Value-Based Insurance Design - Cardiac Bypass Surgery

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Introduction

Health Insurance is one of the major issues that companies consider when taking into consideration the needs of their employees. However, this is expensive and at times, greatly affects the profitability and further growth of the company. Choosing which health insurance option is best for the workers provided their diversity and uniqueness has always been a complicated process for the employers owing to the fact that they wish to attain the highest level of profitability as well while at the same time responding to the health insurance regulations that they have to follow (Stecker, Ayanian, & Fendrick, 2015). Thus, it brings in the concept of a Value-Based Insurance Design that primarily focuses on lowering or rather completely waiving away the financial barriers to vital high-value clinical services. This concept is based on two concepts. Firstly, is a difference in the amount of medical assistance provided by a healthcare service and, secondly, the healthcare benefit that comes from the use of a particular service depends on the person to whom it is administered (Chee, Ryan, Wasfy & Borden, 2016). As such, there is a need for a flexible insurance plan that takes into account different health needs of the employees of a single company. This is a strategy and plan for structuring a Value-Based Insurance Design for cardia bypass surgery.

Scope

Value-Based Insurance Design & Cardiac bypass surgery health covers.

Purpose

Value-based Insurance Design is a cost-sharing model of insurance that is primarily developed to enable the employees and their families who get sick to seek for medical care services that are perceived to be notably expensive at lower costs. As such, this is explicitly

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intended in recommending to the company whose workforce is of over 10.000 employees a strategy and a plan for structuring a Value-Based Insurance Design (VBID) cardiac bypass surgery.

Value-Based Insurance Design

When it is mandatory for every employer to pay the same amount of money for health care services, it is most likely that the benefits will depend on the characteristics and frequency with which someone gets health issues and there will be both over-and underuse (Fonarow, Keech, Pedersen, Giugliano, Sever, Lindgren & Sabatine, 2017). In other words, for every health care service offered, the cost-sharing amounts are expected to remain constant, even though the clinical values of such services are overly disparate, and there are higher chances that they will be dependent on who they are meant for. Apart from screening and preventive services, the level of cost-sharing usually is in most cases in close connection to the likely benefit provided by each service (Chee et al., 2016). Ideally, this is the problem with the majority of the health insurance plans on market as well as those that some employers offer. However, there is a need to have an acknowledgement, and apparent response to the unique needs as well as the heterogeneity of patients, which is precisely how Value-Based Insurance Designs come into play (Stecker et al., 2015). This design makes it rather possible for a patient to have all healthcare services when there are more clinical benefits in comparison to the cost; however, it discourages the use of healthcare services when it is perceived that the value cannot be justified by the clinical benefits.

Company/Employer Situation

The company employs more than 10,000 workers and has between 40,000 - 50,000 people on its health insurance plan. With such a large number of people comes an excellent opportunity for the company to enhance the quality of care that it purchases for its employees in

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the form of insurance coverage through helping the beneficiaries to gain a more in-depth understanding that different providers can offer varying quality of care at different costs.

Plan Design

The Population

It is crucial that a particular health risk is assessed out of all the most probable ones to concentrate on that in the workforce and their families. Such an approach has benefits, which include being easy for vendors to administer. As such, it is important that data of the workforce is critically analyzed to understand the whole situation as well as how much both parties may have to pay in terms of cost-sharing (Fonarow et al., 2017). In this way, this VBID design will primarily concentrate on patient that may need cardiac bypass surgery. There will be a need for close coordination among the chosen vendors managing the program to collect as much information as possible and to also ensure that there is accurate tracking of participation and correct administration of all incentives (Stecker et al., 2015). Systematic plan of how all the health promotion programs is also required due to the fact that there are more methods other than self-reporting. This is because the number of participants in this insurance design is very large and needs to be tracked closely to avoid fraud.

The VBID initiative

In the first place, this VBID is aimed at reducing the factors or financial issues that hinder access and the delivery of health care services of high value. In fact, the services that are considered to be of high value are those that have been proven to be effective in improving the well-being or health of a person (Fonarow et al., 2017). This the strategy will concentrate on the modification of deductibles for completing a personal health assessment, the reduction of the amounts of co-payments for office visits that are considered as wellness visits, decrease in

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amounts of co-payment due to the use of high-quality health care providers, as well as the reduction of amount of co-payment for particular drugs used in the treatment process.

