

Ambulatory care

**Physicians and other
health professionals**

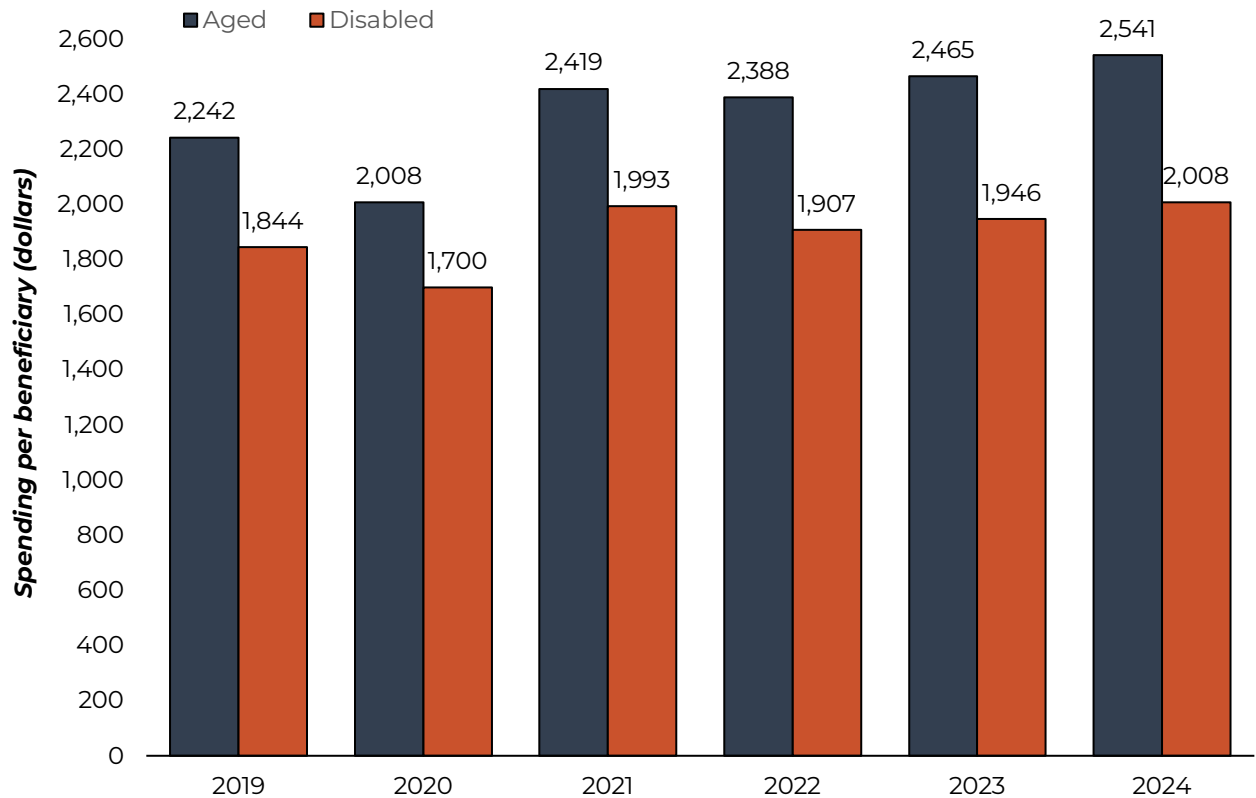
Hospital outpatient services

Ambulatory surgical centers

Low-value care

**Results of MedPAC's
access-to-care survey**

Chart 7-1 Medicare spending per FFS beneficiary on services in the physician fee schedule, 2019–2024



Note: FFS (fee-for-service). Dollar amounts are Medicare spending only and do not include beneficiary cost sharing. The “disabled” category excludes beneficiaries who qualify for Medicare because they have end-stage renal disease. All beneficiaries ages 65 and over are included in the “aged” category. Dollar amounts are nominal figures, not adjusted for inflation.

Source: The 2025 annual report of the Boards of Trustees of the Medicare trust funds.

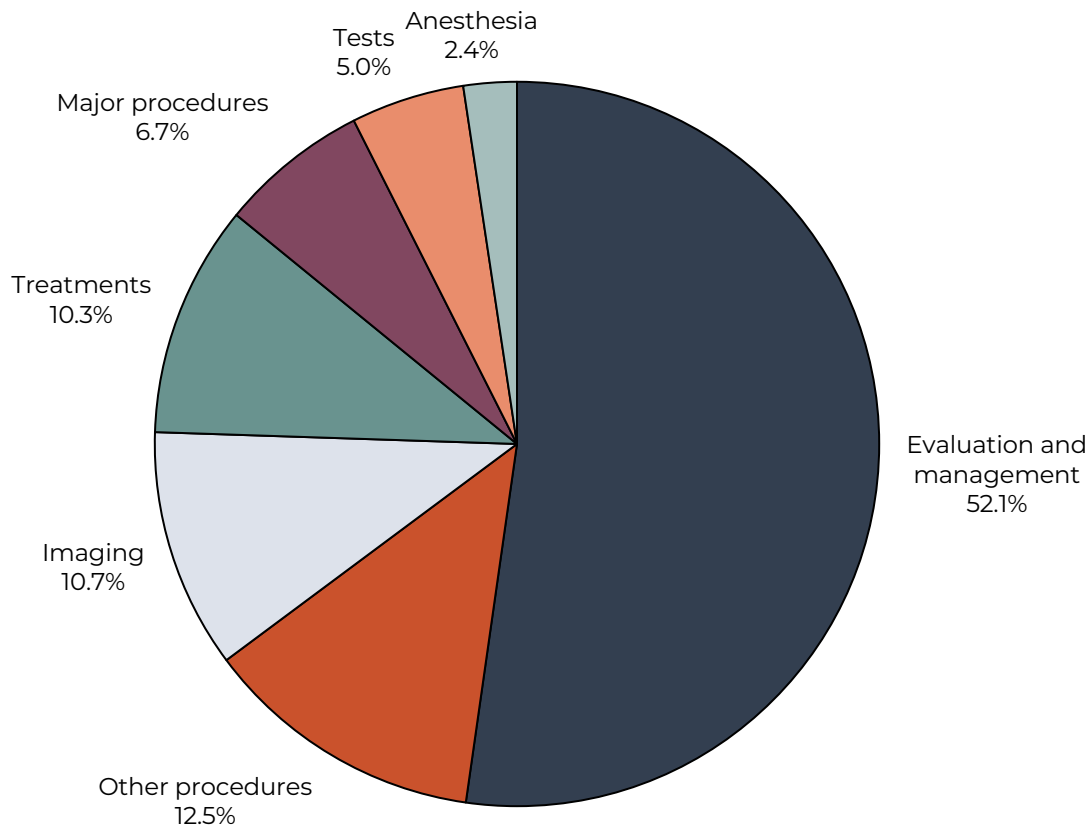
> The physician fee schedule includes a broad range of services, such as office visits, surgical procedures, and diagnostic and therapeutic services. Total fee schedule spending (excluding beneficiary cost sharing) was \$71.4 billion in 2024 (data not shown).

> Spending per FFS beneficiary for fee schedule services declined in 2020 due to the effects of the coronavirus pandemic but rebounded in 2021. From 2021 to 2024, spending per beneficiary grew slowly among aged beneficiaries and was flat for those with disabilities.

> Per capita spending on fee schedule services for beneficiaries with disabilities (under age 65) is lower than that for aged beneficiaries (ages 65 and over). In 2024, per capita spending for beneficiaries with disabilities was \$2,008 compared with \$2,541 for aged beneficiaries.

Chart 7-2 Physician fee schedule—allowed charges by type of service, 2024

Total allowed charges in 2024 = \$93.8 billion



Source: MedPAC analysis of CMS's Carrier Standard Analytic File for 100 percent of beneficiaries.

- > In 2024, allowed charges for physician fee schedule services totaled \$93.8 billion. “Allowed charges” includes both program spending and beneficiary cost-sharing liability. Allowed charges increased by 1.7 percent from 2023 on a nominal basis (data not shown). That slow growth rate is partly attributable to a 2.5 percent decline in the number of beneficiaries enrolled in fee-for-service Medicare as enrollment in Medicare Advantage continues to grow.
- > In 2024, more than half of all allowed charges were for evaluation and management (E&M) services.
- > Within the E&M category, about half of allowed charges were for office/outpatient visits (data not shown). The remaining allowed charges in the E&M category were for various types of services provided across a broad range of settings, including hospital inpatient departments, emergency departments, and nursing facilities (data not shown).
- > The “treatments” category includes physical therapy, cancer treatments, and dialysis. The two procedure categories (“major” and “other”) include various eye, cardiovascular, skin, and vascular procedures. The distinction between major procedures and other procedures is determined by the amount of the payment rate for each procedure and whether it is typically furnished in a facility setting.

Chart 7-3 Total number of encounters per FFS beneficiary was higher in 2024 compared with 2019, and the mix of clinicians furnishing them changed

Specialty category	Encounters per beneficiary						Percentage change in encounters per beneficiary		
	2019	2020	2021	2022	2023	2024	2019–2020	Average annual percent change 2020–2023	2023–2024
Total (all clinicians)	22.3	19.8	21.6	22.3	23.3	24.3	–11.2%	5.6%	4.3%
Primary care physicians	3.5	3.1	3.1	3.1	3.1	3.2	–10.2	0.1	1.7
Specialists	12.9	11.4	12.3	12.4	12.8	13.1	–12.0	4.0	2.8
APRNs/PAs	2.5	2.4	2.7	3.0	3.3	3.7	–2.8	11.5	11.8
Other practitioners	3.4	2.9	3.5	3.7	4.0	4.3	–15.2	11.4	6.1

Note: FFS (fee-for-service), APRN (advanced practice registered nurse), PA (physician assistant). We define “encounters” as unique combinations of beneficiary identification numbers, claim identification numbers (for paid claims), and the national provider identifiers of the clinicians who billed for the service. Figures do not account for “incident to” billing, meaning, for example, that encounters with APRNs/PAs that are billed under Medicare’s “incident to” rules are included in the physician totals. We use the number of FFS beneficiaries enrolled in Part B to define encounters per beneficiary. “Primary care physicians” includes family medicine, internal medicine, pediatric medicine, and geriatric medicine. “Specialists” includes physicians who specialize in areas such as cardiology, dermatology, and oncology. “Other practitioners” includes clinicians such as physical therapists, psychologists, and social workers. This category also includes podiatrists, optometrists, dental surgeons, and chiropractors, which are defined as physicians in Section 1861 of the Social Security Act. Components may not sum to totals due to rounding.

Source: MedPAC analysis of CMS’s Carrier Standard Analytic File for 100 percent of beneficiaries and the 2025 annual report of the Boards of Trustees of the Medicare trust funds.

