INSIDE: Successful benefits communication

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SELLING SOLUTIONS FOR BROKERS

ACCESS DENIED!

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Illustrations by Jeff Hinchee

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BY DAN COOK

The U.S. health care system continues to struggle with the concept of universal access to basic medical services. For success stories, we are referred to the millions who now have health coverage thanks to the Patient Protection and Affordable Care Act. Or we are told to consider Medicaid expansion, which theoretically opened up access to millions more.

Yet the reality is far different.

Even for those now theoretically able to receive health care via Medicaid expansion, accessing those services has proven elusive. A shortage of physicians is one cause; clinics' reluctance to accept new Medicaid patients another. Additionally, a generally low level of health literacy among all U.S. adults is a third, and more troubling, cause of lack of access.

It's telling to take a closer look at the effects of the ACA. Yes, the number of Americans with health insurance increased under the ACA, from 72 percent in 2010 to 78 percent in 2018, according to a recent Commonwealth Fund survey. However, Commonwealth said the number of insured Americans who are designated as underinsured increased by nearly the same percentage during that time—from 16 percent to 23 percent.

Then dig a bit deeper. Look at those employees who receive health insurance through an employer. Ominously, Commonwealth reported, "the greatest deterioration in the quality and comprehensiveness of coverage has occurred among people in employer plans."

The Commonwealth Fund study—and considerable other academic research—raises serious questions about access to essential services for those who get their health insurance through an employer.

This data tells us two kinds of barriers to accessing health care exist: Services that simply cannot be accessed by an individual; and services that, in theory, are accessible, but are blocked by an obstacle that can be overcome only through education, assistance or improved resources.

Studies show that the number-one obstacle to medical care for employer plan members is financial. (See sidebar on page 15.) As high deductible health plans (HDHPs) have become the new norm for employers to offer their workers, study after study has demonstrated that plan members simply don't access services due to the shared cost.

The financial barrier to care is critical, because that fear of paying for access ends any meaningful discussion of the benefits of drug adherence, or of the long-term efficacy of primary care services, or the merits of one physician or health care system over another.

But removal of copays and deductibles is only the first step to increasing access for plan members. Consumers' access to health care is limited by far more entrenched trends that require strategic solutions. Among them:

1. Low overall health literacy among all U.S. health care consumers
2. The tendency of many insurance plan designs, including HDHPs, to demand more independent research and decision-making from the plan member
3. Logistical difficulties with scheduling and finding transportation to doctor's appointments
4. The looming physician shortage

Low health literacy: Silent killer

Health literacy is generally defined as the ability to obtain, read, understand and use health care information in order to make appropriate health decisions and follow instructions for treatment. Different organizations have been measuring health literacy for decades. While there are differences in measurement techniques, a clear trend has emerged: U.S. adult health literacy is low overall, and it has not improved since measurements began.

Today, as in the past, health literacy experts say about one-third of American adults score low in health literacy, while about 10 percent would be considered experts. The rest fall somewhere in between. A national survey by the U.S. Department of Education said 88 percent of U.S. adults do not have the health literacy skills needed to manage all the demands of the current health care system.

Low health literacy, like the flu, affects everyone. Although it is sometimes associated with lower levels of education or certain demographics, those with college degrees, and even those in the health care profession, suffer as well. For an employer, it is best to assume your workforce's overall health literacy is low.

What are the general outcomes of low health literacy? The National Institutes of Health says those with inadequate health literacy:

- Make less frequent use of preventive services
- Have a higher chance of taking medications incorrectly
- Exhibit poorer control of chronic conditions
- Experience more emergency room visits and hospitalizations

Dr. Lisa Fitzpatrick, a noted health literacy expert, thinks health literacy in America is even worse than we think. "The average health literacy is a lot lower than what we document in the literature," she says. "We don't have good measures of it and the measures we have don't reflect the lived experience."

HEALTH CARE ACCESS

The result: Most plan members struggle with even the most basic terms and concepts in their plans.

