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My name is Katherine Baicker, and I am the C. Boyden Gray Professor of Health Economics in the Department of Health Policy and Management at the Harvard T.H. Chan School of Public Health. I would like to thank Chairman Tiberi, Ranking Member McDermott, and the Distinguished Members of the Committee for giving me the opportunity to speak today about how we can address the crucial policy challenge of improving the quality and value of care that Medicare delivers to beneficiaries and ensuring that it provides the vital protections they need for generations to come. This testimony is derived in part from recent academic work with colleagues.

For decades, Medicare enrollees have had the choice between traditional fee-for-service (FFS) Medicare and Medicare managed care plans. Medicare Advantage (MA) managed care plans often offer more generous benefits or lower cost sharing than the traditional, largely unmanaged FFS program, using some of the tools for managing care often deployed in private markets.[1] For much of the program's history, MA enrollees comprised only a small share of Medicare enrollees. However, over the past decade MA enrollment has grown more than 2.5-fold, with over 16 million or about 30 percent of Medicare beneficiaries now enrolled in MA plans.[1] This growth has been driven both by enrollment of the newly eligible and by switching from FFS to MA. There remains a great deal of variability in MA enrollment across areas (see Figure 1).

The rapid growth of MA over the past decade has the potential to increase the value of health care delivery by using better insurance design, limiting incentives to deliver low-value services relative to those inherent in FFS, and using care management tools increasingly seen in the private sector.[2,3] The success of the program in managing utilization while maintaining or improving quality has been the subject of active research, complicated by evolving payment schedules, differing patient pools, and limited data (although MA "encounter data" should provide an avenue for more detailed comparisons).

There is a substantial body of evidence suggesting that managed care enrollees have lower utilization than FFS enrollees.[4-6] Utilization rates for services such as emergency department visits, days in the hospital, ambulatory surgery, and other procedures have been estimated to be substantially lower for MA managed care enrollees than for comparable FFS enrollees.[7,8]

In addition to affecting the quantity and type of care used, managed care incentives may impact the quality of care delivered to enrollees. Measuring the quality of care delivered is much more

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difficult than measuring the quantity, and evidence is mixed.[6] The parts of the country in which FFS is the most expensive do not have the highest quality care (see Figure 2).[9] There seem to have been modest improvements in some (but not all) measures of the quality of care delivered to MA beneficiaries.[1] Some recent evidence suggests that by coordinating care, MA managed care plans generate moderate improvements in the quality of care relative to FFS.[10] MA plans can also be more innovative in designing benefits that better serve members, such as experimenting with hospice benefits, telemedicine, or value-based insurance design.[11,12]

MA plans can also offer better financial protections than the basic Medicare benefit. We need health insurance not just because of the cost of health care, but because there is great uncertainty about who will need very expensive and potentially life-saving care and when they will need it. Medicare should give beneficiaries not just access to medical care, but also protection from the risk of catastrophic spending. Medicare by itself offers only limited protection against economic ruin.[13] The basic Medicare benefit lacks a cap on out-of-pocket spending, so that beneficiaries are exposed to the risk of open-ended cost-sharing. This risk is one reason that 90 percent of beneficiaries obtain some other insurance – including MediGap (which may not be affordable for disadvantaged populations) and MA.[14] One of the ways that MA plans attract enrollees is by reducing their exposure to out-of-pocket costs.

Beyond the effect of care management on MA enrollees themselves, there is also the possibility that better care management might have wider-ranging effects: by shifting financial incentives and physician practices, a critical mass of patients covered by insurance plans that promote better management could generate spillover effects that change the utilization of other patients in the health care system. While challenging to estimate, evidence suggests that a higher managed care market share can lead to lower utilization, with more limited evidence on quality.[15-17] For example, parts of the country where a greater share of Medicare beneficiaries are enrolled in MA may have lower rates of hospitalization and overall utilization for Medicare FFS enrollees (although these changes do not necessarily lead to lower FFS program spending).[18-20]

The MA program thus has the potential to serve as an avenue for innovative coverage that provides beneficiaries with choice and flexibility, and delivers care more efficiently without observed loss in quality. Achieving the full potential benefits of the program, however, depends not just on having high-value plans available, but on payments that foster competition on quality and premiums. There are of course many challenges in designing an optimal payment system, including creating robust risk adjustment methods that promote beneficial plan competition; incentivizing providers to deliver care of consistently high quality and health benefit; and promoting beneficiary choice of high-value plans that are right for them.

