

**Health Insurers Addressing Social Needs:
Opportunities for Effective Social Spending and Returns on Investment**

by

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Abstract

Unmet social needs pose a widespread and expensive detriment to the health of every individual. These social factors that influence health are not sufficiently addressed by the United States government, leaving health insurers with the task to meet the needs of their members. These win-win relationships of offering programs that meet members' needs while realizing a health expenditure saving can be coined as the 'social impact' business model. Rising in popularity across the country, this model allows insurers to move beyond care management and have more control over their margins and the health metrics of the members they serve. Savvy health insurers are offering a variety of programs like housing assistance, transportation, food, and benefit enrollment assistance to harness the cost savings of these unmet needs that contribute to the disproportionate health expenses of the United States compared to peer nations. Many of these programs can be funded by existing tax incentive programs for providing community resources, making them a low cash investment and high reward option for participating insurers. Using these programs as a business strategy is the future of health insurance and a symptom of the increasing amount of responsibility that government agencies are placing on private companies that administer their programs. To stay competitive, health insurers should assess the social needs of their members and implement evidence-based assistance programs to promote whole-person well-being.

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Preface

The content of this essay builds upon the goals and purpose of work I conducted at the UPMC Health Plan Center for Social Impact (CSI), where I began my MPH Practicum experience in January 2022. Being a member of the CSI exposed me to the various ways that a health insurer can make an impact on health through addressing social factors in the lives of members and participants. Specifically, my work focuses on addressing food insecurity across our membership through SNAP enrollment, mobile grocery access, and a food as medicine pilot targeting HbA1C in Type 2 diabetics.

The barrier I have witnessed most in this work is sourcing funding and establishing a financial return on investment on a case-by-case basis for social need interventions. This essay strives to explain how and why the economic rationale for funding social need programs for insurance members is a best-practice business strategy. Further, this essay argues that these social programs represent a unique business opportunity in a highly competitive and regulated industry.

I would like to thank my essay advisor, Eric Roberts, and all of my professors, co-workers, mentors, family, and friends who have supported my career long passion for public health. Specifically, I would like to thank Ray Prushnok and Dan LaVallee for giving me the opportunity to enter the health insurance industry while still pursuing my degree and affording me the opportunity to design, implement, and evaluate programs that address SDOH. I would like to dedicate this essay to my mother and father who have loved and supported me through every endeavor, passion, and interest throughout my life and academic career.

1.0 Introduction

The World Health Organization defines health as “a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity (WHO, 2023).” When this understanding of health was first articulated by the World Health Organization in 1948, it was initially thought to be ahead of its time. Prior to this, health was often defined solely as the state of not being sick. If one was able to function in daily life and not require treatment of any kind, they were healthy. However, this circumscribed definition of health did not consider the social, environmental, and economic determinants of health. Today, we recognize that these factors contribute substantially to health, yet health care systems are still configured primarily for treating health conditions rather than addressing the social, environmental, and economic causes of these conditions. When the gains from clinical health innovations plateau due to diminishing returns, the next step to revolutionize the improvement of health is to treat social needs with the same level of importance as health conditions. Health insurers can advance these goals by embracing the social impact business model.

Social needs have a vast impact on healthcare, both in the wellbeing of people and the costs of their health care. Unaddressed needs can impose a substantial burden on communities and the economy. Approximately 18% of the United States’ GDP, or \$12,941 per capita, is spent on health care each year (National Health Expenditure Accounts, 2022). Research has begun to estimate the health care costs that are attributable to specific social needs. *Table 1* highlights some of the cost of care implications of most common social needs.

Table 1. Health Cost Burdens of Common Social Needs

Health Cost Burdens of Common Social Needs			
<i>Social Need</i>	<i>Attributed Health Costs Per Person</i>	<i># of Population Members Affected</i>	<i>Total Additional Cost to the Government and Insurers</i>
Housing	Risk adjusted \$4,386 more spent annually on homeless individuals compared to Medicaid averages (Koh, 2020)	582,462 homeless Americans in 2023 (Security, 2023)	\$2,554,678,332 annually due to homelessness
Food	\$1,400 more spent annually on Medicaid members not enrolled in SNAP compared to those who are enrolled (Carlson & Keith-Jennings, 2018)	6,333,000 Americans eligible for SNAP but not enrolled (Foster et al., 2021)	\$8,866,200,000 annually due to food insecurity
Employment	Unemployed workers spend \$3,200 more annually on health than employed workers in the same demographic (Goodman, 2015)	6,011,000 Americans unemployed in 2022	\$19,235,200,000 annually due to unemployment
Total Cost:			\$30,656,078,332
Potential National Healthcare Spending Reduction			.0713% or \$92/ per American

In light of these substantial expenses, developing programs to address SDOH is not just suggested but essential for a sustainable future of healthcare. Understanding the need for social programming is not new, with CMS first encouraging spending on transportation needs during Medicare and Medicaid’s infancy in 1966 evolving to an understanding of the health impact of countless social needs today. This essay will outline how health insurers have implemented an SDOH focus into their operations and identify the benefits of expanding SDOH programs and resources into their business strategies.

2.0 The Past Approach to SDOH

One of the earliest investigations of the correlation between social factors and health was conducted in 1967, when civil servants in the United Kingdom were grouped by socio-economic status (SES) and health outcomes of different socioeconomic groups were compared (Marmot et al., 1991). That study found a clear relationship between higher SES and more favorable health outcomes. These findings launched studies of what we know today as the social determinates of health (SDOH). SDOH are defined by the US Department of Health and Human Services as ‘the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks (US Department of Health and Human Services, 2020).’ Succinctly, every component of an individual’s life has the potential to affect their health. With this understanding, one of the most powerful ways to improve health status would be to provide resources that improve these social factors, particularly for more disadvantaged groups who may benefit most from such investments. This may lead to external parties to work to improve SDOH. But the question remains: which parties have the greatest vested stake in the health of individuals and are willing to take on this work?