- > An “encounter” is a measure of beneficiary interaction with clinicians. For example, if a physician billed for an office visit and an X-ray on the same claim, we count that as one encounter.
- > Over the 2019 to 2024 period, the overall number of encounters per FFS beneficiary grew, on average, by 1.8 percent annually (data not shown). The growth rate over that period was impacted by the coronavirus pandemic, which reduced encounters by 11.2 percent in 2020, but includes a rebound that occurred after 2020, with an annual growth rate of 5.6 percent from 2020 to 2023.
- > Encounters with specialist physicians accounted for the majority of all encounters. These encounters fell by 12.0 percent in 2020 but increased by an average of 4.0 percent from 2020 to 2023 and grew by 2.8 percent in 2024.
- > In 2024, encounters with APRNs and PAs grew rapidly (11.8 percent), and encounters with primary care physicians grew more slowly (1.7 percent). These changes continue a longer-term trend of slow growth in services billed by primary care physicians and large increases in the number of services billed by APRNs and PAs.

Chart 7-4 The number of clinicians billing Medicare’s physician fee schedule increased, and the mix of clinicians changed, 2019–2024

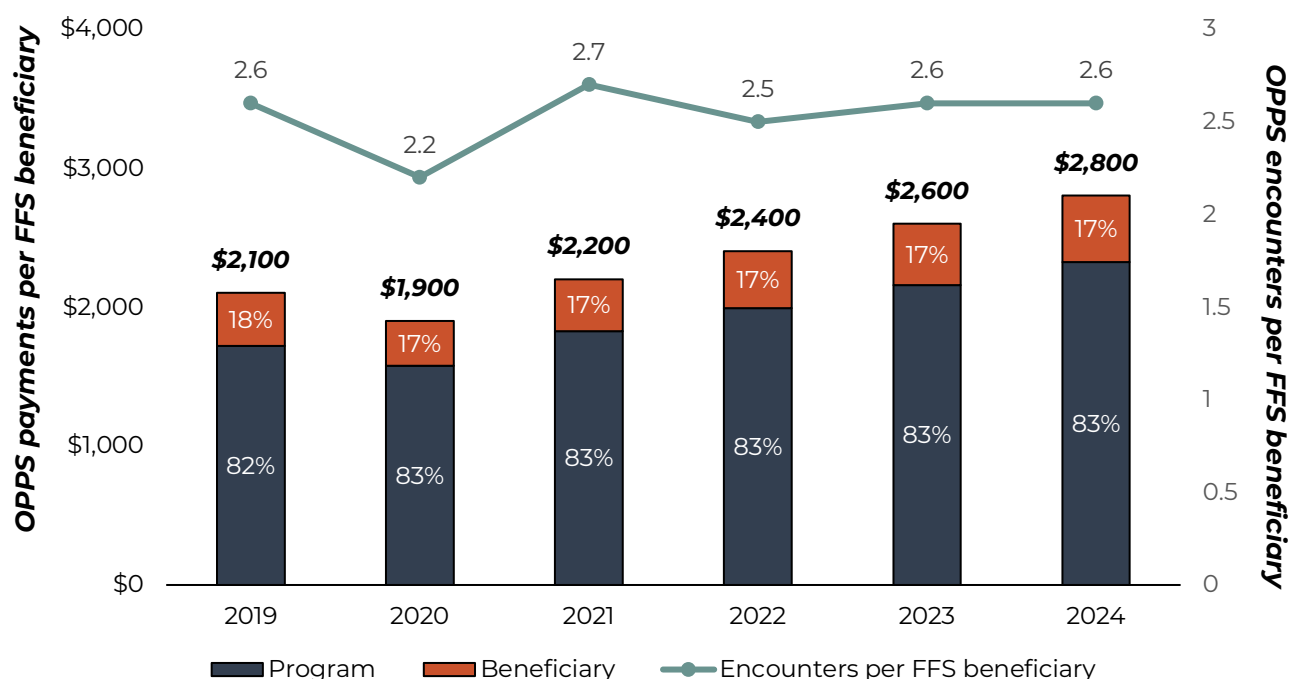
Year	Number (in thousands)					Number per 1,000 FFS beneficiaries				
	Physicians				Total	Physicians				Total
	Primary care specialties	Other specialties	APRNs and PAs	Other practitioners		Primary care specialties	Other specialties	APRNs and PAs	Other practitioners	
2019	138	468	258	180	1,044	4.2	14.2	7.8	5.4	31.6
2020	135	468	268	172	1,043	4.2	14.5	8.3	5.3	32.3
2021	134	472	286	180	1,072	4.3	15.3	9.3	5.8	34.8
2022	133	477	308	184	1,102	4.5	16.1	10.4	6.2	37.2
2023	132	483	327	189	1,131	4.6	16.9	11.4	6.8	39.5
2024	133	491	348	193	1,165	4.8	17.6	12.5	6.9	41.7

Note: FFS (fee-for-service), APRN (advanced practice registered nurse), PA (physician assistant). “Physicians” includes only clinicians who are licensed as a doctor of medicine or doctor of osteopathic medicine. “Primary care specialty” includes family medicine, internal medicine, pediatric medicine, and geriatric medicine, with an adjustment to exclude hospitalists. Hospitalists are counted in “other specialties.” “Other practitioners” includes clinicians such as physical therapists, psychologists, and social workers. This category also includes podiatrists, optometrists, dental surgeons, and chiropractors, which are defined as physicians in Section 1861 of the Social Security Act. This table includes only physicians with a caseload of more than 15 FFS beneficiaries in the year. Beneficiary counts used to calculate clinicians per 1,000 beneficiaries include those enrolled in FFS Medicare Part B. Numbers exclude nonperson providers, such as clinical laboratories and independent diagnostic-testing facilities. Components may not sum to totals due to rounding.

Source: MedPAC analysis of CMS’s Standard Analytic File for 100 percent of beneficiaries and the 2025 annual report of the Boards of Trustees of the Medicare trust funds.

- > From 2019 to 2024, the total number of clinicians billing the fee schedule grew in absolute terms and relative to the size of the FFS Medicare population.
- > The total number of clinicians per 1,000 FFS beneficiaries increased from 31.6 to 41.7 over the 2019 to 2024 period, a total increase of 32 percent.
- > Over the 2019 to 2024 period, the number of primary care physicians billing the fee schedule slowly declined—yielding a net loss of about 5,000 primary care physicians by 2024. However, on a per FFS beneficiary basis, the number of primary care physicians grew over the same period. Over the same five-year period, the number of APRNs and PAs billing the fee schedule grew rapidly from about 258,000 to 348,000. The number of specialist physicians and other practitioners, such as physical therapists and podiatrists, who billed the fee schedule increased at a steady pace.

Chart 7-5 OPPS spending per Part B FFS beneficiary has continued to grow, while the number of encounters per beneficiary has been steadier

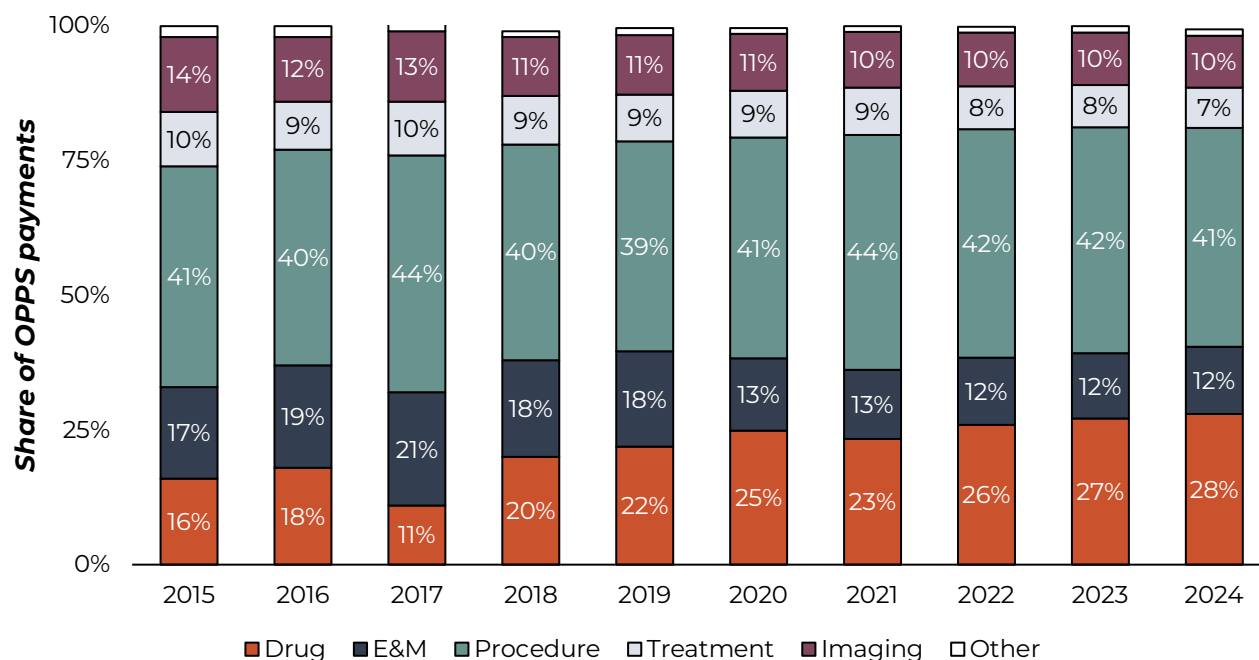


Note: OPPS (outpatient prospective payment system), FFS (fee-for-service). “OPPS payments” includes FFS Medicare program payments and beneficiaries’ cost-sharing liabilities. “FFS beneficiaries” is limited to those who resided in the U.S. and had Part B. “OPPS encounters” are unique combinations of claims, beneficiaries, and providers, regardless of the number of separately payable OPSS services provided in that encounter. Dollars are nominal, not adjusted for inflation.

Source: MedPAC analysis of outpatient claims data and enrollment data from CMS.

- > OPSS payments per FFS beneficiary increased in 2024 to \$2,800, well above the pre-pandemic level of \$2,100. Beneficiaries’ cost-sharing liability—which includes the Part B deductible and 20 percent coinsurance on most services—remained at about 17 percent.
- > In contrast, OPSS encounters per FFS Medicare beneficiary have been steadier, apart from a dip in 2020. In 2024, there were 2.6 OPSS encounters per FFS Medicare beneficiary, the same level as in 2019.
- > While the number of FFS Medicare beneficiaries declined from 2019 to 2024, OPSS payments per FFS beneficiary grew fast enough that aggregate OPSS payments rose to \$76.1 billion in 2024, or \$1,100 per encounter (data not shown).

Chart 7-6 Procedures accounted for the largest share of OPSS spending, but separately payable drugs have been the fastest growing, 2015–2024



Note: OPSS (outpatient prospective payment system), E&M (evaluation and management). “OPSS payments” includes fee-for-service Medicare program payments and beneficiaries’ cost-sharing liabilities. “Drugs” reflects separately payable drugs, identified by the status indicators G and K. All other categories reflect restructured Berenson-Eggers Type of Service (BETOS) classifications. The “other” category accounted for 2 percent or less of OPSS payments each year; components may not sum to 100 percent due to rounding.

