communities (AHC) are a cost-effective approach to identifying and addressing select unmet social needs of Medicare and Medicaid beneficiaries across the country.[16]

Lastly, states are actively looking at ways to improve or implement SDOH data collection and standardization processes to better inform health-related programs. For example, Oregon's Accountable Care Organization (ACO) model, Care Coordination Organizations (CCO), has implemented multiple SDOH-centered screening measures to its CCO program quality metrics. Tennesse's Medicaid program has implemented a handful of assessments—including an MCO comprehensive needs assessment, a standardized employment data sheet, and a housing profile assessment, among others—to better inform care management and coordination as well as identify overall system needs. Vermont has implemented severall SDOH assessments and worksheets to better develop person-centered care plans and care coordination strategies. Generally, several states are currently implementing, or planning to

[11] http://www.milbank.org/publications/medicaid-coverage-social-interventions-road-map-states/.
[12] http://www.chcs.org/media/Supportive-Services-Brief-Final-120315.pdf.
[13] http://www.chcs.org/resource/supporting-social-services-medicaid-accountable-care-organizationsearly-efforts/
[14] http://www.sciencedirect.com/science/article/pii/S074937971630304X.
[15] https://files.nc.gov/ncdhhs/CMS-1115-Approval-FactSheet-FINAL-20181024.pdf
[16] https://innovation.cms.gov/initiatives/AHCM.

implement similar data collection initiaves to better inform comprehensive population health initiatives.[17]

Medicare Advantage: Supplemental Benefits and V-BID Demonstration

MA supplemental benefit requirements were defined under the *Bipartisan Budget Act of 2018*, as well as subsequent guidance from CMS. Notably, MA plan sponsors can now provide individually tailored Special Supplemental Benefits for the Chronically Ill (SSBCI), which permit supplemental coverage of traditionally non-health related services for qualified beneficiaries.[18] Examples of these benefits include: meals, food and produce, transportation for non-medical needs, pest control, indoor air quality equipment and services, social need benefits.[19] Non-primarily health related benefits closely parallel the flexibilities provided within the current V-BID CMMI demo, which allows even further flexibility for MA plans to tailor benefits.

Outside of Special Supplemental Benefits for the Chronically Ill (SSBCI), standard MA supplemental benefits are still required to show some degree of uniformity; however, this requirement has been significantly revised since 2018—MA plan sponsors can now tailor separate supplemental benefit packages to different disease states and medical criteria groups.[20] MA plans are also now permitted to cover additional services under traditional supplemental benefits, such as: adult day health services; home-based palliative care; and support for caregivers of enrollees, among others. Given MA experience with vision, dental, and other supplemental benefits, MA plans have a unique additional opportunity to improve utilization of high value SDOH services.

Barriers to Expansion

Medicare and Medicare Advantage: Anti-Discrimination

To date, extending the principles of V-BID to traditional Medicare Parts A and B have been limited because of uniformity of benefit requirements in Medicare Advantage (MA) that limit the ability to tailor specific benefits for specific populations. However, in 2019, CMS updated regulations related to the "uniformity requirements" for Medicare Advantage plans, and allows MA plans to offer non-uniform benefits to enrollees based on diagnosis, as long as "similarly situated" enrollees were treated equally (e.g., all people with the same diagnosis are eligible for the same benefits). For example, MA plans could choose to reduce cost-sharing for diabetic eye exams or testing for all people with diabetes in that plan.

[17] https://www.chcs.org/media/CHCS-SDOH-Measures-Brief_120716_FINAL.pdf
[18] https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/Supplemental_Benefits_Chronically_Ill_HPMS_042419.pdf
[19] https://www.cms.gov/newsroom/fact-sheets/2019-medicare-advantage-and-part-d-rate-announcement-and-call-letter
[20] https://www.cms.gov/newsroom/fact-sheets/2019-medicare-advantage-and-part-d-rate-announcement-and-call-letter

The new uniformity flexibilities for Part C (MA), however, *do not* include Part D prescription drug benefits available through MA plans. This means MA plans may not vary prescription drug cost-sharing for enrollees with certain diseases unless they participate in the MA V-BID demonstration model within CMMI, which does allow for cost-sharing changes in Part D benefits. The change in uniformity requirements aligns well with the core principles of V-BID.