The logical first thought would be the government. Many other developed countries have taken a robust SDOH approach to social programming. The United Kingdom established the National Health Service to provide healthcare services to all people, eliminating the barrier that cost of care poses to maintaining health. In Sweden, homelessness has been addressed through a social security style program where housing vouchers are given to all citizens who cannot afford shelter independently. This has nearly eradicated homelessness and the negative impact that the

unmet need of housing can have on health expenditures and service demand nationwide. The longstanding existence of these programs in other countries paired with the absence of such consistent national strategies in the US, could easily be understood as why the United States falls behind on social statistics, like poverty rates, and way higher in healthcare expenditure per capita compared to its peers.

In the United States, addressing multifactor social needs involves local, state, and federal policies and funding public programs. Many programs exist with the focus to address social needs like the Supplemental Nutrition Assistance Program (SNAP), Housing and Urban Development (HUD) vouchers, and Temporary Assistance for Needy Families (TANF). As of 2020, there are eighty-three documented social need-focused programs supported by the United States Government spanning eight different categories of assistance (SMG, 2022). With the exclusion of federal contributions to Medicaid spending, these programs cost \$380.3 Billion in 2020 alone. Distributed across the 37.2 Million Americans who meet the definition of living in poverty, this is around \$10,200.00 of spending per person annually on social programs not including health care (Congressional Research Service, 2022). This metric does not include the amount of money each state spends on providing additional programs to their citizens.

The spending on government social programs rises each year with the hope that funding programs to improve quality of life for low-income populations has the potential to reduce an individual's need for assistance in the long term. The discussion of why a government may fund these programs is controversial, but the two main arguments fall between a representation of national values and the economic benefit of a healthy, working, population. Despite high levels of spending on social programs, a high burden of unaddressed social needs remains, and the capacity to finance additional programs is limited. With governmental efforts facing barriers in tackling the

inter-related health and social needs of Americans, the cost and responsibility of meeting social needs falls on the next most vested party in the wellbeing of every individual. In the unique environment of the United States healthcare structure, this party is the health insurer, specifically those who offer Medicare Advantage plans and other government products. To understand why the health insurer is next in line to assist in meeting social needs, it is essential to understand why health insurers were established and how the health insurer business model is structured.

3.0 The Establishment of Health Insurance

At the turn of the 20th century, the system of health insurance in America began to take shape as a mechanism to ensure workers could pay for medical bills related to on-the-job injuries. In response to poor margins in during the Great Depression, hospitals sought opportunities to stabilize their income by charging a monthly fee in exchange for guaranteed care at that facility. Taking this further, these arrangements expanded to guaranteed coverage of inpatient care at any facility, catching the attention of the American Hospital Association. Shortly after, Blue Cross Commission was established following WWII which provided this style of coverage in distinct geographic regions to promote community health and welfare. Charged with the influence of unions on employee benefits and the innovation of various iterations and structures of coverage plans, by 1965 nearly three quarters of the United States population had health insurance (Morrisey, 2014).

The Social Security Act championed by presidents Truman and Johnson eventually established the largest components of our present-day health public health insurance system: Medicare and Medicaid. The Medicare product is comprised of four components to serve those age 65 years and older as well as the population of Americans with long term disabilities. At its core, Medicare covers the components of care that have historically been challenging to finance for retired and unable to work populations like hospital care, surgery, skilled nursing/home care, and laboratory services. Part B extends this coverage to outpatient care like primary care visits, preventative screenings, and some mobility device needs (*What Medicare Covers*, 2023). Medicare Part D, the most recent element to be added in 2006 covers prescription drugs.

The unique element of Medicare is known as Part C. This part allows for eligible members to elect into Advantage Plans hosted and managed by private insurance companies. These plans combine the guaranteed coverage of Part A and Part B for better care coordination and ease of membership. Since Part D was added, these Advantage Plans also provide varying levels of prescription drug coverage as well as options for vision and dental. Other than these guidelines set by Health and Human Services, payers offering Advantage Plans have autonomy to provide different benefits, offerings, and payment systems to attract members. There is constant competition between these plans to offer lower cost-sharing, more provider choice, and supplemental benefits that appeal to consumers (HHS, 2021).

While Medicare is a Federal insurance program, Medicaid is a state-administered insurance program, paid for through a mix of state and federal funding sources. As a baseline, Medicaid is an insurance product for low-income Americans, children, pregnant women, and adults living with disabilities, specifically those requiring long term care. The biggest variance in Medicaid coverage is between states who have and have not undergone Medicaid expansion since the initiation of the Affordable Care Act in 2010 (Rudowitz & Garfield, 2019). Medicaid beneficiaries receive covered benefits with little or no premiums and cost sharing. As of 2023, thirty-nine states have adopted this legislation to create a new Medicaid expansion pathway for nonelderly adults, which serves people making \$20,120 or less annually. The Affordable Care Act (ACA) also established an individual insurance marketplace where people can purchase subsidized private insurance (KFF, 2023). Regardless of state variances resulting from waivers and legislation, Medicaid services improve access to care for those who cannot afford coverage in traditional insurance markets, do not have access to insurance as a benefit of employment, and cannot afford the high out of pocket costs associated with American healthcare (KFF, 2023).