Source: MedPAC analysis of outpatient claims data from CMS.

- > Many types of outpatient services are covered under the OPSS.
- > Procedures such as hip and knee replacements continued to comprise the largest share of OPSS payments.
- > However, the fastest growing share of OPSS payments are separately payable drugs, which increased from 22 percent in 2019 to 28 percent in 2024. (For more information on Part B drugs across settings, see Chapter 10).
- > Over this same period, there were smaller declines in the share of OPSS payments E&M services (such as clinic visits and emergency department visits), treatments (such as injections of chemotherapy drugs), and imaging.
- > The volume of outpatient services is harder to compare given the wide variety of services, what counts as a single unit, and different levels of packaging. However, the most common OPSS services on a paid line-item basis were E&M, imaging, and treatment services.

Chart 7-7 The top 20 APCs comprised 44 percent of OPPS payments in 2024

APC	APC title	OPPS payments (billions)	Share of OPPS payments
05115	Level 5 musculoskeletal procedures	\$4.6	6.2%
01490	Injection, pembrolizumab (Keytruda)	3.5	4.6
05012	Clinic visits and related services	2.7	3.6
05213	Level 3 electrophysiologic procedures	2.6	3.5
08011	Comprehensive observation services	2.1	2.8
05025	Level 5 Type A ED Visits	1.8	2.4
05024	Level 4 Type A ED Visits	1.5	2.0
09378	Daratumumab, hyaluronidase (Darzalex Faspro)	1.4	1.9
05116	Level 6 musculoskeletal procedures	1.4	1.9
05193	Level 3 endovascular procedures	1.3	1.8
05114	Level 4 musculoskeletal procedures	1.1	1.5
05693	Level 3 drug administration	1.1	1.5
09453	Injection, nivolumab (Opdivo)	1.1	1.4
05623	Level 3 radiation therapy	1.0	1.4
05361	Level 1 laparoscopy and related services	1.0	1.3
05524	Level 4 imaging without contrast	0.9	1.2
05572	Level 2 imaging with contrast	0.9	1.2
09272	Injection, denosumab (Prolia)	0.9	1.2
05191	Level 1 endovascular procedures	0.9	1.2
05312	Level 2 lower GI procedures	0.9	1.2

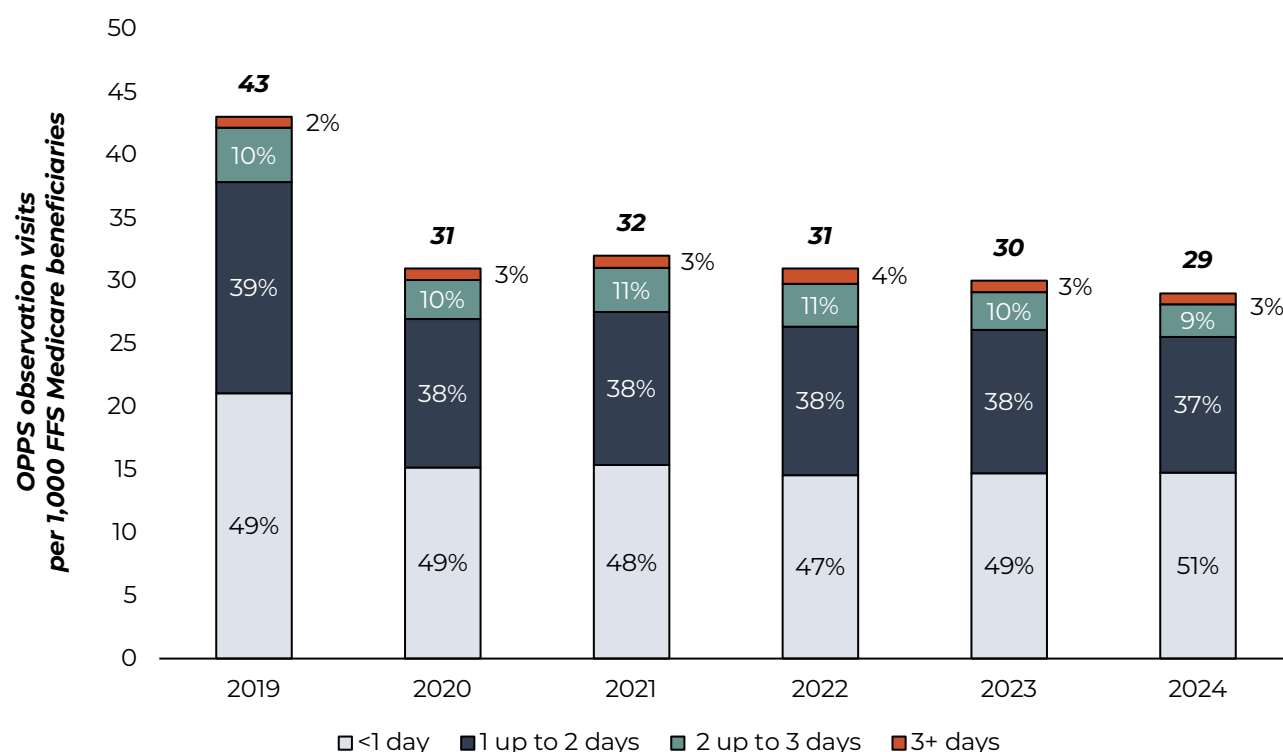
Note: APC (ambulatory payment classification), OPPS (outpatient prospective payment system), ED (emergency department), GI (gastrointestinal). "OPPS payments" includes fee-for-service Medicare program payments and beneficiaries' cost-sharing liabilities.

Source: MedPAC analysis of outpatient claims OPPS Addenda A data from CMS.

> The unit of payment in the OPPS is the APC; in 2024, there were about 860 APCs. Some of these represent a single service, some a collection of services, and some separately payable drugs or devices.

> OPPS payments were concentrated in a much smaller number of APCs. The top 20 APCs comprised 44 percent of OPPS payments in 2024, led by Level 5 musculoskeletal procedures (such as total knee and hip replacements), and Keytruda (a drug used to treat cancer).

Chart 7-8 Number of OPPS outpatient observation visits per 1,000 FFS Medicare beneficiaries in 2024 remained well below the prepandemic level



Note: OPPS (outpatient prospective payment system), FFS (fee-for-service). “OPPS observation visits” refers to separately payable visits under the OPPS; these visits last at least eight hours and do not result in an inpatient admission. “FFS beneficiaries” are limited to those who resided in the U.S. and had Part B. Components may not sum to 100 percent due to rounding.

Source: MedPAC analysis of hospital outpatient claims and enrollment data from CMS.

> Hospitals sometimes use observation care to determine whether a patient should be hospitalized for inpatient care, transferred to an alternative treatment setting, or sent home.

> In 2020, with the onset of the coronavirus pandemic, the number of observation visits per capita declined to 31 visits per 1,000 FFS Medicare beneficiaries (down from 43 visits per 1,000 beneficiaries in 2019). However, the distribution of the observation visits by length of stay remained relatively steady, with nearly half lasting less than one day, another nearly 40 percent lasting one up to two days, about 10 percent lasting two to three days, and about 3 percent lasting three or more days.

> The volume of observation visits per 1,000 FFS Medicare beneficiaries and the distribution of the length of those visits remained relatively steady from 2020 through 2024.

Chart 7-9 Number of Medicare-certified ASCs, 2019–2024

	2019	2020	2021	2022	2023	2024	Average annual percentage change 2019–2024
Medicare payments (billions of dollars)	\$5.3	\$4.8	\$5.7	\$6.0	\$6.6	\$7.5	7.0%
New centers (during year)	243	189	266	225	256	248	N/A
Closed centers (during year)	128	92	108	95	105	108	N/A
Net total number of centers (end of year)	5,760	5,857	6,015	6,145	6,296	6,436	2.2
Volume per 1,000 FFS Part B beneficiaries	211	175	205	210	222	230	1.7
Share of all centers that are:							
Urban	96	93	93	94	94	94	N/A
Rural	4	7	7	6	6	6	N/A

Note: ASC (ambulatory surgical center), N/A (not applicable), FFS (fee-for-service). “Medicare payments” includes program spending and beneficiary cost sharing for ASC facility services. “Closed” refers to an ASC that terminated operations, either because it closed operations or merged with another facility. Dollar amounts are nominal figures, not adjusted for inflation. Numbers may differ from prior years due to small methodological changes and updates to data.

Source: MedPAC analysis of Provider of Services file from CMS, 2025. Payment data are from MedPAC’s analysis of ASC claims from CMS’s Carrier Standard Analytic Files.

> ASCs are distinct entities that furnish ambulatory surgical services that do not require an overnight stay in a hospital. The most common ASC procedures are cataract removal with lens insertion, upper gastrointestinal endoscopy, colonoscopy, and nerve procedures.

> Total Medicare payments per FFS Part B Medicare beneficiary for ASC services increased by approximately 11 percent per year, on average, from 2019 through 2024 on a nominal basis (data not shown). From 2023 to 2024, total payments per FFS Part B beneficiary rose 16 percent as the average complexity of ASC services provided increased (data not shown) and the number of services per FFS Part B Medicare beneficiary increased.

> The number of Medicare-certified ASCs grew at an average annual rate of 2.2 percent from 2019 through 2024. In this same period, an annual average of 238 new facilities entered the market, while an average of 106 closed or merged with other facilities (data not shown).