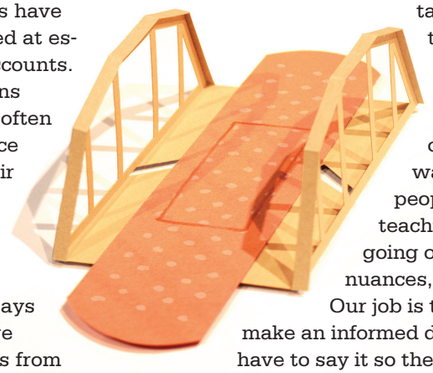
The cost of poor choices

High deductible health plans assume a high level of health literacy on the part of employees. HDHPs assume members will weigh every penny they spend and consider every medical treatment option when confronted with choices. Because the assumption is flawed, employees often make poor decisions based on their limited knowledge of how different kinds of medical care will affect their health in the short and long term.

A 2018 Accenture study of the costs of low health literacy ("The hidden cost of health care system complexity") estimated the price tag at $4.8 billion a year in administrative costs alone. And much of that cost can be traced to poor decisions made by plan members during the annual enrollment period.

Studies suggest that one-third to one-half of employees choose a plan that does not meet their medical and financial needs because they do not understand the language used to explain the plan. Those who choose plans with health savings accounts have proven to be particularly challenged at estimating funding levels for their accounts.

When plan members choose plans that don't match their needs, they often fail to access care that would reduce their overall costs and improve their health, eventually accessing much more costly services like the ER and hospitalization downstream.



Umair Khan, vice president, solution marketing for Accolade, says his firm's products and services are designed to support plan members from enrollment through plan utilization. Accolade's plan member support services include in-depth guidance through the enrollment process by Accolade staff and technology; the use of everyday language descriptions of available benefits; and conversations about treatment options with nurses. Harnessing Big Data, tutorials and advice nurse services are based upon data from billions of bits of claims data.

"For the average plan member, it can be a mystery as to what's in your health plan. And then you have other benefits offered by independent companies. It's incredibly difficult for most everyday users of health plans to understand and use them well. We help people understand all their benefits."

More plans today include telemedicine services, but if the plan members do not understand when and how to access those services, their experiences won't be positive, and they'll stop using them— if they even access them to begin with.

Accolade's services include explanations of how to best use such benefits. At the same time, Accolade can review workforce claims and tell employers which benefits are being used, and which aren't. Plan design then becomes an ongoing process, not a once-a-year ritual based mostly on the cost.

Services like Accolade focus on interpreting plan benefits for members and guiding them through treatment options. Fitzpatrick—known as "Dr. Lisa"—dedicates her time to working with insurance and medical providers to translate their instructions to consumers into common language. With her company Grapevine, she consults with health plans to help them break the communications barriers with patients.

She says that because medical professionals don't take the time to explain the relationship between drug adherence and improved health, many consumers stop taking their prescription medications—especially if the drugs "didn't make them feel any better."

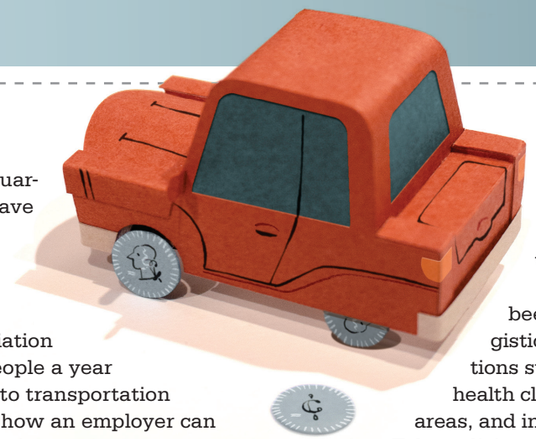
"We tell them, 'Do this,' but we don't say why. Health literacy is not going to change until the way we train medical and insurance people changes," she says. "We are teaching medical jargon. No translation is going on so that they can learn about the nuances, or how to approach a population. Our job is to help people understand how to make an informed decision to assess the risk. But we have to say it so they can hear and understand it."

