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Letter from the Editor

By Kurt Wrobel

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I think Greger Vigen best summarized the intent of this edition of *Health Watch* when in his article he said, "We are in the middle of extraordinary times." While the policy debates and media have mostly focused on the expansion of government programs, the mandate or tax to purchase health insurance, and the dramatic change in underwriting rules, we are also seeing a profound change in how payors compensate and incent providers. These initiatives will provide the focus for this edition of *Health Watch*.

In our opening article, Ed Cymerys highlights the work he and his actuarial team have done in developing an innovative accountable care organization (ACO) structure for Blue Shield of California. Going well beyond developing a simple capitation rate, the actuarial team actively engages their provider partners in a program that motivates all stakeholders to improve the quality and efficiency of care through a more effective incentive structure. By being front and center throughout the development of the program, the actuarial team showed how their skill set can be used beyond more traditional rate setting.

In an effort to frame the challenges and opportunities in provider payment programs, Vigen contributes a convincing argument on why system transformation and provider payment reform will succeed, even when and where other attempts were less successful in the past. As Vigen highlights, much of this work will rely on technical skills and enhanced technology and data that we have developed in other aspects of our health insurance work.

Continuing with the theme of highlighting programs that go well beyond simple capitation rate setting to improve the incentive structure for providers, Matthew Day and Jill Wilson discuss the detailed structure and organization of the Blue Cross Blue Shield of Massachusetts program. Like the Blue Shield ACO program, they rely heavily on changing the existing provider incentive structure.

Along with these innovative private programs, several government programs have been developed to use a better incentive structure to encourage more effective and better coordinated care. Michael Cook and Shelly Brandel provide the details on a new dual-eligible program facilitated by the Medicare-Medicaid Coordination Office in the Affordable Care Act (ACA) legislation. By combining payment and assigning clear accountability, the Centers for Medicare and Medicaid Services (CMS) expect that health plans will provide more effective and efficient care. In addition, several leaders from the Health Section's Medicaid subgroup highlight several states' Medicaid innovations, including cutting edge payment changes based on episodes of care, patient outcomes, and quality metrics.

This edition concludes with an article that ties these initiatives by highlighting the significant change required to operate in these new payment models. As highlighted by the authors from Deloitte, this change requires the development of several new capabilities that go well beyond the skills necessary to operate in a fee-for-service model.

In total, this edition emphasizes that many innovative provider payment programs are starting to improve the incentive structure that providers have operated under for so many years. Based on the preliminary evidence, these structures have the promise to improve the coordination of care and provide more efficient care. As a profession, we are in a unique position to help promote and drive this change through our analytic capabilities as well as our broad knowledge of health insurance and the delivery system.