Risk adjustment methods that adequately capture the future health risks of beneficiaries and are robust to choices made about patient care (and documentation thereof) are key to multiple

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aspects of a well-functioning Medicare Advantage market. Appropriate risk-adjustment minimizes plans' incentives to enroll disproportionately healthy patients. It is also crucial for accurate measurement of the quality of care delivered. Risk-adjustment methods have improved substantially since the MA program's inception, but are still sensitive to coding choices.[21-25]

Quality must be both evident to enrollees and rewarded for plans and providers. Beneficiaries need enough information to be able to choose the high-quality plan that is best for them – and to foster competition between plans on the basis of quality. But quality information alone is not likely to be sufficient: payments also need to provide incentives for providers and insurers to deliver not more care, but better care. The current Star system can be strengthened both to provide better information and to be a more effective basis for rewarding high-quality care.[1]

Aligning incentives for providers and plans to deliver high quality care is important, but beneficiaries who choose options that deliver high quality care should share fully in the benefits. Of course, competition between plans works best to improve quality and lower costs when there is real choice among diverse options that all compete on a level playing field. Efforts to promote coordinated care delivery must be balanced with promoting robust competition among both plans and providers.[26] MA plans competing with other options on equal footing can attract enrollees by delivering innovative, higher quality plans with more affordable premiums, generating savings that benefit both enrollees and taxpayers.

For more than 50 years, Medicare has provided invaluable benefits to enrollees, but the program overall consumes an ever-rising share of federal spending, straining the federal budget and generating costly economic distortions. A "one size fits all" Medicare program will be increasingly difficult to maintain.[27,28] A thriving and competitive Medicare Advantage program can be a vital contributor to high quality beneficiary care in a sustainable health care system.

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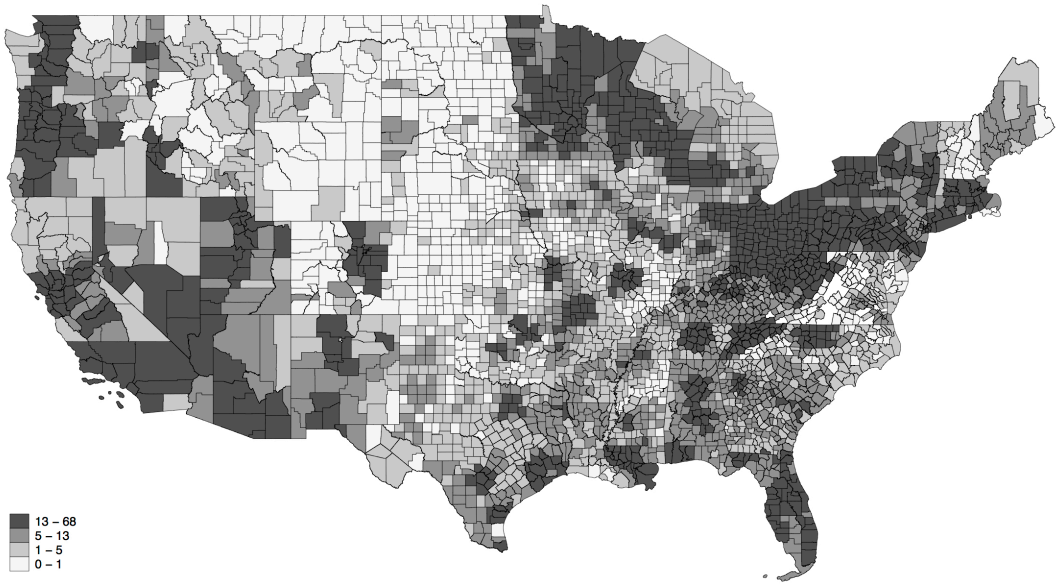
Figure 1: Share of Medicare Beneficiaries Enrolled in MA Managed Care



Source: Baicker and Robbins, *American Journal of Health Economics* (2015)

Figure 2: Relationship Between FFS Spending and Quality

Source: Baicker and Chandra, *Health Affairs* (2004)

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