Logistics: Getting there is half the battle

Logistics is an obstacle to timely access for appropriate medical care employers could address. But many underestimate the difficulty involved in scheduling and getting to a medical appointment.

Most medical clinics continue to maintain daytime office hours, disregarding the inconvenience this imposes on working patients. And if employees have their pay docked for leaving work to see the doctor, they are less likely to get the care they need when they need it.

But that may be changing. As more employers move to one lump sum of paid time off, medical appointments can be scheduled during the day. Recent studies indicate about three-quarters of large businesses have moved to a PTO model.



Transportation to appointments is also related to scheduling. The American Hospital Association reports that 3.6 million people a year neglect medical care due to transportation issues. But it is less clear how an employer can address the transportation issue.

Meanwhile, the long-forecast physician shortage represents the third component of the logistics of medical care. If, as predicted by the Association of American Medical Colleges, the U.S. is facing a 122,000 gap in number of physicians versus demand for services by 2032, both employees and employers will feel the squeeze.

Health care organizations have been gradually addressing the logistics gaps in access through innovations such as longer clinic hours, retail health clinics scattered throughout service areas, and increased telemedicine services.

Telemedicine and other remote health care service providers have made inroads with employer sponsored plans, but online and real time telephone and Skype advice lines cannot replace face-to-face time with a medical professional.

How skin-in-the-game plans can undermine employee health

Skin-in-the-game plans have been promoted by insurers as a way to contain cost increases for employers. But in most cases, employers still pay more each year for high-deductible coverage plans. Meanwhile, the overall health of their workforce deteriorates as plan members, discouraged by their skin in the game, forego routine medical care.

Innumerable studies support this scenario. The Los Angeles Times and the Kaiser Family Foundation collaborated on a May 2019 nationwide poll of individuals covered by employer sponsored health insurance. In its report, the Foundation said, "The experiences and attitudes of people with employer coverage differ vastly depending on whether they are in a higher or lower deductible plan. The higher the deductible, the more likely an individual is to have negative views of their health plan, and the more likely they are to experience problems affording care or to put off care due to cost."

In a separate report, the Kaiser Family Foundation said: "Four in ten [of those surveyed] report that their family has had either problems paying medical bills or difficulty affording premiums or out-of-pocket medical costs, and about half say someone in their household skipped or postponed some type of medical care or prescription drugs in the past year because of the cost. Seventeen percent say they've had to make what they feel are difficult sacrifices in order to pay health care or insurance costs; for some, the sacrifices they report making are extreme."

A 2019 study by the Commonwealth Fund found the fastest growing segment of underinsured Americans are those covered by health insurance through work.

"Of people who were insured continuously throughout 2018, an estimated 44 million were underinsured because of high out-of-pocket costs and deductibles," the study said. "This is up from an estimated 29 million in 2010. The most likely to be underinsured are people who buy plans on their own through the individual market including the marketplaces. However, the greatest growth in the number of underinsured adults is occurring among those in employer health plans."

A 2018 study of patients with Type 2 diabetes revealed that, once a copay hits $10, a high percentage of those with insurance stop filling prescriptions for medications proven to arrest or even reverse the disease.

Researchers wrote: "This study investigated whether the price the patient paid for their pills was linked to whether they took their pills as their doctor ordered or stopped taking them. The results showed that people who had to pay more money for their brand name pills did not take them as their doctor ordered or stopped taking them. This did not tend to be true if the pills cost $10 or less." Even at this low copay level, if the plan member's cost hit $10, adherence plummeted.

A 2016 study of high-deductible health plan members by Harvard University and University of Southern California researchers confirmed the link between cost-shifting and lower utilization. "High-deductible health plan enrollment is associated with lower health care spending. However … these savings are primarily owing to decreased use of care and not because HDHP enrollees are switching to lower-cost providers."