Medicare Advantage: Supplemental Benefit Crowd-Out

Supplemental benefits provided through Medicare Advantage (MA) plans offers an opportunity to explore SDOH through benefit design, but the current system of funding supplemental benefits through rebate dollars is limited.

Despite new flexibilities described above under the uniformity requirement changes, MA supplemental offerings remain relatively restricted because of how these supplemental benefits are financed. MA plans receive "rebate dollars" based on the differential between plan bids to CMS and a Medicare fee-for-service benchmark (a lower bid creates available rebate dollars). Rebate dollars can be used to offer benefits that are not offered by traditional Medicare, such as dental, vision, SSBCI, and others. The limited rebate dollars result in limited flexibility to fund additional benefits. Most MA plan sponsors continue to direct the majority of rebate funds toward medical services that remain excluded from the traditional fee-for-service benefit, such as vision, dental, or hearing, as these benefits are important for plans to compete in their respective markets.

Milliman reports that only 364 of the 3,734 MA plan offerings in CY 2020 will implement the expanded supplemental benefits approved by CMS in 2018 (e.g., adult day health services; home-based palliative care; in-home support services; support for caregivers of enrollees; therapeutic massage).[21] Considering the potential impact such MA plans could have within low-income or otherwise vulnerable seniors, it is imperative that policy makers consider ways to improve requirements governing supplemental benefits, in a way that eliminates the practical limitations mentioned, to improve uptake of innovative services that directly and indirectly address SDOH.[22]

Medical Loss Ratio Requirements

Limited flexibility with respect to the Medical Loss Ratio (MLR) numerator (medical claims and quality improvement expenses) could restrict how plans incorporate SDOH into their benefit design or expenses – it's not clear how some SDOH benefits would be included into these calculations, and plans have previously expressed concern that more restrictions in the definitions of the MLR calculation can limit innovative approaches to non-medical benefits and quality improvements.

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[21] Murphy-Barron C. & Buzby E. (2019). Review of Contract Year 2020 Medicare Advantage supplemental healthcare benefit offerings. Retrieved at https://www.bettermedicarealliance.org/sites/default/files/2019-11/Review_of_Contract_Year_2020_Medicare_Advantage_Supplemental_Healthcare_Benefit_Offerings.pdf

[22] Amber Willink Phd. (2019). The High Coverage of Dental, Vision, and Hearing Benefits Among Medicare Advantage Enrollees. *Inquiry: The Journal of Health Care Organization, Provision, and Financing*, *56*, 46958019861554. https://doi.org/10.1177/0046958019861554

Policy Recommendations

The following policy recommendations are options aimed at relieving barriers to expanding access to SDOH services, better capitalizing on current opportunities, or allowing more flexibility for plans to tailor benefits to address an individual's social needs. The list is not exhaustive, but a first step.

Medicare

Federal Policy Option #1: CMS should expand Supplemental Services and Benefits for the Chronically Ill (SSBCI) in Medicare Advantage to include more qualifying indicators, such as functional status, or other qualifying indicators as determined by the Secretary.

Background: The Bipartisan Budget Act of 2018 expanded SSBCI to include benefits that are not "primarily health related", and may be offered non-uniformly to eligible chronically ill enrollees, as long as the SSCBI has a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollees. Benefits include:

a. Reduced cost sharing for Medicare covered benefits;
b. Reduced cost sharing for primarily health related supplemental benefits;
c. Additional primarily health related supplemental benefits; and/or
d. Non-primarily health related supplemental benefits.

The definition above would allow for addressing social determinants of health, such as access to nutrition, transportation, housing, pest-control, or non-medical equipment (e.g. indoor air quality equipment), among many others.[23] However, the definition of chronically ill may be limiting and could be improved by expanding the definition as set by the Congress to allow those with social barriers to health improvement to access such benefits – *especially those individuals at high risk of becoming chronically ill but who are not already*.

Section 1852(a)(3)(D)(ii), as amended, defines a chronically ill enrollee as an individual who:

a. has one or more comorbid and medically complex chronic conditions that is life-threatening or significantly limits the overall health or function of the enrollee;
b. has a high risk of hospitalization or other adverse health outcomes; and
c. requires intensive care coordination.

