Thank you all for being here. I’d like to take this moment to right away recognize our exemplary planning committee, which included our former board member and now Obama Administration official Peter Lee.

I’d like to thank my old friend Arnie Milstein, who recently left Mercer to join Stanford University. I’d like to thank Patricia Smith and Howard Shapiro, who both represent America’s Community Health Plans to outstanding effect.

Christie Travers with the Memphis Business Group on Health has been an indispensable ally of NCQA’s on a variety of fronts, and her help in putting this event together is evidence of her longstanding commitment to health quality.

Finally I’d like to thank Mark Smith with the California Health Care Foundation, who gave us a lot of the original direction for this project, but unfortunately could not be with us today. Finally, I’d like to mention Sam Ho, who spent time with me on the phone discussing these issues and who regrets that he can’t be here today.

I would also like to recognize the invaluable support from our sponsors, whose belief in our mission to improve the quality of care in America so vital and so heartening.

This summit comes in a series of events that mark the 20th year of NCQA’s existence as a leading evaluator of health care quality in America. We were pleased to welcome some of you to our Health Quality Awards Dinner in March, and we look forward to your participation at our year end policy conference.

This, however, is quite a different affair. We have called it a summit, and we have kept the group small so that we can use the opportunity to engage with you in a dialogue and collective thinking session about how health plans can help to drive a value agenda. In our twenty years at NCQA, it is really this kind of collective thinking that has helped us advance the nation’s first national quality agenda.

We stand at a unique moment in history. This year the nation passed the accountable care act, one of the most ambitious pieces of legislation in our history. There is much to like in this law: it even has accountability in its name. Concepts like quality reporting, delivery system reform, shaping the market to reward quality, wellness and patient engagement are all present, and often in thoughtful and innovative ways.
And yet, there is one issue that haunts our future: the steady rise of costs, costs that our nation can ill afford today and that are truly frightening in the coming decades.

Many of you here today understand deeply that this rise of costs can and must be addressed. You understand that much of the cost-quality tradeoff that we all used to believe in doesn’t really exist in many domains. We have watched the work of the Dartmouth Group, Jack Wennberg and Elliott Fisher and others, since the 1970’s. They have shone a light on Ellyria, Ohio (the stent capital); Miami, Florida and Los Angeles, where in one famous hospital, the average dying patient sees 52 specialists at the end of life. We have all watched the phenomenon of cancer treatment, and an immoral payment scheme that rewards for overtreatment. We have read the report of the Massachusetts Attorney General and Bob Berenson’s study of Southern California pricing, and we understand that we need a stronger agenda to buy value in health care.

But the politics of this are very challenging. Several forces—uniquely American—have conspired over the decades to render that pursuit elusive.

It helps to keep these forces in mind. While government and large employer participation in the health care space has driven some innovation, it has also led to a highly fractured market place. This has obviously made it difficult to implement coordinated strategies to improve the way care is paid for and delivered.

Indeed, one of the most frustrating products of the debate around health care reform and implementation has been the vilification of health plans. This is particularly a concern because health plans have an important role to play in reform—as market makers and I hope in the future, as activators of the patient, the missing party so far in the pursuit of a health care value agenda. Unless we abandon the naïve notion that health plans are the source of all the problems in health care, we forgo the possibility of moving forward together to consider real health policy solutions that are grounded in evidence and draw from the analysis and research of our best thinkers and those who have been closest to this problem for so long.

So the focus of our summit today is the health insurance plan. To be sure vital consumer protections will be enacted as a result of the Accountable Care Act. But the new insurance rules would not have been feasible to enact without comprehensive reform and the individual requirement to purchase coverage for all Americans.

At NCQA we began our mission twenty years ago by challenging below average plans to improve, but also by recognizing and celebrating high-performing ones. We know that leading edge health plans in America, large and small, have devoted serious resources to the project of keeping their members healthy. We know this not only because it is in their core business interest to do so, but because we have met and worked with the leadership of these health plans for over two decades.

We witness every day their character and expertise at work; their mission oriented pursuit of strategies that will lead their members to improve lifestyle choices, seek preventive care, effectively manage chronic conditions, comply with medication programs, avoid medical errors, and the list goes on. They are real professionals, who use evidence and their experience to propose innovative ways to restructure incentives to providers and improve access to high quality care for their members.
It might even be argued that much of the difficulty we experience today results from the insurance plan’s weakened and tenuous position, caught between providers and their patients. But patients—and by that I mean those without a medical degree—would be confounded if left to their own devices to navigate the American medical system. And as costs are inevitably passed off to the patient, plans have an important role to play in constructing value choices for their members, choices where they are better off not only financially, but because they are not overtreated, overpaying or the victims of medical errors. Today we are gathered to push ourselves on how we can advance this agenda more effectively.

So there is clearly an important role for health insurance plans to play going forward. Today we bring together a diverse group of thinkers and leaders, in the spirit of comity, to drive towards a value agenda for health plans; and to consider how we can leverage the tools with which the Patient Protection and Accountable Care Act has equipped us.

Our objective in seeking a value agenda is to move towards what Don Berwick has termed the “Triple Aim”.

- Improving individual experience of care,
- Improving population health,
- And reducing the overall cost of care.

I have had the privilege of cochairing with Don over the past couple of years the National Priorities Partnership, a terrific group of quality organizations, purchasers, consumers and other health care leaders who have put forward a set of priorities that would cut costs by reducing harm to patients, calling out oversuse, and activating patients and making their voices heard.