4.0 The Business of Health Insurers

Today, the public and private components of health insurance coverage have converged, allowing health plans to offer both private and government funded insurance products based on regional care needs and resources. Like Medicare Advantage Plans, the majority of Medicaid enrollees—about two in every 3—receives their coverage through a private insurance company. These Medicaid managed care plans cover most or all Medicaid benefits for enrollees, which are financed by premiums paid to private insurers by state Medicaid administrators. This means that, just like a private plan, payers have the opportunity for a profit margin in providing these Medicare and Medicaid plans, so long as the total cost for their population does not exceed the expense of providing care (Rudowitz & Garfield, 2019).

Medicare Advantage Plans and Medicaid managed care plans represent not only an opportunity for payers to realize profits through efficiencies, but also a method for state and federal governments to delegate risk and responsibility of administering public insurance products to private companies. This allows for more of the government funding to go directly toward the cost of care instead of administration costs. These insurers have an incentive to manage health care costs. Covering a large population of individuals also reduces financial risk to insurers through averaging costs across all members, known as pooling. Further, when the private insurer saves money, so does the government entity financially responsible for the insurance program.

The United States has the highest healthcare spending per capita in the world at a rate of 18.3% of the annual GDP or about \$13,000 per capita annually (National Health Expenditure Accounts, 2022). The lucrative characteristics and promising future spending in this industry makes it highly attractive for private business following the capitalist economic structure. This

appeal has led to one of the United States economy's most competitive industries, with over nine hundred individual firms in the insurance sector alone forming several nationwide insurance conglomerates (Collective Medical, 2023).

In a rudimentary perspective a business either offers goods or services in exchange for a fee. It is debatable which of these, if either, health insurance can be categorized as. Calling insurance options 'products' allows consumers to view them as such. This is framed as a tangible 'package' that one pays for coming with different benefits and features based on price. Here, the main good can be looked at as a coupon or voucher for health care when you need it. On the contrary, health insurance can be considered a service where you, or the government on your behalf, pay for mitigated risk against medical expenses. Instead of having to estimate and budget for costs that the uncertainty of health can bring, the insuree assumes this risk for you or for the government on your behalf based on the fee. The price you pay is the amount you are willing to pay in avoidance of medical cost risk. The mechanics of health insurance lie in the concept of pooling risk. If you have a group representative of the population's variability, you can expect some will consume a large amount of care, not will consume an average amount, and the others will consume a low amount. Having this 'pool' on individuals as an insurer allows you to defer the expense of high-cost members onto those who consume much less than the value of their premium.

After the initial establishment of health insurance to promote healthcare and incentivize employment, those in the business began to focus on ways to reduce their pool's cost of care, while maximizing their premium revenues. Logically, they first sought to exclude individuals who have pre-existing health conditions, are older, and live in environment or belong to a demographic where there is a greater risk of poor health. Fortunately for these individuals, Section 1552 of the

Affordable Care Act established that these mechanisms of pool manipulation are both unethical and unlawful (Office for Civil Rights, 2023). While taking on the responsibility of Medicare and Medicaid members the health insurance industry fully embraced the idea of care management as a cost saving mechanism.

Care management can be defined as a team-based approach to coordinate the health care needs of and services for an individual with the assumption that coordination of care leads to higher rates of preventative care and care adherence (Harrison et al., 2018). The evidence of care management's success is unclear but this unreliable financial return is not enough to discount the value of care management, as quality is a key metric of evaluation in insurance contracts and a way for organizations to compete for enrollees in our present-day health insurance market.

As of 2022, only 2% of the entire US population has access to only one health insurance provider option (Carlton et al., 2022). This high level of consumer choice leads a competitive industry where there are 831 health and medical insurance businesses operating within the industry's \$1.2 Trillion annual revenues (IBIS World, 2023). Insurance as a product is also expansive with an all-time low of the uninsurance rate of all ages, leaving only 8% or 26.4 Million Americans without insurance in 2022 (Lee et al., 2022). This uninsurance rate continues to steadily decrease over time, accelerated by milestone legislation like the Affordable Care Act, and, more recently, the American Rescue Plan passed at the beginning of the Biden Administration. This enrollment stability and legislative support continues to make the insurance industry increasingly attractive industry for key market share holders like UnitedHealth, CVS Health, and Anthem is predicted to grow industry revenue by 0.9% in 2028.

5.0 Moving Beyond Care Management

Such competition has continued the focus on care management to maintain membership through value and quality. Industry experts estimate that health insurers spend nearly 10% of their administrative costs on care management (Bestsenny et al., 2021). This prioritized service is targeted to specific high cost, high utilization members. For most of these members, the health insurer has maximized the possible cost benefits of care coordination activities. Given the challenging dynamics of member needs and limitations of care coordination, the next step to reduce per member expenses is to begin managing resources beyond clinical care. This realization is pivotal in shifting health insurance companies to focus on SDOH by providing programs and resources to meet social needs of members. Recognizing that improving one's social wellbeing can improve health, and thus reduce health expenses throughout a lifetime, is a valuable business strategy for payers that offer Medicaid managed care and Medicare Advantage Plans to adopt.

