Committee on Energy and Commerce

Opening Statement as Prepared for Delivery
of
Chairman Frank Pallone, Jr.

Hearing on "Protecting America's Seniors: Oversight of Private Sector Medicare Advantage Plans"

June 28, 2022

We are here today to conduct oversight of the Medicare Advantage program. Nearly 27 million seniors are enrolled in Medicare Advantage plans, which is run by private health insurance companies. While the program offers seniors flexibility in the way that they receive their medical care, it is important that we ensure that Medicare remains financially viable and that seniors are receiving the high-quality care they deserve.

I am deeply concerned with recent reports that seniors in private sector Medicare Advantage plans are facing unwarranted barriers to accessing timely, medically necessary care. Several studies have raised concerns that insurance companies are denying beneficiaries' access to treatment and imposing burdensome requirements that delay care. Improper claim denials and increased use of prior authorizations are preventing beneficiaries from receiving the care they need.

While there are many plans that appear to be acting responsibly, some are not, and these bad actors are costing taxpayers money and, more importantly, jeopardizing the health of seniors. This oversight hearing is critical to ensure we are protecting the health and well-being of Medicare beneficiaries. It is also important to determine whether Medicare Advantage is providing good value for our federal dollar.

When Medicare Advantage was created, the hope was that private-sector efficiencies would reduce the cost of care for seniors. Unfortunately, that has not been the case. In fact, the Medicare Payment Advisory Commission, one of today's witnesses, has consistently found that providing care under Medicare Advantage has cost more than under traditional Medicare. Studies have repeatedly found that some Medicare Advantage plans, particularly the largest plans, receive greater compensation from Medicare without necessarily providing better health care services to beneficiaries. In short, some insurance companies appear to have figured out a way to game the system.

This is in large part due to the way we reimburse Medicare Advantage plans. Plans receive more money from the federal government based on various factors, including the underlying medical risks of the individuals enrolled in their plans.

To ensure they receive more money, insurance companies use tools like in-home health-risk assessments to claim that individuals on these plans have additional health conditions that

their provider has not formally diagnosed them with. This allows the plans to claim that beneficiaries are in riskier health and therefore the plans receive more funding from Medicare.

But, as today's witnesses will help explain, those new diagnoses do not always reflect reality. Additionally, seniors that receive these new diagnoses from insurance companies rather than their doctors do not always then receive health care services for those diagnoses.
This phenomenon is called coding intensity, and it suggests that some plans are focusing their efforts on finding ways to pad their profits rather than ensure seniors are receiving appropriate care. We will hear a great deal about coding intensity today and what can be done to put a stop to it.

One benefit to enrollees under the Medicare Advantage program is that plans can use portions of their funding to provide supplemental benefits beyond what traditional Medicare offers. These supplemental benefits can include transportation to and from appointments, nutrition planning, memberships for fitness centers, or dental coverage.

These supplemental benefits can certainly provide real positive impacts for seniors. But there has not been any meaningful accounting about whether or not seniors are actually using these services and if their usage correlates to the additional money insurance companies are being paid.

As Medicare payments for these supplemental benefits continue to increase, we must better understand if they are helping seniors and whether they are being delivered at a reasonable cost. We simply need more transparency and reliable data from the insurers to make sure that taxpayer funds are benefiting seniors and not the insurers.

America's seniors expect and deserve high quality health care, and we must ensure that is what they are receiving. I thank the witnesses for being here today as we conduct important oversight of the Medicare Advantage program.