In writing of the triple aim, Don Berwick emphasizes the role of an “integrator.” The integrator must, as he describes it, take responsibility for all three aims for a given population. Berwick offers five components that define the integrator’s role, and I’m quoting from his May 2008 Health Affairs article:

- partnering with individuals and families,
- redesigning primary care,
- managing population health,
- financial management,
- and integrating with the macro system.

Although patients generally believe that medical providers are primarily responsible for the quality of care they receive, thinking about the triple aim model clearly highlights the role plans can and must play to improve quality.

How then can health insurance plans be effective integrators?

We propose to attack this question from two vantage points during our program today. The morning discussion will focus on what new ideas and activities plans are currently engaged in, and those that they regard as most promising, to achieve the triple aim.

In the afternoon we will shift our focus to the future. Many of the health plan and delivery system provisions in the reform law were written by people in this room, or with your research close at hand. Many concepts arise out of a body of thought that has been percolating in the academic
communities, among quality organizations like NCQA, results from health plan demonstration projects, input from medical professional societies, and think tank work.

We got a lot of what we asked for in this law, and now we need to think about how to implement these programs in a coordinated way with a focus on achieving the triple aim. We also need to consider how to move towards the triple aim in ways that can be objectively and reliably measured. Berwick cites the need for new measures as a primary driver to achieving the triple aim.

How do we know patient experience of care is improving? How do we know if the health of beneficiary populations is getting better? How do we know if we are saving costs in ways that results in safer more effective care, and not through the rationing or denial of needed care? These are vitally important questions as you all know. In order to answer them we need rigorous, evidence based, clinically tested and proven outcomes measures.

NCQA has done much during its twenty years to get us moving down this road, beginning at a time when few measures existed. Our staff has developed some of the most penetrating and widely used quality indicators. We are hard at work on the next generation of measures that will look at resource use, emergency room admissions, and care coordination.

But much more research is needed to answer the age-old question of what observable and reliably collectible data points correlate to “good health outcomes.” We are grateful that the Accountable Care Act proposes to fund research that will answer this question. But much of that money is yet to be formally appropriated by Congress. Until it is, we risk wasting yet more time that could be used developing a solid evidence base upon which to build a coordinated approach.

A reliable battery of performance measures is also a necessary precursor to many of the ambitious pay for performance programs the Accountable Care Act promotes. When we lower reimbursement for Hospitals with poor re-admissions rates, we need to make sure we’re counting the avoidable ones.

When we reward primary care physicians for reducing the amount of tests, x-rays, procedures they prescribe, we need to ensure the quality of their patient outcomes remain favorable.

When the Medicare program shares savings with Accountable Care Organizations that provide medical services to a group of beneficiaries, we need to be vigilant to ensure that efficiencies generated have not resulted at the expense of patient care.

Sound performance measurement is at the core of all we are trying to achieve here today, in terms of programmatic reforms to bring us closer to the triple aim.

But to truly reward plans for improvements in key measurement areas, we must figure out a way to make those gains meaningful to consumers.

The entire concept of the new insurance marketplace, facilitated by exchanges, subject to greater transparency and reporting requirements, is based on the premise that we can get consumers to compare plans on the basis of cost and quality.

I believe the accreditation requirement for exchange plans can be integral to this. Information collected in the survey process can be fed into standardized, consumer friendly report cards. These
reports would not only include outcomes and clinical quality measures. They would also allow consumers to compare plans along categories like access to primary care and subspecialists, member experience, and the quality of utilization management decisions.

The success of this vision depends heavily on activating consumers. The jury is still out as to whether we can get health plan end users to truly care about quality. We also have to be cautious not to overwhelm plan members with too much information, and even too much choice. Ultimately though, consumers voting with their feet has the potential to reshape insurance markets in ways that government and employer sponsored P4P programs cannot.

So I’d like to challenge plans to work on making demonstrable progress towards the triple aim in ways that can be effectively measured and communicated to customers.

This project is not easy, and of course, has been ongoing for many years. The increased customer base, increased consumer protections, and increased regulatory oversight generated by reform only serves to raise the stakes.

I’d like to say, finally, that I am extremely impressed by the brain trust we have managed to assemble in this room, and extremely gratified by all of you joining us.

We’ve setup the program to be as interactive as possible. There will be no power points, no lectures or seminars, little rigidity in terms of the time allotment given to each subject. Our speakers will serve more as discussion leaders than panelists.

I hope and expect that during the course of our discussion you will ask provocative and uncomfortable questions that cause us to confront some of the paradoxes that define what we do. It’s also worth noting that this is a completely private affair. There is no press. The video camera you see there will be shut off; it’s only on right now to capture my remarks for NCQA’s future work to advance a value agenda. We have a note taker who is also doing an audio recording, but that will be strictly for internal use only, and the recording will not be made available to anyone outside of NCQA.

The key is that we want you to be as frank and honest as possible. We don’t want political correctness to interfere with the passion we all clearly feel about our time spent studying health policy, and the passion with which we can express our most deeply held beliefs about what’s wrong and how we propose to fix it. Let’s not worry about hurting anyone’s feelings. Again, I thank you all for coming, and look forward to a stimulating debate that can help us shape a more vigorous agenda for health plans to be the market makers we need them to be.