Chart 7-10 Between 36 and 74 low-value services were provided per 100 FFS beneficiaries in 2023; Medicare spent between about \$2.0 billion and \$5.9 billion on these services

Measure	Broader version of measure			Narrower version of measure		
	Count per 100 beneficiaries	Share of beneficiaries affected	Spending (millions)	Count per 100 beneficiaries	Share of beneficiaries affected	Spending (millions)
Imaging for nonspecific low back pain	13.9	9.9%	\$269	3.8	3.5%	\$74
PSA screening at age >75 years	11.1	7.5	97	6.5	5.2	57
Spinal injection for low back pain	6.8	3.8	1,293	2.5	1.5	478
PTH testing in early CKD	6.7	4.0	125	5.6	3.4	104
Colon cancer screening for older adults	6.0	5.8	431	0.2	0.2	2
T3 level testing for patients with hypothyroidism	5.9	3.5	35	5.9	3.5	35
Carotid artery disease screening in asymptomatic adults	4.2	3.9	223	3.5	3.2	182
Preoperative chest radiography	3.4	3.1	49	0.8	0.7	11
Head imaging for uncomplicated headache	3.3	3.0	218	2.1	1.9	137
Stress testing for stable coronary disease	3.0	2.8	834	0.3	0.3	92
Cervical cancer screening at age >65 years	2.0	1.9	40	1.7	1.7	35
Homocysteine testing in cardiovascular disease	1.1	0.9	9	0.2	0.1	1
Head imaging for syncope	1.0	1.0	68	0.6	0.6	40
Preoperative echocardiography	1.1	1.1	87	0.3	0.3	28
BMD testing at frequent intervals	0.6	0.6	13	0.4	0.4	9
Preoperative stress testing	0.6	0.6	171	0.2	0.2	52
CT for uncomplicated rhinosinusitis	0.6	0.6	44	0.3	0.3	18
Vitamin D testing in absence of hypercalcemia or decreased kidney function	0.5	0.4	8	0.5	0.4	8
Imaging for plantar fasciitis	0.5	0.4	10	0.2	0.2	4
Screening for carotid artery disease for syncope	0.5	0.4	24	0.3	0.3	15
PCI/stenting for stable coronary disease	0.3	0.3	1,174	0.04	0.04	181
Cancer screening for patients with CKD on dialysis	0.3	0.2	7	0.1	0.1	1
Hypercoagulability testing after DVT	0.2	0.2	6	0.1	0.1	2
Vertebroplasty/kyphoplasty for osteoporotic vertebral fractures	0.2	0.1	308	0.2	0.1	303
Arthroscopic surgery for knee osteoarthritis	0.2	0.2	136	0.02	0.02	21
Preoperative PFT	0.2	0.2	2	0.1	0.1	1
IVC filter to prevent pulmonary embolism	0.1	0.1	15	0.1	0.1	15
Renal artery angioplasty/stenting	0.1	0.1	134	0.01	0.01	31
EEG for headache	0.04	0.04	2	0.02	0.02	1
Carotid endarterectomy for asymptomatic patients	0.05	0.05	124	0.02	0.02	50
Pulmonary artery catheterization in ICU	0.01	0.01	0.2	0.02	0.005	0.2
Total	74.2	37.5	5,929	36.3	23.5	1,990

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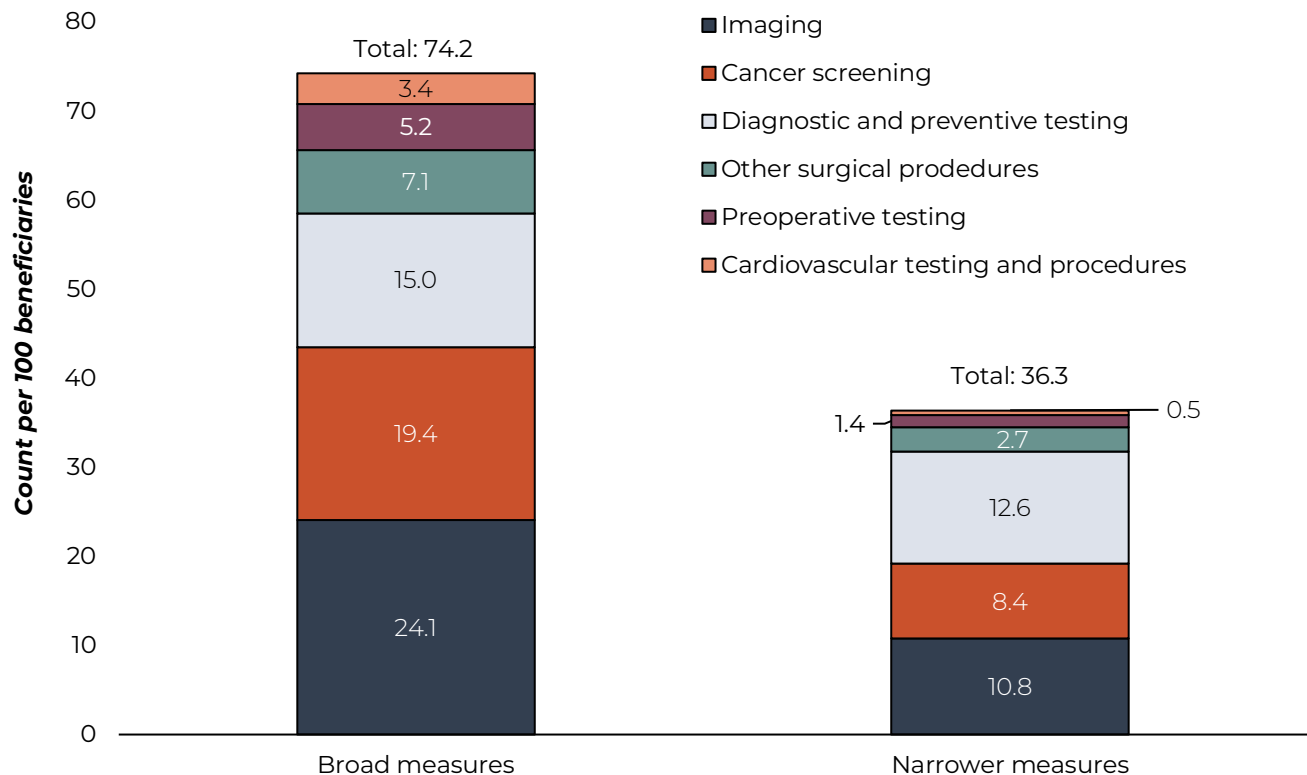
Chart 7-10 Between 36 and 74 low-value services were provided per 100 FFS beneficiaries in 2023; Medicare spent between about \$2.0 billion and \$5.9 billion on these services (continued)

Note: FFS (fee-for-service), PSA (prostate-specific antigen), PTH (parathyroid hormone), CKD (chronic kidney disease), BMD (bone mineral density), CT (computed tomography), PCI (percutaneous coronary intervention), DVT (deep vein thrombosis), PFT (pulmonary function test), IVC (inferior vena cava), EEG (electroencephalography), ICU (intensive care unit). Note that carotid endarterectomy now includes carotid stenting. “Count” refers to the number of unique services. Some totals do not equal the sum of their components due to rounding. The total for “share of beneficiaries affected” does not equal the column sum because some beneficiaries received services covered by multiple measures. “Spending” includes Medicare Part A and Part B program spending and beneficiary cost sharing for services detected by measures of low-value care. To estimate spending, we used standardized prices to adjust for regional differences in payment rates. The standardized price is the median payment amount per service in 2009, adjusted for the increase in payment rates between 2009 and 2022. This method was developed by Schwartz et al. (2014) with updates to reflect changes to diagnosis and procedure coding over time. The broad and narrow versions of the measures for T3 level testing for patients with hypothyroidism and IVC filter to prevent pulmonary embolism are the same.

Source: MedPAC analysis of 100 percent of Medicare claims from CMS using measures developed by Schwartz and colleagues (Schwartz, A. L., M. E. Chernew, B. E. Landon, et al. 2015. Changes in low-value services in Year 1 of the Medicare Pioneer Accountable Care Organization Program. *JAMA Internal Medicine* 175: 1815–1825; Schwartz, A. L., B. E. Landon, A. G. Elshaug, et al. 2014. Measuring low-value care in Medicare. *JAMA Internal Medicine* 174: 1067–1076).

- > Low-value care is the provision of a service that has little or no clinical benefit or care in which the risk of harm from the service outweighs its potential benefit.
- > The 31 measures of low-value care in this chart were developed by a team of researchers. The measures are drawn from evidence-based lists—such as Choosing Wisely—and the medical literature. We applied these measures to 100 percent of Medicare claims data from 2023. These 31 measures do not represent all instances of low-value care; the actual number (and corresponding spending) may be much higher.
- > The researchers developed two versions of each measure: a broad version (more sensitive, less specific) and a narrower version (less sensitive, more specific). Increasing the sensitivity of a measure captures more potentially inappropriate use but is also more likely to misclassify some appropriate use as inappropriate. Increasing a measure’s specificity leads to less misclassification of appropriate use as inappropriate at the expense of potentially missing some instances of inappropriate use.
- > Based on the broad versions of the measures, our analysis found about 74 instances of low-value care per 100 beneficiaries in 2023, with about 37 percent of beneficiaries receiving at least 1 low-value service that year. Medicare spending for these services was \$5.9 billion. Based on the narrower versions of the measures, our analysis showed about 36 instances of low-value care per 100 beneficiaries, with 23 percent of beneficiaries receiving at least 1 low-value service. Medicare spending for these services totaled about \$2.0 billion.

Chart 7-11 Imaging, cancer screening, and diagnostic and preventive testing accounted for most of the volume of low-value care in 2023



Note: “Count” refers to the number of unique services provided to fee-for-service Medicare beneficiaries.

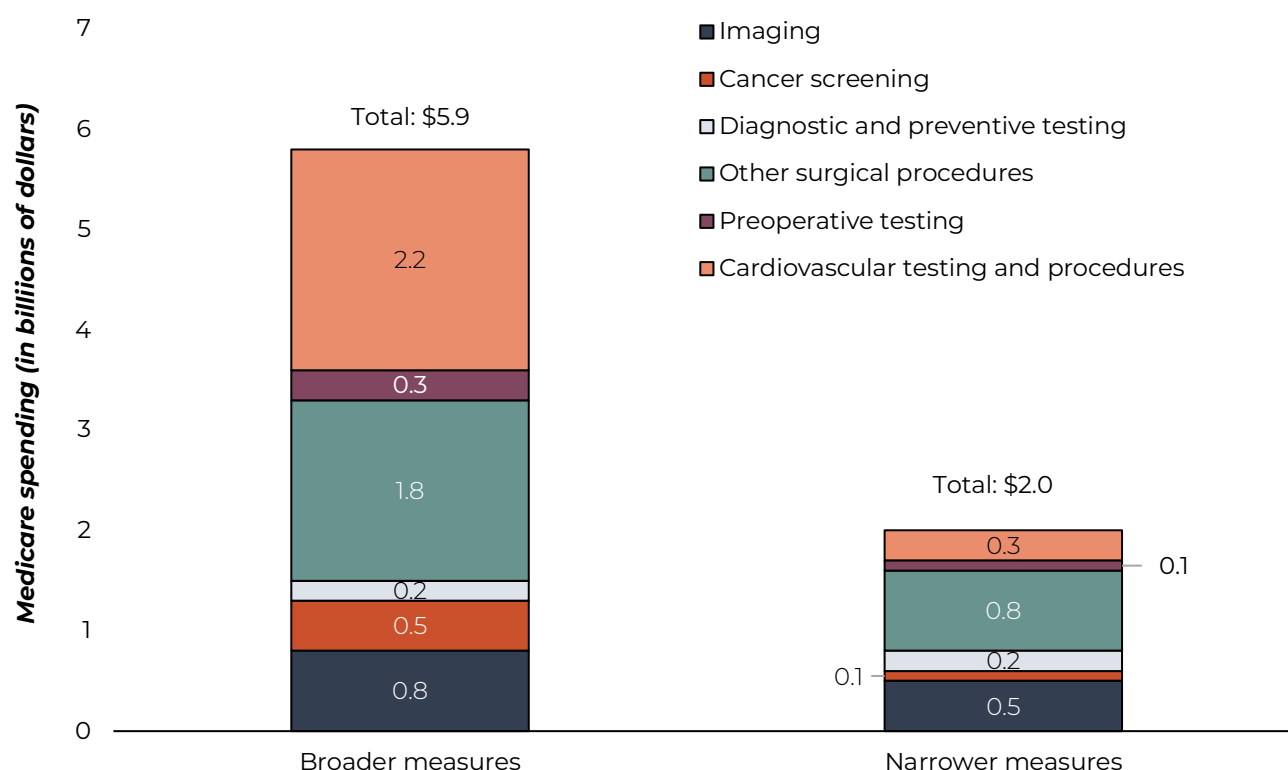
Source: MedPAC analysis of 100 percent of Medicare claims from CMS using measures developed by Schwartz and colleagues (Schwartz, A. L., M. E. Chernew, B. E. Landon, et al. 2015. Changes in low-value services in year 1 of the Medicare Pioneer Accountable Care Organization Program. *JAMA Internal Medicine* 175: 1815–1825; Schwartz, A. L., B. E. Landon, A. G. Elshaug, et al. 2014. Measuring low-value care in Medicare. *JAMA Internal Medicine* 174: 1067–1076).