Functional status could be defined by existing tools.[24] Such an expansion would allow plans to target individuals who have a reasonable expectation of health improvement. Importantly, the list of allowable SDOH services has been expanded, but the scope of qualifying indicators could do more to target individuals who stand to benefit the most from these SDOH services.

[23] https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/Supplemental_Benefits_Chronically_Ill_HPMS_042419.pdf
[24] https://hmsa.com/portal/provider/PRC_Guide_COA_Functional_Status_Assessment.pdf

Federal Policy Option #2: CMMI should expand MA V-BID demonstration SDOH qualifying indicators beyond LIS. As a potential model for the above recommendation (expanding SSBCIs), the Medicare Advantage Value-Based Insurance Design (V-BID Demo) currently allows supplemental benefits to address social determinants of health to be targeted to enrollees on the basis of their medical condition or socio-economic status, as defined by an enrollees Low-Income Subsidy (LIS) or dual-eligible status. This provision of the demonstration, and the demonstration's value to future MA reforms, could be improved by expanding the SDOH benefit qualifying indicators beyond LIS to other indicators of social needs, including functional status, activities of daily living, and others[25] – and a number of tools exist already to measure social needs, including the Accountable Health Communities Social Needs Screening.[26] CMS needs to address how to apply these benefits to more MA beneficiaries outside the context of the VBID demonstrations to allow for more variations in the marketplace.

Federal Policy Option #3: Congress should make the MA-VBID demonstration, and an expanded scope of qualifying indicators for SDOH services, a permanent part of the MA program. Congress would therefore allow plans to adopt value-based insurance design plan elements, including expanded scope of qualifying indicators, without going through the demonstration project. Section 50322(a) of the Bipartisan Budget Act provides MA plans the opportunity to provide individually tailored, and non-primarily health-related SSBCI to certain beneficiaries that (1) have one or more comorbid and medically complex chronic conditions that are life threatening or that significantly limit the overall health or function of the enrollee, (2) have a high risk of hospitalization or other adverse health outcomes, **and** (3) require intensive care coordination. The MA-VBID demonstration underway at CMMI offers similar flexibilities in supplemental benefits under expanded inclusionary criteria for beneficiaries, which encapsulates both clinical considerations and SES status. This has resulted in an expanded reach of SSBCI to other vulnerable populations outside the scope of those defined in CHRONIC Care Act.[27] To build on the current potential of SSBCI in addressing SDOH, Congress should consider legislation that incorporates the additional qualifying indicators expressed in the MA-VBID demonstration to expand the reach of such benefits to more underserved and at-risk beneficiary population groups.

Commercial

Federal Policy Option: Congress should update the current MLR standards such that a defined list of "Allowed Social Need Expenses" would be counted towards a commercial (individual market, small and large group) plan's Medical Loss Ratio (MLR).

Background: MLR limits the portion of premium dollars health insurers may spend on administration, marketing, and profits.[28] Specifically, the MLR for individual and group market plans is a function of:

[25] https://www.cms.gov/blog/actively-addressing-social-determinants-health-will-help-us-achieve-health-equity
[26] https://innovation.cms.gov/Files/worksheets/ahcm-screeningtool.pdf
[27] Creating High Quality Results and Outcomes Necessary to Improve Chronic Care Act of 2018, passed as part of the Bipartisan Budget Act of 2018.
[28] https://www.kff.org/health-reform/fact-sheet/explaining-health-care-reform-medical-loss-ratio-mlr/

$$(\boldsymbol{Health\ Care\ Claims} + \boldsymbol{Quality\ Improvement\ Expenses} + \boldsymbol{State\ Adjustments})$$
$$\div$$
$$(\boldsymbol{Premium\ Dollars} - \boldsymbol{Taxes}, \boldsymbol{Licensing}, \boldsymbol{Regulatory\ Fees})$$

If an insurer fails to meet the applicable MLR standard, they must pay rebates to its members. MLR standards vary by sector: the individual and small group market, this standard is 80%, leaving 20% for administration, marketing, and profit. The MLR threshold is higher for large group plans at 85%. In the Medicaid managed care space, states must use the individual market minimum, with flexibility to impose higher standards. Importantly, the MLR standard does not apply to self-funded plans, in which a plan sponsor (e.g., an employer) purchases health care on behalf of its members or employees.