The attempt to increase profit margin past the industry average of 8.3% is most challenging for health plans that offer government insurance products including Medicare Advantage plans (IBIS World, 2023). Given the bargaining power these government has over capitation and reimbursement rates for these products, innovation in reducing per member cost is much more important for their business models. Not only this, but those on government insurance plans are also the same population that experiences social needs and disparities at the greatest magnitude. A study conducted in 2020 concluded that 20% of adults surveyed who were enrolled in Medicaid self-reported that they are food insecure (Hall & Artiga, 2020). Further, in June 2021 9.9% of Americans over the age of 65 reported being behind on rent, making them housing insecure and at risk for eviction (Pagaduan, 2021). These are just a few examples of why addressing social

determinants in Medicare Advantage and Medicaid managed care plans has a high potential impact.

The decision for an insurer to make business investments that address the social needs of members, regardless of the product, depends on the insurance business model and on organizational values. These organizations have a similar opportunity to gain profit margin with social needs programs to the extent these programs help manage enrollee health care costs; but it is also a way to fulfill philanthropic missions. These programs targeted to benefit members can bridge relationships between the payer and the communities they serve. Often, these social programs lead to partnerships to support community organizations, schools, and government benefits that help improve population health across the entire pool of membership. For payers that have a mission of leading people to their best life, social needs programs are an avenue to have this claim be credible and garner membership because of it.

In addition to the opportunity to fulfill their mission beyond core insurance product offerings, many payers are beginning to experience varying levels of requirements for member-facing SDOH programs. In 2021, CMS released its first guidance to payers on addressing social needs as part of what it means to provide value-based care. Moving away from fee-for-service arrangements towards value-based care, or value-based agreements within insurers networks, may provide physicians with the flexibility and impetus to address social factors during care. Specifically, CMS issued the requirement that “states must assess all available public and private funding streams, including Medicaid, to cover assistance with unmet social needs such as housing, nutrition, employment, education, and transportation when developing a strategy for addressing beneficiaries’ SDOH (Costello, 2021).” This opens states to the ability to leverage Medicaid and

CHIP funding to mandate that insurers with Medicaid managed care contracts offer social needs programs.

On the Medicare front, much earlier measures have taken place to encourage the expansion of social need resources for all members. In 2016, the Medicare Regulations and Guidance Manual outlined the new extended benefits that Advantage Plans can offer (CMS, 2016). These options outlined the ability to offer transportation services, home modifications, education and condition specific counseling, and telemedicine equipment resources. Most notably, the document outlined the specific parameters for meal benefits, focusing on member populations that are post-acute and/or diagnosed with a chronic condition that can benefit from medically tailored meals. Beyond these regulatory parameters, CMS has continued to release frameworks and guidance on how payers can address SDOH with a lens of health equity improvement (CMS, 2023). This work was been further propelled by flexibilities granted by the CHRONIC Care Act of 2018, which permitted Medicare Advantage plans to use premium dollars to finance benefits such as new models of caregiving, home modifications, and other non-medical health resources (Hostetter & Klein, 2020). These approaches combined have led to a national increase of data collection, resource referrals, and evaluation analyses conducted by Medicare Advantage payers (Better Medicine Alliance, 2021).

6.0 Financing Opportunities for Social Needs Programs

Recognizing that most payer organizations, even those offering government insurance products, are for-profit organizations, these SDOH guidance implementations have been carefully designed and financed to align with financial goals. Tax credits are a popular mechanism of financing payer-run programs focusing on social needs of membership populations. Using Pennsylvania as a case study, the State’s Community and Economic Development has upheld the Neighborhood Assistance Program since 1967, offering Pennsylvania business opportunities to reduce their tax obligations through donations that support the needs of their communities (Rendell, 2011).

Table 2. Pennsylvania Neighborhood Assistance Program Tax Credit Types

Pennsylvania Neighborhood Assistance Program Tax Credit Types		
<i>Name</i>	<i>Requirement</i>	<i>Tax Credit Benefit</i>
Neighborhood Assistance Program (NAP)	Funding goes towards affordable housing programs, community services, crime prevention, education, job training or neighborhood assistance (conservation).	55% of the donated amount
Neighborhood Partnership Program (NPP)	Five plus years of financial support combining business, government, and community efforts to a comprehensive community development plan.	75-80% of the donated amount
Special Program Priorities (SPP)	Helps in targeting specific programs and problem focuses outlined by the state’s priorities.	75% of the donated amount
Charitable Food Program (CPF)	Funding to reduce food insecurity by providing food to low-income populations	55% of the donated amount

Source: (DCED, 2021)

Traditionally, these funds have been used for local infrastructure and revitalization plans, assistance to charitable organizations, and supportive contributions to larger philanthropic initiatives. In recent years, participating in this tax credit program has allowed payers to create strategic relationships with community groups where funding can be targeted to organizations that serve communities with high membership density or can fulfill a common social need that the payer does not have resources to do themselves. The relationships built through this strategic giving also provides payers with influence on future community programs, which has led to many initiatives that focus on SDOH. These funding opportunities are not unique to Pennsylvania, with similar tax credit opportunities in Ohio, Indiana, Missouri, Delaware, and Virginia to name a few (Virginia DDS, 2017).

Another financing mechanism that payers can leverage to support social needs programs are those focusing on education. In Pennsylvania, this tax program is called the Educational Improvement Tax Credit Program (EITC). These donations can be given to organizations that provide scholarships or education beyond the school system. Recognizing that ‘education’ is a broad form of outreach, this funding can be leveraged to go towards health-related education programs that meet clinical and social needs. Examples of this are diabetes management education, health literacy, insurance literacy, and healthcare workforce trainings. Organizations that participate in the EITC program can receive a tax credit equal to 75% of their contribution up to contributions of one million dollars or 90% of the contribution amount if the funding agreement spans two or more years (DCED, 2021).