> We assigned each of the 31 measures of low-value care in Chart 7-10 to one of six clinical categories.

> Using the broader versions of the measures, imaging and cancer screening accounted for 59 percent of the volume of low-value care. The “imaging” category includes back imaging for patients with nonspecific low back pain and screening for carotid artery disease in asymptomatic adults. The “cancer screening” category includes prostate-specific antigen testing for men ages 75 and older and colorectal cancer screening for older adults.

> Using the narrower versions of the measures, imaging and diagnostic and preventive testing accounted for 64 percent of the volume of low-value care.

Chart 7-12 Cardiovascular testing and procedures, other surgical procedures, and imaging accounted for most spending on low-value care in 2023



Note: “Spending” includes Medicare Part A and Part B program spending and beneficiary cost sharing for services detected by measures of low-value care. To estimate spending, we used standardized prices to adjust for regional differences in payment rates. The standardized price is the median payment amount per service in 2009, adjusted for the increase in payment rates between 2009 and 2023. This method was developed by Schwartz et al. (2014).

Source: MedPAC analysis of 100 percent of Medicare claims from CMS using measures developed by Schwartz and colleagues (Schwartz, A. L., M. E. Chernew, B. E. Landon, et al. 2015. Changes in low-value services in year 1 of the Medicare Pioneer Accountable Care Organization Program. *JAMA Internal Medicine* 175: 1815–1825; Schwartz, A. L., B. E. Landon, A. G. Elshaug, et al. 2014. Measuring low-value care in Medicare. *JAMA Internal Medicine* 174: 1067–1076).

> Cardiovascular testing and procedures and “other surgical procedures” accounted for about 67 percent of total spending on low-value care using the broader measures. Other surgical procedures and imaging made up 59 percent of spending on low-value care using the narrower measures.

> The “cardiovascular testing and procedures” category includes stress testing for stable coronary disease and percutaneous coronary intervention with balloon angioplasty or stent placement for stable coronary disease. The “other surgical procedures” category includes spinal injection for low back pain and arthroscopic surgery for knee osteoarthritis. The “imaging” category includes back imaging for patients with nonspecific low back pain and screening for carotid artery disease in asymptomatic adults.

> The spending estimates probably understate actual spending on low-value care because they do not include the cost of downstream services (e.g., follow-up tests and procedures) that may result from the initial low-value service. Also, the 31 measures do not capture all low-value care.

Chart 7-13 In MedPAC's 2025 survey, Medicare beneficiaries were more likely to report being satisfied with their access to care than privately insured people

Survey question	Medicare beneficiaries (ages 65 and older)	Privately insured (ages 50–64)
Received health care in past year: “Have you received any health care in the past 12 months in any type of setting, such as a hospital, physician office, or clinic?”		
Yes	94%*	92%*
Providers that accept your insurance: Among those who received health care, “In the past 12 months, how satisfied or dissatisfied have you been with your ability to find health care providers that accept [Medicare/your insurance]?”		
Satisfied (net)	97*	93*
Very satisfied	83*	66*
Somewhat satisfied	15*	28*
Dissatisfied (net)	3*	7*
Somewhat dissatisfied	2*	5*
Very dissatisfied	1*	2*
Providers with timely appointments: Among those who received health care, “In the past 12 months, how satisfied or dissatisfied have you been with your ability to find health care providers that have appointments when you need them?”		
Satisfied (net)	90*	81*
Very satisfied	58*	43*
Somewhat satisfied	32*	38*
Dissatisfied (net)	10*	19*
Somewhat dissatisfied	7*	14*
Very dissatisfied	3*	6*

Note: Survey completed by 4,788 Medicare beneficiaries (including in fee-for-service Medicare and Medicare Advantage) and 5,079 privately insured individuals. Sample sizes for questions varied. Surveys completed online in English or by mail in English or Spanish, depending on respondent preference. Survey data weighted to be nationally representative. Components may not sum to totals due to rounding.

* Statistically significant difference between Medicare beneficiaries and the privately insured at a 95 percent confidence level.

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 18 to September 8, 2025.

> MedPAC surveys Medicare beneficiaries ages 65 and over and privately insured people ages 50 to 64 each year to compare these two groups' experiences accessing care in the prior 12 months.

> In our 2025 survey, higher shares of Medicare beneficiaries reported receiving any health care in the past year (94 percent) compared with privately insured individuals (92 percent).

> Among those who received health care in the past year:

>> Higher shares of Medicare beneficiaries were satisfied with their ability to find health care providers that accepted their insurance (97 percent) compared with privately insured people (93 percent).

>> Higher shares of Medicare beneficiaries were satisfied with their ability to find providers that had appointments when needed (90 percent) compared with privately insured people (81 percent).

Chart 7-14 In MedPAC's 2025 survey, Medicare beneficiaries reported better access to primary care providers than privately insured people

Survey question	Medicare beneficiaries (ages 65 and older)	Privately insured (ages 50–64)
Have a primary care provider: “A primary care provider is the doctor you see in an office or a clinic for routine medical care, medical check-ups, or when you first experience a medical problem. Do you have a primary care provider that you go to for this type of care?”		
Yes	96%*	92%*
See an NP or PA for primary care: “People can see a nurse practitioner or physician assistant, rather than a doctor, for their primary care. How often do you see a nurse practitioner or physician assistant?”		
For none of my primary care (I always see a doctor)	40*	37*
For any of my primary care (net)	58*	61*
For some of my primary care	39*	37*
For all or most of my primary care	19*	24*
I don't know	2	2
Tried to get a new primary care provider: “In the past 12 months, have you tried to get a new primary care provider?”		
Yes	12%*	14%*
Reason looked for new primary care provider: Among those who tried to get a new primary care provider, “Which of the following best describes the main reason you tried to get a new primary care provider in the last 12 months?” (Overall share)		
My provider retired or stopped practicing	47* (5)	35* (4)
I changed my health plan and had to find a new provider who participated in the new plan	10* (1*)	14* (2*)
I recently moved, so I needed to find a primary care provider in my area	9 (1*)	11 (1*)
My primary care provider was no longer accepting [Medicare/my insurance]	2* (0*)	7* (1*)
My primary care provider started charging a membership fee, and I didn't want to pay it	1* (0*)	3* (0*)
Other	31 (3)	30 (4)

Note: NP (nurse practitioner), PA (physician assistant). Survey completed by 4,788 Medicare beneficiaries (including in fee-for-service Medicare and Medicare Advantage) and 5,079 privately insured individuals. Sample sizes for questions varied. Surveys completed online in English or by mail in English or Spanish, depending on respondent preference. Survey data weighted to be nationally representative. “Overall share” refers to the share of all respondents with this insurance.

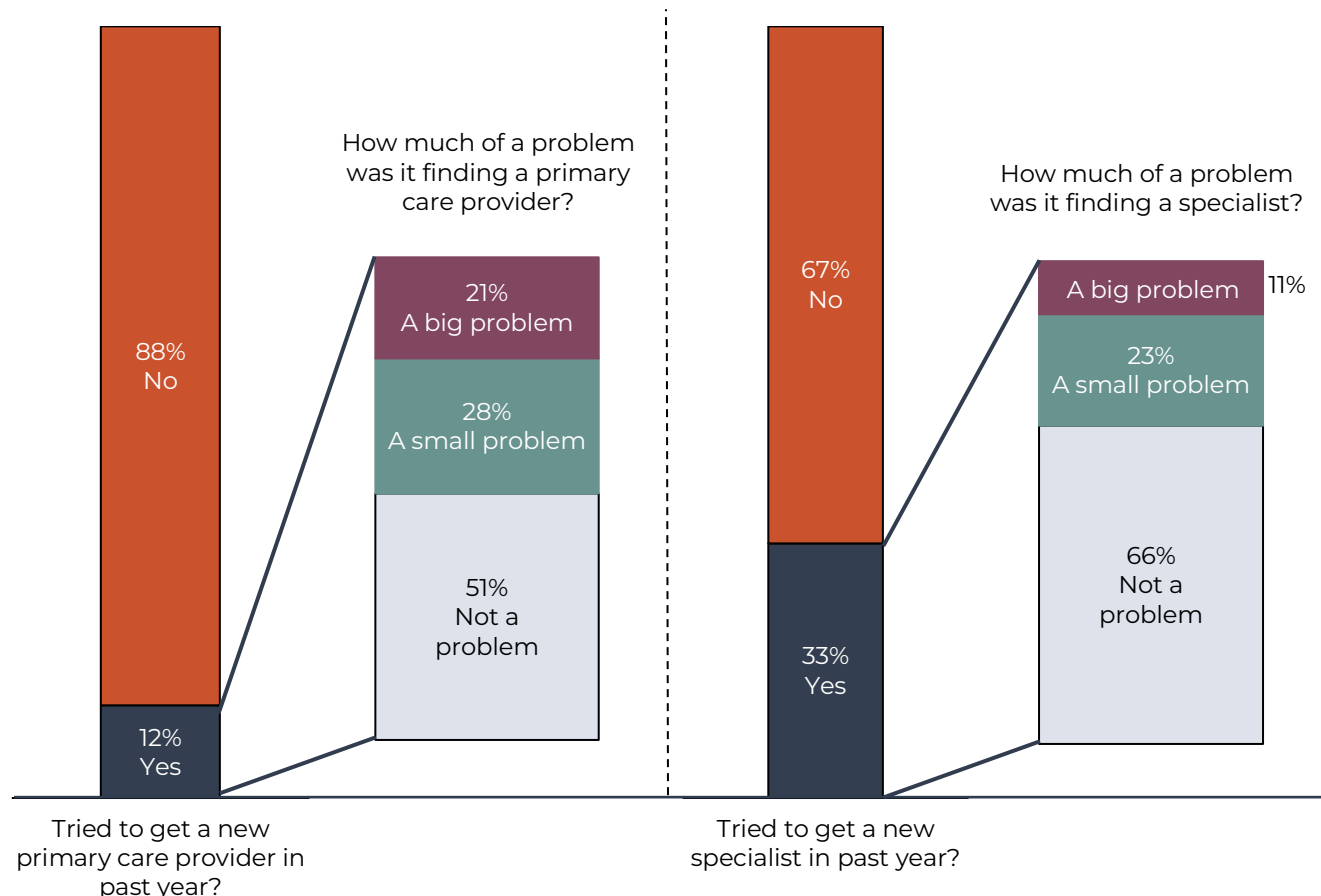
* Statistically significant difference between Medicare beneficiaries and the privately insured at a 95 percent confidence level.

