AMA
AMERICAN MEDICAL ASSOCIATION

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March 17, 2026

Michael E. Chernew, PhD
Chair
Medicare Payment Advisory Commission
425 I Street, NW, Suite 701
Washington, DC 20001

Re: American Medical Association's Comments on March 2026 Meeting

Dear Chair Chernew:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the Medicare Payment Advisory Commission's (MedPAC) discussion of the complexity of Medicare enrollment decisions for beneficiaries at its recent meeting. The staff presentation and commissioners' comments focused particularly on the difficulties beneficiaries face in choosing between traditional Medicare and Medicare Advantage (MA) plans when they initially enroll and during each annual open enrollment period. The AMA shares the concerns raised by many commissioners about the large number of factors that affect these choices and the absence of trusted and objective sources of information to assist beneficiaries.

The AMA also shares MedPAC's concerns about the lack of information and notifications being provided to Americans approaching the age of 65 about the need for them to take steps to avoid late enrollment penalties (LEPs) for Medicare premiums. According to AARP and the Medicare Rights Center, nearly 800,000 people were subject to LEPs for Part B in 2021, on average paying 27 percent higher premiums than those without the penalty. These financial penalties fall disproportionately on individuals who mistakenly assume that Medicare enrollment is automatic or that Medicare eligibility aligns with Social Security retirement. As MedPAC discussed, because the age of Medicare eligibility is no longer the same as Social Security, people must take active steps to enroll in Medicare during their seven-month Initial Enrollment Period, yet many people are likely unaware that they risk incurring significant LEPs if they miss certain deadlines. The AMA has recommended that the Social Security and Medicare agencies develop a coordinated campaign to make information about the penalty risk more accessible and widely available to people before they become Medicare eligible in order to prevent lifetime LEPs.

We are also concerned about the lack of education from trusted and objective sources about the differences between traditional Medicare and MA. Although it is true that, as the commission discussed, these enrollment decisions are complex, we believe that many beneficiaries lack more fundamental information about how these health insurance programs work. For example, beneficiaries enrolled in traditional Medicare can generally see any physician who accepts Medicare patients, whereas MA plans operate through provider networks. As a result, patients may need to change physicians if their current doctor is not included in the plan's network. In addition, depending on how narrow or expansive the network is, patients may find it more difficult to locate a specialist when needed or may experience longer wait times for appointments.

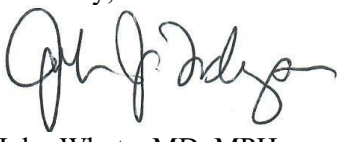
Out-of-pocket costs are also different. Some beneficiaries may choose an MA plan because the information provided by the plan indicates they will spend less than they would in traditional Medicare or if they pay for traditional Medicare and a Medigap supplemental premium. Even with MA out-of-pocket spending limits, many patients will struggle to afford MA cost-sharing for chemotherapy medications or other high-cost services. Unlike Medigap premiums, these costs are unpredictable.

MedPAC noted that there are a variety of Special Enrollment Periods for which beneficiaries may become eligible, in addition to the annual enrollment period and MA open enrollment period. Beneficiaries who obtain most of their Medicare information from plan marketing representatives or brokers, however, are likely unaware that they have Special Enrollment Period opportunities available when their circumstances change or if, for example, they made their MA plan choice based on incorrect information about the plan's physician network. As commissioners observed, beneficiaries may be inundated with marketing materials from MA plans about switching away from traditional Medicare, but they see very little information about their opportunities to leave those plans and return to traditional Medicare.

The discussion touched upon another serious problem with MA at this meeting–prior authorization–and this should also be considered in developing better beneficiary education strategies so that they can make the decisions about their Medicare enrollment that will best meet their health care needs. Whereas patients are likely to face prior authorization requirements for medications whether they are in an MA or standalone Part D plan, they are far more likely to face prior authorization for referrals, tests, procedures, therapies, and admissions in MA than traditional Medicare. These requirements frequently delay care, and they also add to the administrative burdens physicians face, making them less likely to want to participate in MA networks.

Once again, the AMA appreciates that MedPAC will include a chapter in its June Report to Congress on this important topic, and we look forward to its future work. Please reach out to me directly at 312-464-5288 or John.Whyte@ama-assn.org if you have questions or need further information.

Sincerely,



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