The federal government has also made commitments to equitable contracting. Prior to 2021, the guideline of 5% of government contracts going to Small Disadvantage Business was established to uplift minority business owners for the benefit of the economy and equity in

business. Specifically, these qualifying businesses must be owned by minorities or women. In December of 2021, the Biden Harris administration raised this guideline to 15% of federal contracts by 2025, focusing on the short-term goal of 11%. Given that both Medicare is fully and Medicaid is partially funded by the Federal government, these expectations apply to insurers that offer government insurance products. In meeting these expectations, insurers are encouraged to contract with local companies that offer unique sets of services like home modifications, assistance enrolling in other benefit programs, and meal services. In turn, supporting these businesses through contract agreements circulate more money in local minority communities which can benefit the health of members. These contracts, similar to NAP and EITC agreements, can be leveraged to focus on programs that address social needs that the organization cannot meet internally, while accomplishing requirements (The White House, 2021).

Beyond explicit Federal and State tax and diversity programs that can be leveraged to fund social programs for members, payer organizations can also build these SDOH programs into their traditional philanthropic efforts. Not only can this aid mission fulfillment, but philanthropic activities that address the social needs of members can also generate positive returns in terms of the satisfaction of members and the payer's workforce. Visible community contributions can positively contribute to members perception of their insurer and build stronger relationships with key community figures and local government. These efforts can also increase employee satisfaction and retention, as many workers take pride in the good deeds of their organization (Page, 2022).

7.0 What is “Social Impact”

The management of these financing mechanisms and social programs is defined differently in every organization, with a popular term for the work being coined as ‘social impact’ or ‘corporate social responsibility.’ It has become the insurance industry norm to dedicate resources to this focus with major organizations like Kaiser Permanente, Aetna, and UnitedHealth all having specified programs for social needs-related work (Kaiser Permanente, 2019).

As a newer term, the definition of ‘social impact’ is up for deliberation. Some define it simply as “a significant, positive change that addresses a pressing social challenge (Moudgil, 2014).” Other academic bodies use a more detailed lens, defining it as ‘any significant or positive changes that solve or at least address social injustice and challenges. Businesses or organizations achieve these goals through conscious and deliberate efforts or activities in their operations and administrations (Mitchell, 2021).’ Regardless of the definition positive results come from organizations of any sector focusing on social impact. Uniquely, the health insurance industry is a business sector that disproportionately benefits financially from SDOH programming, as any reduction in inequities can have a positive impact on the focus individual’s health at some point throughout their life. This industry focus could easily be viewed as an effort of last resort, trying to reach individuals who the formalized social service safety net has failed to reach before their health status deteriorates permanently.

To offer perspective, some regions have attributed an average of \$9,800 more or a ratio of 2.48 times greater expenses for individuals experiencing homelessness compared to a typical Medicaid enrollee, showing that insurers have the most to gain from addressing a need such as housing (Koh et al., 2020). As established earlier, an individual’s health insurer is the most

invested party in their physical wellbeing beyond themselves and falls in line after the government when placing importance on social wellness.

A wise health insurance company should recognize and define ‘social impact’ on the following three elements. First, and reflective of a traditional definition, social impact is an opportunity to introduce solutions for the cause of equity and societal benefit. Second, it is a way in which an insurer can target the needs and inequities faced by their membership populations. This can be determined based on enrolled insurance product, demographic, or region. But last, and most importantly, health insurance organizations should view social impact as a core business strategy to control profit margins through the reduction of member costs. This means that health insurers can introduce programs through the social impact model and philosophy that target pain points of their members that have an influence on health and healthcare spending. Not only can these social programs administered by the payer uplift communities, but they also create a healthier membership pool that is in turn more profitable for the insurer to cover.

8.0 Implementing the “Social Impact” Business Strategy

Once social impact is recognized as a business strategy, the initial step of implementation is choosing a population and program of focus. Sometimes this makes sense to do based on geography, such as providing transportation services in a rural region or telemedicine equipment to members who do not live near certain specialists. Other times, these member populations can be defined by demographic variables such as age, race, or more specific categories, like an area deprivation index. It is also critical to consider the excess health expenditures of these population groups and how much research shows those expenses can be reduced by programmatic intervention. The challenge with these approaches is that these regions and demographic span insurance products. This not only makes impact and cost evaluation for these interventions challenging, but it assumes a one size fits all approach is appropriate in the environment of the ever-changing rules and regulations across the health insurance industry and specifically with government insurance products.

Narrowing a social program’s focus to one insurance product’s membership population allows the best advantage for identifying high-cost members of government insurance product members and the services they are using to design programs with the highest possible return on investment. To have such a return, members targeted by these SDOH programs should have room for improvement in their per member per month (PMPM) cost. Specifically, the best candidates for social impact are those who utilize care management resources and still have a PMPM that is higher than the rate at which the government reimburses the payer for their membership. Although a higher-than-average PMPM can be linked to acute care needs or having several conditions, many of these high spend individuals cannot have their surplus costs attributed to clinical factors,

meaning they can be reduced through more comprehensive social resources. This filter typically results in members that experience disability and chronic disease. Less expected, these higher cost members also tend to belong to minority and marginalized communities that consistently screen positive for health-influencing social needs, making them the easiest to identify as candidates for social impact programming since their current costs exceed per member reimbursement rates.

