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Written Testimony – ***Alternative Payer Models Show Improved Health-Care Value***

Chairman Pitts, Ranking Member Pallone and members of the subcommittee, thank you for the opportunity to testify today.

My name is Jon Kaplan, and I am a Senior Partner at The Boston Consulting Group (BCG). I have been a health care consultant for the past 25 years, working closely with both for-profit and not-for-profit entities throughout the industry, including managed care companies, hospitals, retail pharmacies, and pharmacy benefit managers.

Earlier this year, I led a BCG team that analyzed the differences in health outcomes between Medicare patients enrolled in traditional Medicare, who see doctors on a traditional fee-for-service basis, and patients who are enrolled in Medicare Advantage health plans provided by private insurers. We found that patients enrolled in Medicare Advantage plans had better health outcomes than those participating in traditional Medicare.

Before discussing our findings in more detail, I want to describe some distinguishing characteristics of our study. First, it had an unusually large sample size, including some 3 million Medicare patients. Approximately 1.3 million of these patients were in traditional Medicare and used providers on a traditional fee-for-service basis. The remaining 1.7 million were enrolled in one of three Medicare Advantage plans at a leading private insurer: either a preferred provider organization (PPO), a non-capitated HMO or a fully capitated HMO.

Second, our large sample size allowed us to reduce selection bias. We used two techniques to do so: statistical regression to risk-adjust our data and matched population to compare a subset of the patients who mirrored each other across a set of measured variables, including age and number of disease co-morbidities.

Finally, we vetted both our methodology and our findings with a number of leading academic health outcomes researchers before publishing it on our website and sharing it publicly.

Now let me describe briefly three high-level findings of our study:

- The Medicare Advantage patients in our sample received higher levels of recommended preventive care and had fewer disease-specific complications, such as the number of diabetic foot amputations and ulcers.

- During acute episodes requiring hospitalization, the patients in the Medicare Advantage plans spent about 19 percent less time in the hospital than those in our traditional Medicare sample – and yet, they also experienced a lower percentage of readmissions.

- Finally, the percentage of traditional Medicare patients who died during the year of our study was 6.8 percent, on a normalized basis. But the analogous single-year mortality of the patients in the Medicare Advantage sample was, depending on the plan, substantially lower: no higher than 2.8 percent and as low as 1.9 percent. This is a striking finding and one that we hope to explore further in a longitudinal, multiyear study.

Our study did not directly address the causes of these differences. In my experience, however, the key factor is Medicare Advantage itself and how the plans are organized and managed. First, these plans align financial incentives with clinical best practice. Second, they recruit the most effective providers and include only those who practice high-quality medicine. Third, they put a strong emphasis on active care management and invest resources in prevention to keep patients healthy, stable, and out of the hospital.

There are many indications in our study that these mechanisms are responsible for the better health outcomes of the Medicare Advantage patients. Take the example of diabetes. Two clinical standards

for diabetes care are frequent testing for glycated hemoglobin (known as HbA1c) and regular screening for kidney disease, which commonly results from poorly-controlled diabetes. Our data show that in 2011 the average number of HbA1c tests for diabetics in the traditional Medicare sample was less than one per patient. However, the average HbA1c tests in Medicare Advantage ranged from 1.26 to as many as 1.36 per patient. The average number of kidney disease screenings per Medicare patient was 0.17, versus at least 0.24 and as many as 0.40 per Medicare Advantage patient.

This stronger focus on prevention helps keep patients healthy and avoid the need for highly disruptive, and expensive, acute care later on. For a striking illustration of this fact, consider the following finding. The diabetic patients in traditional Medicare had an average of 11.5 amputations for every 1,000 patients. By contrast, the Medicare Advantage samples had no more than 1.1 and as few as 0.3. There were 212 foot-ulcer procedures for every 1,000 patients in Medicare, whereas Medicare Advantage had no more than 131 and as few as 25 per 1,000 patients.

Aligned incentives and active care management also helps explain lower utilization rates. Take the example of emergency room visits. About 4 in 10 of the patients in our traditional-Medicare matched sample visited the emergency room at least once in 2011. But for Medicare Advantage, this figure drops to between 2 and 3.

One last finding is also worth considering. Among the three types of Medicare Advantage plans that we studied, the very best health outcomes were for those patients in the *capitated* Medicare Advantage plan. Under capitation, primary-care physicians are paid a risk-adjusted, contracted rate for each member regardless of the number or nature of services provided. The findings suggest that capitation is extremely effective at supporting provider investment in preventive medicine and active care management.

Let me conclude by suggesting some implications of our study for health policy. In my opinion, Medicare Advantage plans are an example of a successful public-private partnership. These plans represent an integrated care-delivery model that uses effective provider incentives, real-time clinical data and analysis, and care-coordination capabilities to improve quality and lower costs.

Medicare Advantage plans also represent a proven model from which the entire system can learn. Insurers that provide Medicare Advantage are already in the marketplace, competing with each other every day to deliver cost-effective, quality care. What's more, they are in a unique position to team with the clinical community to bring about change. They have the scale, the broad access to data, years of experience learning what works in local marketplaces, and the flexible infrastructure to help innovate and improve health care delivery.

For these reasons, federal policy should be encouraging – not discouraging – more Medicare patients to enroll in Medicare Advantage programs. Their health outcomes – and the entire U.S. health care system – are likely to be better as a result.

Please refer to the BCG report "Alternative Payer Models Show Improved Health-Care Value" for additional findings in our study of the differential health outcomes for patients in traditional Medicare and in Medicare Advantage plans. The appendix to the report outlines the full research methodology and limitations of our study.