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 18 to September 8, 2025.

> In our 2025 survey, higher shares of Medicare beneficiaries reported having a primary care provider (PCP) (96 percent) compared with privately insured people (92 percent).

> Small shares of Medicare beneficiaries and privately insured people reported needing to find a new PCP in the past year (12 percent and 14 percent, respectively). The most common reason for looking for a new PCP was that a PCP had retired or stopped practicing, which was reported by 47 percent of Medicare beneficiaries looking for a new PCP and 35 percent of privately insured people in this situation (equivalent to 5 percent and 4 percent, respectively, of these groups overall).

Chart 7-15 In MedPAC's 2025 survey, beneficiaries encountered more problems finding a new primary care provider than a new specialist



Note: Survey completed by 4,788 Medicare beneficiaries (including in fee-for-service Medicare and Medicare Advantage). Sample sizes for questions varied. Surveys completed online in English or by mail in English or Spanish, depending on respondent preference. Survey data weighted to be nationally representative.

Source: MedPAC's annual access-to-care survey fielded by Gallup from July 18 to September 8, 2025.

> In our 2025 survey, beneficiaries looking for a new primary care provider encountered more problems finding one than those looking for a new specialist. Among the 12 percent of Medicare beneficiaries who tried to get a new primary care provider in the past year, about half reported a problem finding a new one; by contrast, among the 33 percent of Medicare beneficiaries who looked for a new specialist, about a third reported a problem finding one.

> Because a larger share of patients look for a new specialist than look for a new primary care provider each year, the problems finding a new specialist affect more beneficiaries. Overall, we estimate that 11 percent of all Medicare beneficiaries had a problem finding a new specialist, while 6 percent of all beneficiaries had problems finding a new primary care provider (data not shown).

> Privately insured people reported more problems finding a new primary care provider or specialist than did Medicare beneficiaries, as shown in the next chart.

Chart 7-16 In MedPAC's 2025 survey, Medicare beneficiaries reported fewer problems finding a new clinician than privately insured people

Survey question	Medicare beneficiaries (ages 65 and older)	Privately insured (ages 50–64)
Get a new primary care provider: “In the past 12 months, have you tried to get a new primary care provider?”		
Yes	12%*	14%*
Problems finding a primary care provider: Among those who tried to get a new primary care provider, “How much of a problem was it finding a primary care provider who would treat you?” (Overall share)		
A problem (net)	49* (6*)	67* (9*)
A big problem	21* (2*)	28* (4*)
A small problem	28* (3*)	39* (5*)
Not a problem	51* (6*)	33* (5*)
Primary care providers not accepting your insurance: Among those who had a problem finding a new primary care provider, “Did anyone from a doctor’s office tell you they didn’t accept [Medicare/your insurance]?” (Overall share)		
Yes	17* (1*)	32* (3*)
Get a new specialist: “Specialists are doctors like surgeons, heart doctors, psychiatrists, skin doctors, and others who specialize in one area of health care. In the past 12 months, have you tried to get a new specialist?”		
Yes	33	33
Problems finding a specialist: Among those who tried to get a new specialist, “How much of a problem was it finding a specialist who would treat you?” (Overall share)		
A problem (net)	34* (11*)	45* (14*)
A big problem	11* (4*)	17* (5*)
A small problem	23* (7*)	28* (9*)
Not a problem	66* (21*)	55* (18*)
Specialists not accepting your insurance: Among those who had a problem finding a new specialist, “Did anyone from a doctor’s office tell you they didn’t accept [Medicare/your insurance]?” (Overall share)		
Yes	14* (2*)	31* (4*)
Get a new mental health professional: “Some specialists and other clinicians focus on mental health. In the past 12 months, have you tried to get a new mental health professional?”		
Yes	3*	7*
Problems finding a mental health professional: Among those who tried to get a mental health professional, “How much of a problem was it finding a mental health professional who would treat you?” (Overall share)		
A problem (net)	59 (2*)	63 (5*)
A big problem	29 (1*)	36 (3*)
A small problem	30 (1*)	27 (2*)
Not a problem	41 (1*)	37 (3*)
Mental health professionals not accepting your insurance: Among those who had a problem finding a new mental health professional, “Did anyone from a mental health professional’s office tell you they didn’t accept [Medicare/your insurance]?” (Overall share)		
Yes	44 (1*)	48 (2*)

Note: Survey completed by 4,788 Medicare beneficiaries (including in fee-for-service Medicare and Medicare Advantage) and 5,079 privately insured individuals. Sample sizes for questions varied. Surveys completed online in English or by mail in English or Spanish, depending on respondent preference. Survey data weighted to be nationally representative. “Overall share” refers to the share of all respondents with the respective insurance.

* Statistically significant difference between Medicare beneficiaries and the privately insured at a 95 percent confidence level.

Source: MedPAC’s annual access-to-care survey fielded by Gallup from July 18 to September 8, 2025.

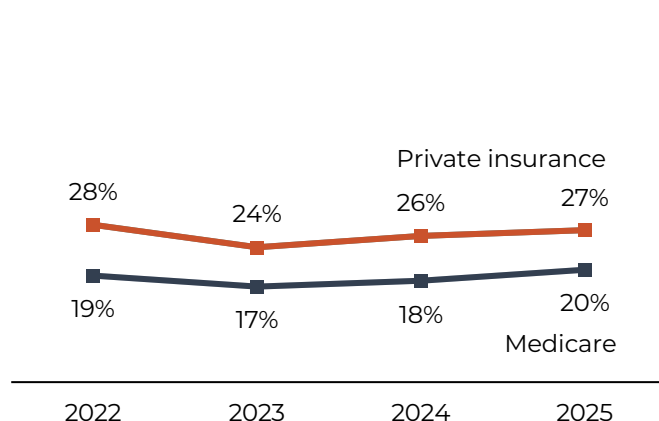
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Chart 7-16 In MedPAC's 2025 survey, Medicare beneficiaries reported fewer problems finding a new clinician than privately insured people (continued)

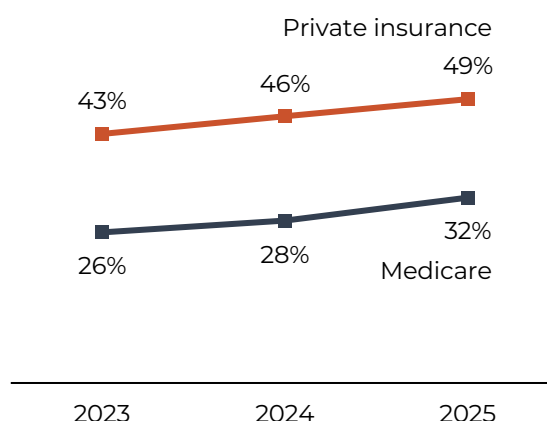
- > Our 2025 survey found that among those who tried to get a new primary care provider in the past year, privately insured people were more likely than Medicare beneficiaries to report problems finding one. In 2025, 67 percent of privately insured people who looked for a new primary care provider (PCP) in the past year reported problems finding one (equivalent to 9 percent of all privately insured people). In contrast, only 49 percent of the Medicare beneficiaries who looked for a new PCP reported problems finding one (equivalent to 6 percent of all Medicare beneficiaries).
- > Privately insured people also reported more problems finding specialists than did Medicare beneficiaries (45 percent vs. 34 percent, respectively, equivalent to 14 percent of privately insured people and 11 percent of Medicare beneficiaries overall).
- > Privately insured people were about twice as likely as Medicare beneficiaries to encounter a PCP or a specialist who did not accept their insurance. For example, among those looking for a new PCP, 17 percent of Medicare beneficiaries and 32 percent of privately insured people encountered a doctor's office that did not accept their insurance (equivalent to 1 percent of Medicare beneficiaries and 3 percent of privately insured people overall). Similar shares reported this experience when looking for a new specialist.
- > Very few people reported looking for a new mental health professional in the past year, but privately insured people were more likely than Medicare beneficiaries to report looking for this type of health care professional (7 percent vs. 3 percent). A majority of both groups reported problems finding this type of clinician: 59 percent of Medicare beneficiaries who were looking for a mental health professional and 63 percent of privately insured people who were looking reported problems finding one, equivalent to 2 percent and 5 percent, respectively, of these groups overall. Among those looking for a new mental health professional, about half of both insurance groups encountered a mental health professional who did not accept their insurance.

Chart 7-17 In MedPAC's annual surveys, Medicare beneficiaries ages 65+ reported using video visits less often than privately insured people ages 50–64 but used telephone visits more often

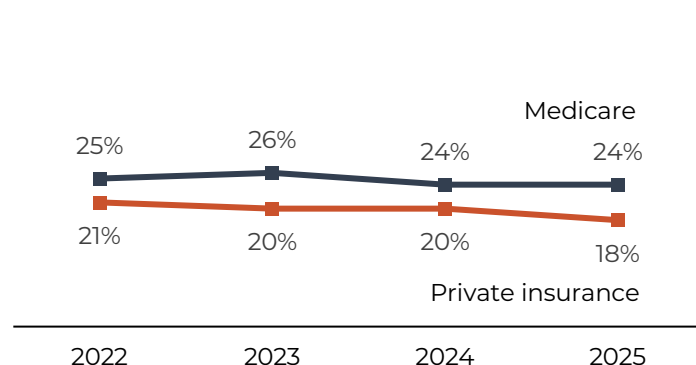
In the past 12 months, have you had a **video** visit?



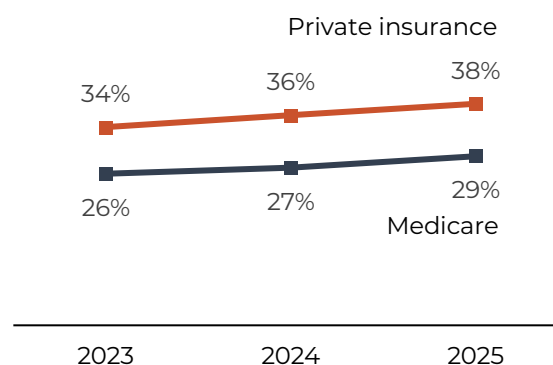
Would you be interested in having the option to use **video** visits in the future?



In the past 12 months, have you had a **telephone** visit?



