Committee on Energy and Commerce

Opening Statement as Prepared for Delivery
of
Subcommittee on Oversight and Investigations Chair Diana DeGette

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

June 28, 2022

Ensuring that our seniors—one of our most vulnerable populations—have access to flexible, affordable, high-quality healthcare is of critical importance to me and this Committee. That was the intent behind the creation of the Medicare Advantage program that we are discussing here today, and we are conducting this oversight hearing to examine whether the program is fulfilling that intent.

Medicare Advantage plans offer an alternative to traditional Medicare. Nearly 64 million Americans are enrolled in Medicare and an increasing number of them are choosing Medicare Advantage plans each year. Enrollment in these privately run plans has more than doubled over the past decade.

Today, nearly 27 million Americans are enrolled in a Medicare Advantage plan. Federal spending for these plans is approximately 350 billion dollars annually and is expected to continue to grow.

Given the tremendous size and growth of the Medicare Advantage program, it is important that the American people and Congress better understand how these plans work, the quality of services being delivered to beneficiaries, and the value to American taxpayers.

Beneficiaries on Medicare Advantage plans are entitled to the same health services as those on traditional Medicare. But reports by the watchdog agencies represented here today indicate that they are not always receiving such care.

A recent report by the HHS Office of the Inspector General indicated that beneficiaries on some Medicare Advantage plans are facing serious impediments to the care they are entitled to. 18 percent were outright denied payment for care that they should have received. Another 13 percent were required to seek prior authorization and then were still improperly denied care.

While Medicare Advantage plans are permitted to require prior authorization for certain health services, organizations have raised concerns that they are now being required for relatively standard medical services. Our seniors and their doctors should not be required to jump through numerous hoops to ensure coverage for straightforward and medically necessary procedures.

In one example, OIG found that a patient with prostate cancer had been denied coverage for routine cancer-treatment services. In another, a patient with endometrial cancer was denied a CT scan. While these denials were ultimately reversed when appealed, seniors dealing with serious health issues should not be forced to spend their precious time and energy fighting needless bureaucracy to receive the care they are already entitled to.

Unfortunately, too many of them are required to do just that. OIG found that, when appealed, plan denials of payment or prior authorization were reversed 75 percent of the time. That is an alarmingly high rate, and we need to better understand why this is happening.

And to be clear, these administrative challenges have very real consequences. When necessary and appropriate care is denied or delayed, patients suffer and conditions worsen—at times requiring additional hospitalization or worse.

Findings by the Government Accountability Office also suggest that individuals on Medicare Advantage may be encountering challenges receiving services when they need them the most—in their last year of life. GAO found that individuals disenroll from their Medicare Advantage plans and switch to original Medicare at twice the normal rate in the final year of life.

This suggests that when care is most critical, Medicare Advantage plans may not deliver. While this is concerning, I was encouraged to see that the Centers for Medicare and Medicaid Services has begun to more closely monitor why beneficiaries are disenrolling from Medicare Advantage plans in their last year of life. Hopefully we will have answers and solutions to that problem soon.

It is not just access to care that is of concern under Medicare Advantage plans, but also the quality of the care itself. For example, studies have indicated that there are concerning disparities in the quality of care that individuals on Medicare Advantage plans receive based on racial demographics or where they live.

Unfortunately, data on the services actually provided to Medicare Advantage enrollees and the quality of that care has historically been incomplete or difficult to substantiate without conducting burdensome audits. Good information is needed for good oversight, and we look forward to hearing more from the witnesses today about what we still lack to ensure accountability.

Today we will hear directly from the government organizations that scrutinize how Medicare Advantage plans are being administered and what steps are necessary to ensure that Medicare Advantage plans are providing quality health care to seniors for the appropriate cost to taxpayers. The HHS Office of the Inspector General, the Government Accountability Office, and the Medicare Payment Advisory Commission have all been vigilant observers of the growth of Medicare Advantage and have assisted CMS in identifying ways to improve the program. I look forward to hearing from each of these organizations today.

The Medicare Advantage program is an important tool for seniors, and we all want to see it succeed. We will continue to conduct the oversight necessary to ensure that plans are

providing beneficiaries with the quality care that they deserve and that taxpayer dollars are being appropriately spent on delivering health care to our valuable seniors.