Designing and attributing value to a social impact program entails overhead cost within a payer organization to design the program and formalize partnerships with community groups and lines of business to make it operational. These costs certainly diminish in time as staff establishes program expertise and set-up costs can be distributed over a larger number of impacted members, but expenses to maintain a social program will persist for its entire duration. Because of this, the ‘low hanging fruit’ to benefit from these social programs are traditional insurance product members meaning those who are only enrolled in one insurance product. This produces the largest cohort of eligible participants without having to design decision points to accommodate more complex needs and financing structures. This makes programming for those eligible for several insurance products, and therefore several different 3rd parties with a financial interest in their cost of care, known as dual eligible members, more challenging to establish a return on investment for.

Regardless of the selected membership population, the most important element of using social needs programming as a payer business strategy is crafting an evidenced-base business case for each program. Understanding the services covered for the targeted population is the first step in discovering the business benefit to a social program. Pin-pointing areas of high cost and high utilization is the best way to select a program’s need of focus that can make a significant financial impact. A health insurer can reference studies on existing social needs interventions that have a proven impact on health care costs to estimate the anticipated ROI of their program, prior to

implementing the program themselves. Modeling after these studies that estimate health cost savings of social needs programming, like those presented in *Figure 1*, makes implementing new initiatives for new member populations much less risky. For interventions that have yet to be linked to health status and utilization, peripheral research can be used to support the cost-saving hypothesis but is certainly a riskier benefit.

Once the benefit of a social program's intervention is applied to the membership population of focus, payers must establish the scale of a program. Piloting these programs with small initial member cohorts makes corrections much easier and affordable to implement. Even with a cohort approach, a SDOH program's cost benefit should be measured by the total number of members it will serve. Multiplying the members serviced by the projected reduced utilization savings provides the payer with a breakeven point to work towards. At the very least, the cost to establish and maintain the social program should cost no more than this amount. Matching cost to this breakeven point is generally considered to be sufficient, knowing that social programs have non-financial benefits as well. However, payers who want to leverage these SDOH programs as a business strategy know that the less the program costs in comparison to its financial benefits, the more profitable it will make participating members for them.

In the assessment of program profitability, one key consideration is the timeline to realize these benefits. Programming targeting major health improvement or lifestyle changes may take several years to reach their projected annual savings results. Other programs may produce instant results that can be fully realized within the same fiscal year that the program was introduced to the participating member. Weighing the time to realize the health savings return on investment with the churn of the targeted membership population is a critical consideration to the social impact business model. With a pure focus on investment stability, members whose enrollment history

show allegiance to the payer administering the social needs program can be preferred, but from a population health model, broad program accessibility is key. Finding a balance between membership stability and time to realize benefits is one of the biggest challenges of this work.

9.0 Non-Financial Benefits

Cost savings on reducing the cost and quantity of member's care utilization is not the only return on investment that payer organizations should attribute to social needs programs. These non-financial ROIs center heavily around the public image of the payer organization. Innovative SDOH programs that meet a strong community need can generate positive press about the payer. This helps with public image but can also serve as an indirect advertisement to prospective members, attracting them to the payer knowing they have a focus on needs beyond health that said individual is experiencing. Advertising-like opportunities like positive press are extremely valuable for health insurers specifically, as there are several restrictions on marketing activities for government insurance products (OCR, 2016). Good public relations can also lend itself to member retention. Research focused on health insurers has linked a positive image and reputations with member satisfaction (Kautish et al., 2021).

It is also important to not overlook the value that community partnerships established through social needs programs can also bring to a payer. These relationships can expand a payer's access to opportunities like events, gatherings, social groups, and trusted representatives in the communities that they serve, creating a unique dimension of access to their members. Strong partnerships can let payers use community organizations as a conduit to reach their members with services that they might not otherwise be able to offer. This also extends the payers workforce to include the capacity of the community organizations, who often can provide a more detailed and relatable approach to outreach and services. Those who regularly engage with community groups have also established a level of trust that, through partnerships, payers can also leverage to provide more robust resources and facilitate a greater impact on the health of a member. Along with all of

these benefits is the overarching ROI of relationship building with all tiers of government who are also focusing on the work of these organizations.

10.0 Beginnings of the Philosophy

Although social impact is newer as an explicit approach to insurers meeting the non-health related need of their members, programs adjacent to health are not new to the health insurance industry. Dating back to the establishment of CMS in 1966, non-emergency medical transportation was a recognized need (Adelberg & Simon, 2017). This benefit was established to eliminate the barrier of transportation insecurity to primary care visit attendance and is arguably the first widely adopted social needs program provided to government product members by insurers. CMS recognized that the cost of providing a ride to the doctors was far less expensive than the health consequences of missed appointment- the exact same philosophy that programs addressing SDOH follow today.

If the philosophy of eliminating barriers to care resulting in better health outcome worked for transportation, it can work with addressing other needs as well. Today, one could argue that there is not a single social need that has not been linked as being a barrier to health. Government led social programs, community organizations, and some large payers have all participated in the effort of reducing social needs. The most common SDOH programs, other than transportation assistance, focus on health literacy, housing, workforce development, benefits enrollment, and food insecurity. Seen in the context of the widely-adopted theory of the hierarchy of human needs, the argument is that an individual cannot progress to the next level of needs until the foundational needs below it are met (McLeod, 2023). This is exactly what members experience when faced with social needs. One cannot worry about scheduling a primary care visit or getting a spot on their skin checked for cancer if they are focused on having a place to sleep or food to eat. Realistically, we cannot expect members to engage at all in their health until these needs are met.