Would you be interested in having the option to use **telephone** visits in the future?



Note: Survey completed by approximately 4,000 to 5,000 Medicare beneficiaries (including in fee-for-service Medicare and Medicare Advantage) and 4,000 to 5,000 privately insured individuals each year. Sample sizes for questions varied. Surveys completed online in English or by mail in English or Spanish, depending on respondent preference. Survey data were weighted to be nationally representative. In our survey questions, video visits were defined as “using a smartphone, computer, or tablet” and telephone visits were defined as “a phone call with audio but no video,” and both questions asked about telehealth visits “with any type of health care provider.” In all years and questions shown above, the shares of Medicare beneficiaries and privately insured people who reported a given response are statistically significantly different from each other at a 95 percent confidence level.

Source: MedPAC's annual access-to-care surveys fielded by Gallup in the summers of 2022 through 2025.

(Chart continued next page)

Chart 7-17 In MedPAC's annual surveys, Medicare beneficiaries ages 65+ reported using video visits less often than privately insured people ages 50–64 but used telephone visits more often (continued)

> In our 2025 survey, a third (35 percent) of Medicare beneficiaries ages 65 and over and a third (35 percent) of privately insured people ages 50 to 64 reported having had **some type of telehealth** visit(s) in the past year (data not shown).

>> Privately insured people were somewhat more likely to have had **video** visits than Medicare beneficiaries (27 percent vs. 20 percent).

>> Medicare beneficiaries were somewhat more likely than privately insured people to have had **audio-only telephone** visits (24 percent vs. 18 percent).

> Across insurance groups and types of telehealth visits, over 90 percent of telehealth users reported being satisfied with their visits (data not shown).

> A third (33 percent) of Medicare beneficiaries and half of privately insured people (49 percent) were interested in having the option to use **some type of telehealth** in the future (data not shown).

>> 32 percent of Medicare beneficiaries and 49 percent of privately insured people were interested in having access to **video** visits.

>> 29 percent of Medicare beneficiaries and 38 percent of privately insured people were interested in having access to audio-only **telephone** visits.

> In analyses of Medicare beneficiary subgroups (not shown):

>> Medicare beneficiaries were more likely to report having used telehealth if they lived in an urban area or had a household income of at least \$50,000 per year.

>>> There were not statistically significant differences in reported telehealth use among Medicare beneficiaries of different races and ethnicities.

>> Medicare beneficiaries were more interested in continuing to have access to telehealth if they lived in an urban area, were under the age of 75, and had a household income of at least \$80,000.

Chart 7-18 In MedPAC's 2025 survey, Medicare beneficiaries were less likely to report long waits for appointments than privately insured people

Survey question	Medicare (ages 65 and older)	Private insurance (ages 50–64)
Long wait for an appointment: Among those who needed an appointment in the past 12 months, “How often did you have to wait longer than you wanted to get a doctor’s appointment?” (Overall share)		
For regular or routine care		
Never	51%* (49%*)	38%* (36%*)
Sometimes	37* (36*)	42* (40*)
Usually	8* (8*)	12* (12*)
Always	3* (3*)	7* (7*)
For an illness or injury		
Never	65* (55*)	54* (44*)
Sometimes	28* (23*)	34* (27*)
Usually	5* (4*)	8* (6*)
Always	2* (2*)	5* (4*)
Response to long wait: Among those who had to wait longer than they wanted for an appointment, “What did you do?” (Overall share)		
For regular or routine care		
I took the later appointment date	84* (38*)	82* (47*)
I went to a walk-in clinic	9* (4*)	11* (6*)
I decided not to schedule the appointment	4* (2*)	6* (3*)
I went to a hospital emergency room	4* (2)	2* (1)
For an illness or injury		
I took the later appointment date	63* (18*)	53* (20*)
I went to a walk-in clinic	21* (6*)	31* (12*)
I decided not to schedule the appointment	5* (2*)	8* (3*)
I went to a hospital emergency room	12* (3)	8* (3)

Note: Survey completed by 4,788 Medicare beneficiaries (including in fee-for-service Medicare and Medicare Advantage) and 5,079 privately insured individuals. Sample sizes for questions varied. Surveys completed online in English or by mail in English or Spanish, depending on respondent preference. Survey data were weighted to produce nationally representative results. Instructions for questions shown above read: “For the next few questions, please think about the number of days or weeks you had to wait to get a doctor’s appointment. Do not include time spent on hold or in the waiting room” and “Please count video visits and phone visits as appointments.” “Overall share” refers to the share of all respondents with the respective insurance. Components may not sum to 100 percent due to rounding.

* Statistically significant difference between Medicare and private insurance groups at a 95 percent confidence level.

Source: MedPAC’s annual access-to-care survey fielded by Gallup from July 18 to September 8, 2025.

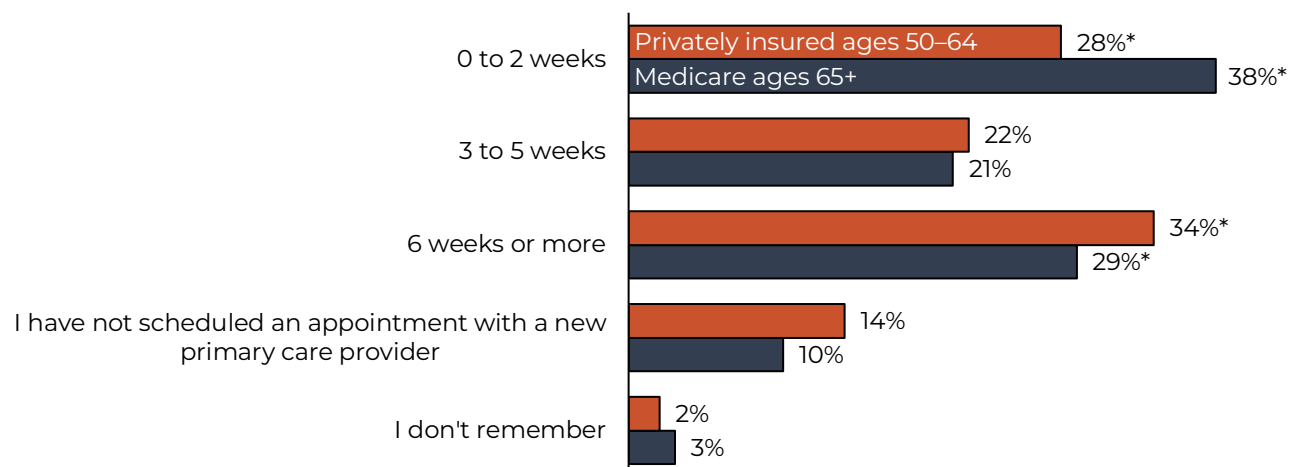
> In 2025, our survey found that among those Medicare beneficiaries who needed an appointment for routine care, half (51 percent) of Medicare beneficiaries reported that they never had to wait longer than they wanted to get such an appointment, while only 38 percent of privately insured people reported this.

> Among those who needed an appointment for an illness or injury, two-thirds (65 percent) of Medicare beneficiaries said they never had to wait longer than they wanted to get such an appointment, compared with 54 percent of privately insured people.

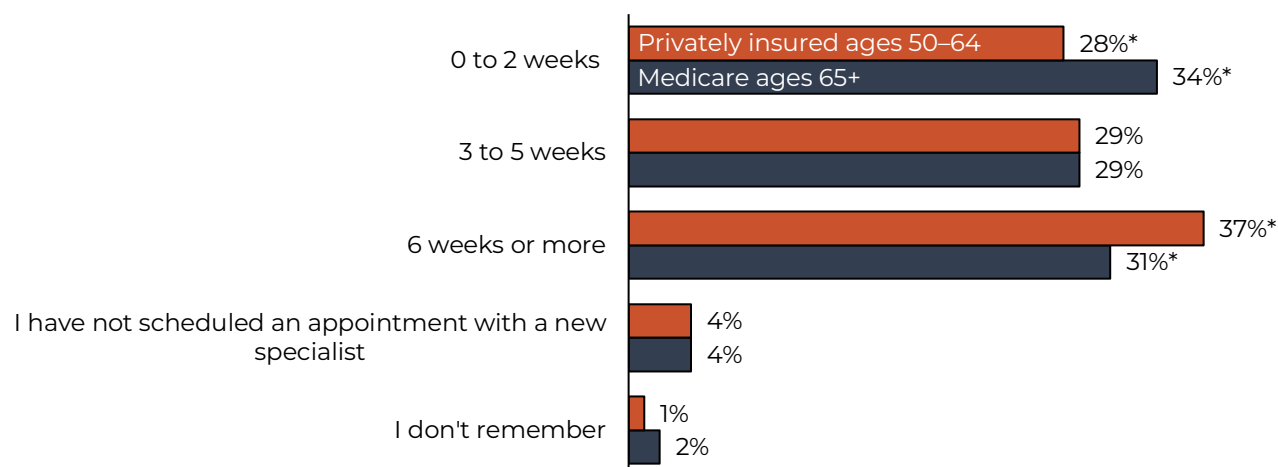
Chart 7-19 In our 2025 survey, Medicare beneficiaries waited slightly less time for their first appointment with a new clinician than privately insured people

Among those who tried to get a new [primary care provider/specialist] in the past 12 months . . .

How long did you have to wait to have an appointment with your new **primary care provider**?



How long did you have to wait to have an appointment with your new **specialist**?



Note: Survey completed by 4,788 Medicare beneficiaries (including in fee-for-service Medicare and Medicare Advantage) and 5,079 privately insured individuals. Sample sizes for questions varied. Surveys completed online in English or by mail in English or Spanish, depending on respondent preference. Data were weighted to be nationally representative. Components may not sum to totals due to rounding.

* Statistically significant difference between Medicare beneficiaries and privately insured people (at a 95 percent confidence level).

Source: MedPAC's 2025 access-to-care survey, fielded by Gallup from July 18 to September 8, 2025.

> Among Medicare beneficiaries who tried to get a new primary care provider in the past year, a little over a third (38 percent) reported waiting two weeks or less for their first appointment. Similarly, among those trying to get a new specialist, a third (34 percent) waited two weeks or less for their first appointment.

> Privately insured people were slightly less likely to report being seen in two weeks or less and slightly more likely to report waiting six weeks or more for their first appointment with a new clinician.

Chart 7-20 In MedPAC's 2025 survey, Medicare beneficiaries were less likely to report forgoing care than privately insured people

Survey question	Medicare (ages 65 and older)	Private insurance (ages 50–64)
Forgoing care: “During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?”		
Yes	17%*	27%*
Reason for forgoing care: “There are different reasons why people do not see a doctor or other medical person about a health problem or condition. Which of these was the main reason you did not see a doctor about this condition during the past 12 months?” (Overall share)		
I just put it off	29 (5*)	27 (7*)
I didn’t think the problem was serious	27* (4)	19* (5)
I couldn’t get an appointment soon enough	23 (4*)	21 (6*)
I thought it would cost too much	6* (1*)	20* (5*)
I couldn’t find a doctor who would treat me	5 (1)	4 (1)
Other	11 (2*)	9 (2*)

Note: Survey completed by 4,788 Medicare beneficiaries (including in fee-for-service Medicare and Medicare Advantage) and 5,079 privately insured individuals. Sample sizes for questions varied. Surveys completed online in English or by mail in English or Spanish, depending on respondent preference. Survey data were weighted to produce nationally representative results. “Overall share” refers to the share of all respondents with the respective insurance. Components do not sum to 100 percent due to rounding.