The financial barriers can also be removed through the provision of education and support to the employees. Therefore, there must be a close link between the purchasers and the vendors to offer a robust infrastructure of support to the employees that are considered eligible for the benefits of the VBID (Chee et al., 2016). To note, this will be instrumental in assisting them to overcome hindrances to improved adherence that are nonfinancial. Through health coaching/case management/ disease management initiative, vendors will identify and reach out to employees that are not compliant and offer them education and support (Schwartz, Chernew, Landon, & McWilliams, 2015). Trained coaches will engage employees regardless of how much knowledge they have about their condition and together establish personal care goals that are deemed to be achievable and at the same time, work with them to attain them (Fonarow et al., 2017). After the initial goals are achieved, setting other goals until the employees reach a stage of self-management will be required.

The other way through which financial barriers can be removed is through patient accountability. Notably, several insurance designs have a limit on the incentives to the employees that desire to enroll for the programs. This is usually based on the understanding that it is prudent that patients with chronic conditions have a certain level of accountability as regards taking care of themselves. The continued participation of the employer is a clear indicator of the responsibility (Stecker et al., 2015). As such, the VBID takes into account the fact that behaviors affect all people through having an impact on costs and the fact that people are unique. As such, the purchaser's needs, as well as those of the employees, are met by healthier behaviors and better care decisions.

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Besides, the company can start with a pilot VBID initiative that primarily pays attention to a single condition, as in this case. In fact, many people in the United States suffer from heart diseases, and it is as such the best option that the company pays attention to cardiac bypass surgery in its insurance options (Chee et al., 2016). In the same way, the selection of this is based on the fact that there are higher chances of realizing cost savings if the compliance rates are improved, the drugs and procedures used in the clinical process are specific and the fact that it is an evidence-based treatment protocol.

Creation of an Efficient Communication Strategy

Ideally, it is very difficult to create and at the same time, put into action a single communication strategy that is deemed right and most effective because almost every employer has their own culture, which is essential in its development. However, this company will employ the use of the enterprise-wide, aggressive public messaging campaign that will focus on every worker in the company and at the same time promote the role of its underlying VBID initiatives as far as cardiac bypass surgery is concerned (Chee et al., 2016). This is based on the fact that this communication strategy offers entirely new ways of defining how health care services can be provided paying significant attention to the wellness and health of the employees (Fonarow et al., 2017). In the same way, it acts as an important tool to make health care benefits more effective. There are several best practices that will be followed while developing this communication strategy.

Firstly, VBID is a concept that is still new and, thus, it requires time for the employees to understand it and it will take between 6 to 12 months to develop a communication plan. Secondly, it is crucial that it is emphasized among the employees that the VBID is primarily aimed at reducing hindrances to services that fetch the most significant benefit to particular

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people that enroll. This is based on the fact that it is a widely held notion among consumers that services of higher quality will cost less counter-intuitive. Thirdly, it is crucial that there is a regular flow of communication from senior management.

Management of Insurance Vendors

In both the development and implementation of a VBID, the effective management of the vendor is one of the aspects that is always overlooked. The aim of this aspect is to make vendors act like partners and, as such have them partake in the solutions and objectives of the purchaser. From a very practical viewpoint, the effective management of the vendor is very crucial. In this particular case, it will be important that all the vendors to have the same understanding of the functional requirements as well as the purpose of the program (Chee et al., 2016). As such, there is a need for consistent and reinforcing messaging, and at the same time all processes have to be interrelated. As well, there is a need for a problem identification and resolution process that is quick and efficient between the purchaser and the vendors for the fact that there are chances that unexpected problems will arise and mistakes will happen (Fonarow et al., 2017). In addition, it is mandatory for vendors to have performance standards that are measurable to serve as benchmarks upon which they can be evaluated in accordance with value-based purchasing principles. Even though managing vendors is essential for success, it is important to note that it is demanding and time-consuming.