11.0 Food as a Demonstration

Looking at the hierarchy, access to food, ideally nutritious food, is arguably the most foundational need that anyone can experience (McLeod, 2023). Nutrients are the building block to life and humans have a finite amount of time they can survive without access to food. However, more than 34 million Americans regularly experience food insecurity (Feeding America, 2023). Over a quarter of these individuals are under the age of eighteen. Due to the prevalence of food insecurity in the US, programs including the Supplemental Nutrition Assistance Program (SNAP) and the Supplemental Nutrition Assistance Program for Women, Infants, and Children (WIC) have been established at the Federal level to be administered by state governments. SNAP was first established as food stamps in the 1930's by the USDA and has since expanded to serve 12.5% of the United States population (USDA, 2019).

With government social programs falling short of meeting the nutrition needs of American's the health insurance provider is next in line to help people meet this need. Given the relationship that food and nutrition have on health, it is logical for health insurers to improve access to food in member populations (Berkowitz et al., 2019). Although varying by state, income eligibility guidelines for SNAP benefits are typically the same as Medicaid eligibility, yet SNAP has lower participation rates among eligible populations. With the higher level of engagement that insurers have with members compared to those just receiving benefits, the payer can be a much more impactful touchpoint for meeting the food needs of members. Understanding the impact and opportunities associated with food insecurity and government product members, programs with a food access focus are valuable demonstrations of social impact business model.

CDC studies have estimated that the health care costs per every food insecure adult is \$1,834 more annually than non-food insecure individuals of the same status (Berkowitz et al., 2019). Additional cost tied to food insecurity are often related to an increased prevalence in chronic disease, poor medication adherence, and a lack of consistency in preventative care (Howard Buffett Foundation, 2017). These adverse health effects are in addition to more direct concerns like nutrition deficiencies and malnutrition. This impact is only expected to increase with the current post-pandemic inflation, specifically related to the price of food, as mean grocery costs rose by 10% in 2022 (Filkins, 2022). As a prevailing issue with a high influence on health and health-related expenditures, organizations, including payers, across the country have successfully adopted the social impact business model to mitigate needs surrounding nutrition access and tap into the estimated \$1,834 annual saving per member once food needs are met.

During the 2022 White House National Strategy on Hunger, Nutrition, and Health, SDOH programs that use food as medicine were highlighted as an opportunity for Medicare and Medicaid payers to address nutritional and disease-related needs of members (Biden, 2022). These types of programs can be highlighted through 1115 waiver projects that serve as pilots for this work. Specifically, the Biden-Harris administration highlighted produce prescription programs (termed *Produce Rx*). A research team at Duke University is assessing the impact that \$40 of monthly free produce can have on food insecure populations (Ng, 2021). Early phases of the study have shown success in increasing participant's produce purchases, with the barrier of cost eliminated by the social program's model. Other long-term results on the health benefits of food security are anticipated to provide stronger evidence of a return on investment from food programs for health insurers.

The *Produce Rx* model is new, lacking comprehensive evidence on long-term investment returns. However, promising early results have already garnered wide scale adoption of these program models. One of the largest health insurers in the United States, Kaiser Permanente, has invested \$50 million nationally to test food as medicine programs, modeled off of *Produce Rx*, with the expectation that these investments will generate returns in the form of reduced health care costs. As of 2018, there were nineteen established studies evaluating the benefit of *Produce Rx* programs, consistently focusing on the benefits they provide to low-income individuals, like the Medicaid population, and how they can improve health while reducing costs (Swartz, 2018).

SNAP programs have been established across the country, yet the biggest barrier to their success is low participation among SNAP-eligible individuals. States like Wyoming, North Dakota, and Arkansas have less than 70% of the SNAP-eligible population using the resource, leaving 40-30% of their Medicaid enrollees—nearly all of whom are SNAP-eligible—without food assistance (Food and Nutrition Service, 2023). Recognizing their impact and already budgeted funding, payers have been leveraging SNAP as a resource for their members facing food insecurity. In 2020, the Humana Foundation funded efforts to facilitate SNAP enrollment for their eligible government insurance product members (Humana, 2020). Centene’s Center for Health Transformation has established a partnership with Feeding America to develop guidelines for SNAP enrollment assistance (Centene Corporation, 2021). These efforts highlight payers’ recognition that increasing SNAP participation is a valuable investment to make in members because doing so can help to address the health impact of food insecurity.

The UPMC Health Plan’s Center for Social Impact has partnered with regional food banks to complete targeted SNAP navigation for their members. Paired with local food pantry navigation, the work of these SNAP navigators can be expected to reduce food insecurity and engage members

by up to 30% more. On average, SNAP participants can realize health expenditure reductions of \$1,400 annually (Carlson & Keith-Jennings, 2018). The sustainability of SNAP assistance programs is impressive, with a one-time price per assisted enrollment ranging from \$100-\$300 per household, an insurer can see a return of \$16,800 of cost savings for a family of four after three years of SNAP enrollment.

A tried-and-true program within the social impact business model is medically tailored meals delivered directly to the home of a member. Emulating the Meals on Wheels model, vendors like Mom's Meals have established hundreds of partnerships with health plans across the United States to deliver nutritionally balanced meals to Medicare members (Mom's Meals, 2023). These meals, paid for by the insurer, can be supplied long term to chronically ill members or in post-discharge and post-acute circumstances. A study in partnership with Tufts University and government insurance product members estimates that serving 6 million Americans with pre-prepared medically tailored meals can eliminate 1.6 million hospitalizations within a ten-month time span (Heath, 2022). This dramatic return on investment totals \$13.6 billion in savings, after covering the costs of the program (Heath, 2022). This shows that through maintaining and expanding meal benefits to members, government insurance product payers can increase margins by over \$2,000 per member serviced by these food-based programs.