However, the current definitions of health care claims and quality improvement expenses (QIE) used to calculate MLR would not explicitly allow for social need benefits.[29] By definition, health care claims are expenses related to medical services and medications, which is clearly unfit. QIE is more broadly defined, but the established criteria could preclude spending on social needs. QIE must achieve health-related goals, such as improving health outcomes, reduce health disparities, and prevent hospital readmission (among other goals). Although services to address social needs may ostensibly meet those goals, the definition of quality improvement expenses also states: "expenses should be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized health care quality organizations." It is likely that benefits to address social needs would not fit cleanly within the meaning of "evidence-based medicine" or "clinical practice," requiring additional action by Congress.

Thus, we propose two possible routes for Congress to incentivize supplemental benefits or programs to address social needs through MLR: 1) incorporate services to address social needs into existing definitions of QIE or 2) create a separate structure for spending on social needs services to count towards the MLR numerator, outside the scope of the existing QIE definition. We believe either of these options would require action by Congress, rather than rulemaking.

Section 2718(c) of the Public Health Service Act, as amended by the Patient Protection and Affordable Care Act (PPACA), directs the National Association of Insurance Commissioners (NAIC) with creating uniform definitions and standardized methodologies for calculating the MLR for the individual and group markets.[30] CMS then adopted these definitions to establish the MLR used today. Congress could enact legislation to direct CMS or NAIC to expand the definition of QIE to include benefits or programs to address social needs. These activities could be expanded by adding a specific list of "Allowed Social Needs Expenses" (for example) to quality improvement activities, under the explicit requirement that

[29] https://www.naic.org/documents/committees_ex_mlr_reg_asadopted.pdf
[30] https://www.govinfo.gov/content/pkg/FR-2010-04-14/pdf/2010-8599.pdf

these new benefits directly connect to an element of clinical care quality. Without other amendments to PPACA, such a connection would likely be necessary for meeting existing parameters.[31]

Alternatively, Congress could expand the MLR variables and direct CMS to conduct novel rulemaking to allow for plan flexibility to meet MLR through investments in narrowly defined "Allowed Social Needs Benefits", *in addition* to health care claims and QIE. Similar to PPACA, Congress could task NAIC to establish a uniform definition of these expenses, for CMS' implementation.

Through this latter option, Congress would change the ACA formula for MLR to:

$$(\boldsymbol{Health\ Care\ Claims} + \boldsymbol{Quality\ Improvement\ Activities} + \boldsymbol{State\ Adjustments} + \mathbf{Allowed\ Social\ Needs\ Benefits}) \div (\boldsymbol{Premium\ Dollars} - \boldsymbol{Taxes}, \boldsymbol{Licensing}, \boldsymbol{Regulatory\ Fees})$$

The advantage to the latter approach (a parallel structure for allowed social needs benefits separate from existing QIE) would be twofold: first, simplicity with respect to what counts as a quality improvement and, second, additional flexibility for health plans to conduct evidence-based innovation in SDOH and social needs benefits, without the explicit requirement to tie these activities to "*health care* quality," which is a core part of defining QIE.

Regardless of the approach to rulemaking or lawmaking, CMS or Congress would need to create specific safe harbors and guardrails to protect the integrity of the MLR and beneficiaries. First, CMS would need to ensure that plans can target specific beneficiaries that would benefit the most from additional services – similar to the language already used for quality improvement by NAIC to target quality improvement to appropriate "segments of enrollees" – while also protecting beneficiaries from discrimination. [32] In addition, we argue that what would qualify for new social needs benefits or expenses should be narrowly defined, for several reasons. As noted early in this paper, the full scope of "social determinants of health" is quite broad and the intersection of health benefits with SDOH may be appropriately narrow. There could be legitimate concern that a broad definition of services to meet social needs for MLR purposes would allow plans to conduct activities for which beneficiaries may see little gain, while meeting the MLR standard more easily. This would undermine the intent of the MLR standard to protect beneficiaries. Therefore, CMS should consider first allowing meaningful and specific investments or services with significant evidence connected to health outcomes for people with one or more unmet social needs, such as non-emergency medical transportation, nutrition and food assistance, and housing assistance.