The Tiered Healthcare Insurance Plan

As per the specifics of a VBID, this program will provide a 1-Tier, 2-Tier and Bundled health care insurance. With Tier 1, the share of the company and employees of the cost for the healthcare services offered will be considerably lower. In this case, the company, on its behalf, as well as that of its employees will have to negotiate the lowest out-of-pocket costs for the

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services to be covered (Fonarow et al., 2017). Besides, it will be the responsibility of the company to lower coinsurance of the plans taken on. In the case of Tier 2, the government is responsible for the provision of primary care, and there exists a secondary tier in which employees and employers can pay for faster access or additional and better-quality services. As for the bundled healthcare insurance, the company will pay different providers for the coordination of the total amount of services that may be needed for a single episode of care that is predefined (Fonarow et al., 2017). This will help the company from becoming part of numerous contracts of different service providers.

Recommendations

For the VBID to be effective and realize its intended goals and objectives, it is crucial that other programs will not only engage but also support the beneficiaries in making sure their decisions are included. This will, as such, require the integration of health coaching or case management/disease management. It is essential that the company offers different types of decision support tools to the employees as well (Chee et al., 2016). These, among others may include disease-specific information and treatment protocol. These may serve as a foundation of the decisions that the employees make. There has been the development of a more sophisticated technology that goes way beyond the treatment, education as well as definition protocols, and gathers all the patient information that may influence their decisions. Such technology is crucial as it gives the employee a chance to make objective conclusions pertaining to the benefits and risks of treatment alternatives that are particularly tied around the unique nature and needs of the employee.

Furthermore, it is crucial that health care providers are involved in the understanding of the structure as well as the goals of the VBID. This is based on the fact that healthcare outcomes

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are usually improved where there is a good relationship between the healthcare providers and the patients. To note, if there needs to be an effective provider-patient relationship, there should be communication that is both open between the two parties. As such, the effectiveness of healthcare providers can be improved through educating them about the VBID initiatives (Stecker et al., 2015). Therefore, the company can either work with the health plans that communicate on a regular basis with other contracted providers or establish communications directly with the providers.

In the VBID initiatives, data is shared among the vendors and the purchasers. As such, it is important that there are systematic guidelines that show how this data is to be protected in relation to all the HIPAA privacy requirements. In the same way, even in cases where there is a need to discuss particular employee conditions, this must be done while meeting all the local as well as federal requirements pertaining to confidentiality.

Cardiac Bypass Surgery

Cardiac Bypass surgery is an intervention option for people with an artery in the heart that has been blocked. As such, the surgery is carried out to redirect blood around the fully or partially blocked section of the artery in the heart and thereby improve the flow of blood in the heart muscle (Patel, Cigarroa, Nadel, Cohen, & Stecker, 2015). This surgery involves getting a healthy blood vessel either from the chest, arm or leg and then having it connected beyond the arteries that are blocked in the heart. To note, this procedure does not fully treat a person from the heart disease that s/he may be suffering from, which may lead to its blockage. These diseases may include coronary artery disease or atherosclerosis (Patel et al., 2015). Nonetheless, the procedure my ease the symptoms of the disease, such as shortness of breath and chest pain. In other people, there is a possibility of this procedure improving the function of their heart and at

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the same time lessen their chances of death as a result of heart disease. Notably, with the company's type of work that involves sitting all day, the employees have a higher chance of developing heart diseases as they have a sedentary lifestyle that does not include physical exercises (Patel et al., 2015). As such, their chances of contracting such diseases increase reasonably. It is for that fact that the VBID that pays particularized attention to cardiac, bypass surgery is considered.

According to present data, 48.5 percent, or rather 121.5 million people have ever dealt with a heart problem or a disease that connents with the blood vessels of the person. As such, roughly estimating that the company has 10,000 employees, it is probable that at any one point, the company may have to cover the insurance of around 4850 employees (Fonarow et al., 2017). Research done in 2017 shows that on average, companies spend over 18,764 dollars every year on every employee, with the employees contributing 5,714 dollars towards this amount (Chee et al., 2016). This implies that every year, the company is likely to part with around 91,005,400 dollars in insurance and the employees are expected to contribute 27,712,900 dollars towards this amount.

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