12.0 Programmatic Considerations

While the ‘one social program fits all insurance products’ approach is challenging, establishing social programs that reach large membership groups or that can be applied to several insurance products is ideal. This allows for more robust resources to be dedicated to the approach in addition to reducing the overhead expense of creating social impact models. Consistency across a payer organization’s portfolio of offered insurance products is also more convenient for members who may be in a multi-product household while needing the same types of assistance. The more broadly applicable a social needs program is, the easier it will be for membership populations to navigate and resource referring parties, like care managers, to keep track of and recommend to the members who can benefit.

Once a portfolio of broadly applicable social programs is established, special focus should be established to develop programs that work for individuals qualifying for several government insurance products at the same time, including dual eligibles who qualify for both Medicare and Medicaid coverage. Dual eligibles qualify for Medicare because of age or the presence of a disability and qualify for Medicaid below of their low incomes, making them a particularly vulnerable population. A growing proportion of dual eligibles are enrolled in Medicare Advantage Special Needs Plans, presenting an opportunity for insurers to integrate social needs programs in care management strategies for dual eligibles. While executing social programs for these populations may be costly and challenging, there is a large opportunity for cost savings in these groups. With higher rates of chronic disease and the presence of disabilities in these groups, dual eligible require more intensive services in a regular basis. At the same time, these individuals present greater levels of social needs as it pertains to food insecurity, telehealth access, and

language services (ATI Advisory, 2022). While these members may be unable to follow traditional models like seeking resources through a community organization based on accessibility barriers, payers should look to create programs that can address social needs from home or offer house call and delivery style services.

Having income as a primary eligibility component for participation in some government insurance products reflects the relationship between wealth and social needs (Krisberg, 2016). This relationship makes it easy to categorize which membership groups face more barriers to health, with those groups being government insurance product members. An important oversight to avoid is that although government insurance products members require the most assistance in terms of SDOH, they are not the only membership groups that face social needs. Even members on employer-sponsored or privately purchased insurance products could benefit from resources. Generally, most Americans lack liquid assets and rely on regular income to meet their needs. These individuals have the ability to pay for non-government product insurance plans, yet 31% of working adults are at risk of financial hardship if they were to miss only one paycheck (NORC, 2019). Missing a paycheck or having a reduction in income is not improbable in instances of illness, family instability, or loss of employment. Guaranteeing that screening for needs and access to assistance is available to all membership populations is essential for any payer looking to adopt the social impact business model.

13.0 Conclusion

Whether applied to a food program, or one that addresses any other social determinant, payers can realize a margin of per member savings beyond what conventional care management may yield. Social impact as a business model allows for exciting innovations, healthier populations, and a more lucrative position in the insurance business. As this competitive industry expands, payers looking to thrive must embrace the social impact business model for the benefit of all members and all lines of business. Those on the cutting edge already have and stand to realize the anticipated long-term benefits of these programs at a greater magnitude. Not only this, but the social impact business model helps build partnerships within communities and government to better position the health insurance organization within its business environment. With Federal and State governments controlling the reimbursement rates to health insurers for their government insurance product members, pressure to control health care costs has fallen on the payer. This expectation persists while the government dollar spent on social programs and benefits falls short of its potential impact. Payers taking on the responsibility for these can create a more cost-effective approach to resolving social needs, based on higher levels of interaction and community awareness, while reducing health expenditures for the benefit of all parties.

As we move into a new era of what health insurance provides, it is important to re-define what it means to be insured. Access to social impact minded insurers will allow members to unlock the true definition of ‘health’ as ‘a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity (WHO, 2023).’ Insured individuals will be equipped with toolboxes full of resources to resolve any barriers that may stand in their way to happy and healthy lives.

The health insurer of tomorrow is an organization that goes beyond mitigating the financial risks of health, has mastered the art of care management, and takes a full picture approach to resolving the needs of their members. These payers at the cusp of innovation will create robust partnerships with community resources, as they previously have with providers, to establish value-based agreements that aim to meet the social needs of members in a cost-effective manner. Resources will span every social factor that can pose a barrier to the pursuit of health and referral to these resources will be efficient and easy to navigate. The result of the social impact business model is a reduction in overall health expenditure for the first time in decades, a healthier population, and a larger, more control, profit margin for the insurer.

Taking on the government's responsibility of meeting constituent needs, reimbursement rates for payers that operationalize the social impact business model require re-balancing. This increase will incentivize the payers to take on this responsibility and cover the costs of establishing SDOH networks. Appropriate adjustments to capitation rates are essential to the sustainability and success of the business model. Administering social programming through insurers is a tactful response to the current legislative and policy environment, where adding to existing social benefit policies is much more attainable than introducing completely new programs. Not to mention, the average American has developed a level of acceptance with the current level of health spending that does not exist for increasing costs in other social spending categories. With the urgency for meeting these needs within the United States, this less ideal approach of creating a more stable social safety net that is routed through health insurance is likely the only way to resolve these population needs in a timely manner.

As we move into a new era of what health insurance provides, it is important to re-define what it means to be insured. Access to social impact minded insurers will allow members to unlock

the true definition of ‘health’ as ‘a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity (WHO, 2023).’ Insured individuals will be equipped with toolboxes full of resources to resolve any barriers that may stand in their way to happy and healthy lives. Social needs programming from health insurers has the opportunity to be robust, but as portfolios of resources expand, payers must question the long-term sustainability of facilitating this work within the current government insurance product funding structure and within how non-insurer run programs are maintained.

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