[31] https://www.law.cornell.edu/uscode/text/42/300gg-18

[32] For example, NAIC stated with respect to quality improvement expenses: "The expenses must be directed toward individual enrollees or may be incurred for the benefit of specified segments of enrollees, recognizing that such activities may provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees other than allowable QI expenses associated with self-insured plans."

The North Carolina Health Opportunities Pilot, while specific to a Section 1115 Medicaid managed care waiver, could provide insight into using the MLR to incentivize insurer investments in social needs.[33] According to the NC Department of Health and Human services, MCOs in the pilot model "may count contributions [to health-related resources] in the numerator of their MLR," as long as they meet state and federal standards of quality improvement activities as defined above. These MCO activities must "reflect meaningful engagement with local communities… to improve outcomes for beneficiaries, such as housing initiatives or support for community-based organizations that provide meals, transportation, or other essential services." The pilot specifically excludes certain expenses and activities, such as salaries and technology investments owned by the MCO. The unique nature of the pilot and entities involved do not translate well to broader commercial markets, but could nonetheless inform how to create a federal policy for the commercial sector that explicitly allows and encourages appropriate investments to count towards MLR numerator.

State Policy Option: States should implement nondiscriminatory health-contingent wellness programs in the individual market (perhaps specifically to target younger enrollees).

Background: Under Section 2705(1) of the ACA, the Administration has the authority to establish a 10-state demonstration that allows selected states to implement nondiscriminatory health-contingent wellness programs in the individual market. HHS released a bulletin in 2019 outlining and establishing this demonstration project (including requirements and requests for application).[34] States can implement a wellness program that provides a reward for individuals to satisfy a standard related to a health factor to obtain that reward, which could include reduced premium liability.

We pose that the existing body of research regarding the effects SDOH on clinical health outcomes is sufficient to justify the inclusion of non-health related interventions within the context of "health-contingent wellness programs". Assuming this demonstration permits the inclusion of SDOH interventions to prevent or manage overall health and wellbeing (thus preventing illness), we propose a creative SDOH wellness program structure as an example of how this demonstration could be utilized, especially for younger people in catastrophic plans. Doing so could attract young adults that desire lower premium and supplemental/social determinants-related services and improve the risk pool for the broader exchange market.

For example, a VBID Wellness Plan could have reimbursement for nutritional counseling and a reward for reaching a BMI target (with appropriate accommodations and adjustments based on individual factors). Reimbursement could also be available for engaging in shared decision-making activities, financial wellness seminars, social engagement programs, and mental wellness activities (e.g. yoga or

[33] https://files.nc.gov/ncdhhs/documents/PHPs-in-Medicaid-Managed-Care-PolicyPaper_revFINAL_20180516.pdf
[34] https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Wellness-Program-Demonstration-Project-Bulletin.pdf

mindfulness meditation). Outcomes incentives could be tied to fitness tracking, non-smoking or vaping, or meeting hypertension or cholesterol targets.

The wellness demonstration allows for a reward that can be up to 50% of enrollee premiums. Currently, catastrophic plans range in premiums from $100-$300 a month, thus 50% incentive package would range from $600-$1,800 a year. Some of the incentive amount would likely be needed to reduce premiums (to attract the price-sensitive uninsured), while part will be needed to reimburse for primary prevention benefits. The value of some of these benefits may be particularly attractive if the plan can negotiate a discounted service rate that would not be available to a non-participating individual.

Benefits to offer in return for premium and cost-sharing incentives could include:

1. Counseling services, focusing on health and insurance literacy, finances, or career development;
2. Transportation for non-medical needs;
3. Housing assistance (non-financial); and
4. Other efforts addressing SDOH, including but not limited to the following:
    a. Interventions to address social isolation and loneliness; and
    b. Coordination of and education on available public services and assistance.