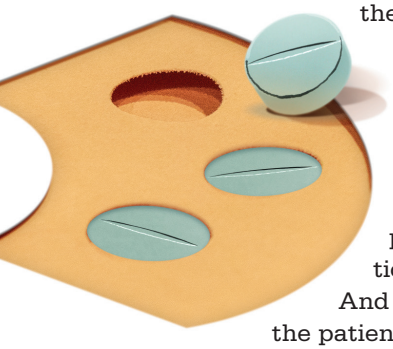
More troubling still are consistent reports that high-deductible plan members often forgo medical treatment covered by their plan due to worries about an unexpected medical bill.

"The second most common misconception we encounter with new plan members is not knowing what is and what is not covered in the plan," says Umair Khan, vice president, solution marketing, Accolade. "As the services become more specific, that's where a lot of confusion exists. People think, 'I have insurance, it should cover everything.' But there are a million types of member needs, and most people have a very limited understanding of what's in the plan itself."

By far the most powerful logistical solution for employers is the onsite, or employer-owned, clinic. These clinics are springing up around the nation, with some housed within the brick-and-mortar headquarters of large organizations and others located nearby. Increasingly, employers (especially small to mid-sized ones) have banded together to share a plan members-only clinic.

These clinics not only address the convenience issue, but the physician shortage crisis. Employers hire medical staff for the clinics, thus securing medical professionals whose hours and skills are only devoted to plan members.

In an interview last year with BenefitsPRO, Dr. David Claud, chief medical officer of onsite clinic provider Activate, explained the value of such clinics.



"The onsite clinic model has several advantages to the employer. The patient population is well defined. You have a clinician assigned to a specific population, and that is helpful because when the clinician knows who is in the population, it opens the way for questions that an employer wants to know. And then you can answer the question, 'Are the patients getting high quality care?'

"One of the key barriers people face is a long wait when they go to a doctor. If they are waiting three or four weeks, at that point the patient's concern is either gone or it has progressed. If it progressed, they have to go to urgent care or the ER. The onsite model gives the purchaser the knowledge and assurance that people have access in the way that they want it, usually the same day or the next day.

"When you know your exact population, the purchaser can say, 'What percentage of diabetes patients became controlled after their diabetes was uncontrolled? How many stay controlled? Did they get better or not?' With a defined population and a medical group responsible for their health, you can ask those questions."

In health care, delayed access easily translates into no access at all when someone is ill. Can all employers afford to set up, or be part of, a clinic for employees only? Of course not. But for those with the resources, the more appropriate question may be, can they afford not to consider such a clinic?

Increasingly, we are learning that unfettered access to appropriate medical treatment at the appropriate time saves on sky-high insurance claims down the road. It also promotes a healthier workforce that is more productive.

Employers and their benefits advisors may not be able to remove all barriers to access, but they should remove the ones they control. And they should be part of the discussion for removing the ones they do not control, but that directly affect the health of workers.

6 steps to support health literacy at work

Anthem Insurance Companies explored the devastating ramifications of low health literacy in America in a 2018 post, "Improving Health Literacy to Boost Employee Wellness."

Anthem noted that low health literacy not only discourages consumers from accessing services that would improve their health, but leads to poor choices when they do seek care.

"The more employees use unnecessary medical services or fail to manage chronic conditions, the more costs go up for everyone involved," Anthem said.

After enumerating many of the causes and effects of poor health literacy, it offered six steps employers can take to address this crisis in the workplace.

1 Provide detailed explanations of benefits in multiple formats. Provide resources that explain in detail what copays, deductibles and out-of-pocket limits are, and explain how people can get billed for unexpected costs. Try offering printed resources, emails and videos.

2 Share easy-to-understand information. Medical information can be complicated and packed with jargon, so share information from reputable sources that uses plain language.

3 Include translations. Many websites offer information in both Spanish and English. If applicable, share Spanish resources with employees.

4 Use picture-based information when possible. This helps employees who have lower literacy skills or just a preference for visual learning. Share infographics as weekly health tips or in employee newsletters.

5 Host seminars or "lunch and learns." Invite experts to speak about specific health topics at work. Consider having an HR representative give a presentation about benefits and explain common health plan terminology. Allow plenty of time for questions at these events.

6 Give them tools. As much information as you give employees, they're going to do their own research online, too. Arm them with a trusty health care glossary for quick reference.