This is not an exhaustive list, nor would plans take up all of these benefits simultaneously, but it does illustrate the opportunities for a creative wellness program benefit could use interventions applicable to the needs of young adults to increase enrollment, improve the broader risk pool, and improve health outcomes for people who need some SDOH support. For states, this could be more attractive than having young individuals looking for the cheapest premiums (catastrophic) purchase short-term, limited-duration plans that may not provide the catastrophic and essential coverage of a QHP.

Additional state consideration: States should consider implementing this type of wellness demonstration in tandem with value-based insurance design principles. A state could encourage issuers in this demonstration project to reduce cost-sharing for drugs or medical services that would ultimately improve adherence to the non-medical, social determinants-focused wellness program and vice versa. For traditional medical services and drugs, the University of Michigan and the Healthcare Management and Regulations Lab at Harvard developed a template V-BID plan ("V-BID X") to demonstrate how altering cost-sharing could be done without increasing premiums.[35] Although not a prescriptive list of services or cost-sharing changes, the template could serve as an example for QHPs. The V-BID X project was also cited in the HHS Notice of Benefits and Payment Parameters for 2021 proposed rule, as a model for QHP consideration.[36]

Non-payer strategies

Value-based arrangements & pricing with SDOH elements between life science and plans.

[35] https://vbidcenter.org/initiatives/vbid-x/
[36] https://www.cms.gov/files/document/proposed-2021-hhs-notice-benefit-and-payment-parameters-fact-sheet.pdf

Life science industry partners could include funding for SDOH services as part of a value-based contract with health plans. In return for an issuer's favorable formulary placement, for example, or a favorable price, the manufacturer or supplier could establish a program for enrollees to receive free or subsidized social services reasonably suited to improve medication adherence (and subsequently health outcomes), including transportation, non-medical home equipment, social worker support, or other support for social needs that prevent access to clinically prudent health care services. Cost-sharing related to this bundle of SDOH services and prescription drugs could be reduced or altered. Beneficiaries under such agreements would see improved quality of life as the result of both the medication adherence and lower social (and financial) barriers to adherence.

Future exploration

The following recommendations are broad ideas for future exploration and expansion. These ideas are either significant changes to current programs, nascent ideas, or are beyond the specific scope of this paper, but are nonetheless important considerations for the future:

1. Congress could explore changing some allowable supplemental benefits (e.g., dental, and vision benefits, among others) to be treated as if they were core benefits under the original Medicare fee-for-service program option for Medicare Advantage, which would free up rebate dollars for supplemental benefits targeting SDOH. On a smaller scale, Congress did something similar with telehealth services; [37]
2. Improving collection of data to inform the evidence base of SDOH intervention;
3. Creating a standard social determinants of health screening tool and associated quality measures;
4. Expanding codable services for SDOH-related care (e.g., continued expansion of Z-codes, similar to developments in Medicare fee-for-service); and
5. Increasing capacity investment in social service delivery system and infrastructure through a community-based, all stakeholder approach.[38]

Conclusion

Innovative opportunities to address social needs through benefit design already exist in some programs such as Medicare Advantage and Medicaid. Health plans, providers, life sciences, and patients alike stand to benefit from these opportunities as we begin to understand more about the impact of social determinants on the health of populations. The local and personal nature of social determinants of health adds complexity to addressing social needs through benefit design specifically, but numerous entities, especially Medicaid managed care organizations and Medicare Advantage plans, have made

[37] Under Section 50323(a)(5) of the Bipartisan Budget Act of 2018, MA plans are permitted to provide "additional telehealth services" and treat them as if they were benefits under the original FFS program option, and not under supplemental benefits. This recommendation is separate from proposals to add more core benefits to Medicare fee-for-service, such as provisions in H.R. 3, the Elijah E. Cummings Lower Drug Costs Now Act.

[38] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.0039

early strides. For more success, Congress and the administration should work to address the regulatory and statutory barriers that prevent or limit the industry from tackling social needs in their communities and address methodologies to pay for these services. Like the early expansion of telehealth flexibilities, the expansion of these SDOH-related opportunities, and mitigation of relevant barriers, could be increasingly important as the COVID-19 pandemic widens pre-existing disparities and unmet social needs.