* Statistically significant difference between Medicare and private insurance groups at a 95 percent confidence level.

Source: MedPAC’s annual access-to-care survey fielded by Gallup from July 18 to September 8, 2025.

> In our 2025 survey, 17 percent of Medicare beneficiaries and 27 percent of privately insured people reported forgoing care that they thought they should have gotten in the past year.

> About half of care forgoers did so because they “didn’t think the problem was serious” or “just put it off.”

> About one in five care forgoers skipped care because they could not get an appointment soon enough: This reason accounted for 23 percent of Medicare care forgoers (equivalent to 4 percent of all Medicare beneficiaries) and 21 percent of privately insured care forgoers (equivalent to 6 percent of all privately insured people).

> Medicare beneficiaries were much less likely to forgo care due to concerns about cost compared with privately insured people: Only 6 percent of Medicare care forgoers skipped care because they “thought it would cost too much” (equivalent to 1 percent of all Medicare beneficiaries), while 20 percent of privately insured care forgoers skipped care for this reason (equivalent to 5 percent of all privately insured people).

Chart 7-21 In MedPAC's 2025 survey, lower-income Medicare beneficiaries reported obtaining less care than higher-income beneficiaries

Survey question	Medicare (ages 65 or older)			Private insurance (ages 50-64)		
	Lower income	Middle income	Higher income	Lower income	Middle income	Higher income
Received health care: "Have you received any health care in the past 12 months in any type of setting, such as a hospital, physician office, or clinic?"						
Yes	92% ^a	95% ^{ab}	97% ^{ab}	88% ^a	91% ^a	94% ^{ab}
Have a primary care provider: "A primary care provider is the doctor you see in an office or a clinic for routine medical care, medical check-ups, or when you first experience a medical problem. Do you have a primary care provider that you go to for this type of care?"						
Yes	95 ^a	96 ^a	98 ^{ab}	90 ^a	91 ^a	93 ^a
Tried to get a new clinician: "In the past 12 months, have you tried to get a new . . . ?" (Share answering "Yes")						
Primary care provider	12	12	11	15	14	13
Specialist	25	34 ^b	42 ^{ab}	24	29	36 ^{ab}
Problems finding a new clinician: Among those who tried to find a new clinician, "How much of a problem was it finding a [primary care provider/specialist] who would treat you?" (Overall share)						
"Big problem" finding a primary care provider	23 (3)	18 (2 ^a)	21 (2)	25 (4)	32 (4 ^a)	28 (4)
"Big problem" finding a specialist	12 (3)	11 (4)	10 ^a (4)	22 (5)	17 (5)	16 ^a (6)
Forgoing care: "During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?"						
Yes	19 ^a	17 ^a	14 ^{ab}	28 ^a	29 ^a	26 ^a

Note: "Lower income" refers to respondents with annual household incomes of \$0 to \$49,999; "middle income" refers to household incomes of \$50,000 to \$79,999; and "higher income" refers to household incomes of \$80,000 or more. Survey completed by 4,788 Medicare beneficiaries (including in fee-for-service Medicare and Medicare Advantage) and 5,079 privately insured individuals. Sample sizes for questions varied. Surveys completed online in English or by mail in English or Spanish, depending on respondent preference. Survey data were weighted to produce nationally representative results. "Overall share" refers to the share of all respondents with the respective insurance. Totals may not sum to 100 percent because of rounding and because the table excludes the following responses: "I don't remember" and "Refused."

^a Statistically significant difference between Medicare beneficiaries and the privately insured within the same income category (at a 95 percent confidence level).

^b Statistically significant difference between lower-income respondents and middle-income respondents or lower-income and higher-income respondents within the same insurance group (at a 95 percent confidence level).

Source: MedPAC's 2025 access-to-care survey, conducted July 18 to September 8, 2025.

> In 2025, we found some differences in care patterns for lower-income Medicare beneficiaries (with household incomes below \$50,000) and higher-income beneficiaries (with household incomes of \$80,000 or more). For example:

>> Only 92 percent of lower-income beneficiaries reported receiving any health care in the past year, compared with 97 percent of higher-income beneficiaries.

>> Lower-income beneficiaries were more likely to report forgoing care in the past year (19 percent) compared with higher-income beneficiaries (14 percent).

Chart 7-22 In our 2025 survey, few differences in urban and rural care access

Survey question	Medicare beneficiaries (ages 65 or older)		Privately insured (ages 50–64)	
	Urban	Rural	Urban	Rural
Received health care: “Have you received any health care in the past 12 months in any type of setting, such as a hospital, physician office, or clinic?”				
Yes	95% ^{ab}	92% ^b	92% ^a	92%
Providers that accept your insurance: Among those who received health care in the past 12 months, “How satisfied or dissatisfied have you been with your ability to find health care providers that accept [Medicare/your insurance]?”				
Satisfied (“very” or “somewhat”)	97 ^a	98 ^a	93 ^a	92 ^a
Providers with timely appointments: Among those who received health care in the past 12 months, “How satisfied or dissatisfied have you been with your ability to find health care providers that have appointments when you need them?”				
Satisfied (“very” or “somewhat”)	89 ^a	92 ^a	80 ^a	81 ^a
Have a primary care provider: “A primary care provider is the doctor you see in an office or a clinic for routine medical care, medical check-ups, or when you first experience a medical problem. Do you have a primary care provider that you go to for this type of care?”				
Yes	96 ^a	97 ^a	92 ^a	93 ^a
Tried to get a new clinician: “In the past 12 months, have you tried to get a new . . . ?” (Share answering “Yes”)				
Primary care provider	12 ^a	11	14 ^a	11
Specialist	34 ^b	28 ^b	34 ^b	26 ^b
Problems finding a new clinician: Among those who tried to find a new clinician, “How much of a problem was it finding a [primary care provider/specialist] who would treat you?” (Overall share)				
“Big problem” finding a primary care provider	22 ^a	16	30 ^a	20
“Big problem” finding a specialist	11 ^a	13	17 ^a	17
Wait time for first appointment with a new clinician: Among those who tried to get a new clinician in the past 12 months, “How long did you have to wait to have an appointment with your new [primary care provider/specialist]?”				
Primary care provider				
0 to 2 weeks	33 ^{ab}	57 ^b	26 ^a	39
3 to 5 weeks	21	19	22	20
6 weeks or more	32 ^b	11 ^{ab}	35	34 ^a
I have not scheduled an appointment	10	11	15	7
Specialist				
0 to 2 weeks	34 ^a	32	29 ^a	28
3 to 5 weeks	29	31	29	27
6 weeks or more	31 ^a	30	37 ^a	40
I have not scheduled an appointment	4	4	4	4
Forgoing care: “During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?”				
Yes	17 ^a	19 ^a	27 ^a	26 ^a

Note: “Urban” respondents live in a metropolitan statistical area, while “rural” respondents do not. Survey completed by 4,788 Medicare beneficiaries and 5,079 privately insured individuals. “Overall share” refers to the share of all respondents with the respective insurance. Totals may not sum to 100 percent due to rounding and the exclusion of the following responses: “I don’t remember” and “Refused.”

^a Statistically significant difference between Medicare beneficiaries and the privately insured within the same area type (at a 95 percent confidence level).

^b Statistically significant difference between urban and rural respondents within the same insurance group (at a 95 percent confidence level).

Source: MedPAC’s 2025 access-to-care survey, conducted July 18 to September 8, 2025.

(Chart continued next page)

Chart 7-22 In our 2025 survey, few differences in urban and rural care access (continued)

> Our survey found only a few differences between rural and urban beneficiaries' experiences accessing care. For example:

- >> More rural beneficiaries reported waiting two weeks or less for their first appointment with a new primary care provider (57 percent) compared with urban beneficiaries (33 percent).
- >> More rural beneficiaries received all or most of their primary care from a nurse practitioner or physician assistant rather than a physician (28 percent) compared with urban beneficiaries (16 percent) (data not shown).
- >> More urban beneficiaries reported receiving any health care in the past year (95 percent) compared with rural beneficiaries and privately insured people living in any type of area (92 percent).

Chart 7-23 In MedPAC's 2025 survey, there were few differences in White, Black, and Hispanic beneficiaries' access to care

Survey question	Medicare beneficiaries (ages 65 or older)			Privately insured (ages 50–64)		
	White	Black	Hispanic	White	Black	Hispanic
Received health care: “Have you received any health care in the past 12 months in any type of setting, such as a hospital, physician office, or clinic?”						
Yes	95 ^a	94	92 ^b	93 ^a	93	89 ^b
Providers that accept your insurance: Among those who received health care in the past 12 months, “How satisfied or dissatisfied have you been with your ability to find health care providers that accept [Medicare/your insurance]?”						
Satisfied (“very” or “somewhat”)	98 ^a	97	98 ^a	93 ^a	97	92 ^a
Providers with timely appointments: Among those who received health care in the past 12 months, “How satisfied or dissatisfied have you been with your ability to find health care providers that have appointments when you need them?”						
Satisfied (“very” or “somewhat”)	89 ^a	95 ^{ab}	91 ^a	81 ^a	86 ^a	75 ^a
Have a primary care provider: “A primary care provider is the doctor you see in an office or a clinic for routine medical care, medical check-ups, or when you first experience a medical problem. Do you have a primary care provider that you go to for this type of care?”						
Yes	96 ^a	95	98 ^a	93 ^a	93	90 ^a
Tried to get a new clinician: “In the past 12 months, have you tried to get a new . . . ?” (Share answering “Yes”)						
Primary care provider	12	8 ^a	12	13	14 ^a	16
Specialist	35	20 ^b	25 ^b	34	25 ^b	32
Problems finding a new clinician: Among those who tried to find a new clinician, “How much of a problem was it finding a [primary care provider/specialist] who would treat you?” (Overall share)						
“Big problem” finding primary care provider	20 (2 ^a)	18 (1)	25 (3)	28 (4 ^a)	24 (3)	32 (5)
“Big problem” finding specialist	12 ^a (4)	11 (2)	15 (4)	16 ^a (5)	15 (4)	22 (7)
Wait time for first appointment with a new clinician: Among those who tried to get a new clinician in the past 12 months, “How long did you have to wait to have an appointment with your new [primary care provider/specialist]?”						
Primary care provider						
0 to 2 weeks	38 ^a	32	46	26 ^a	37	29
3 to 5 weeks	20	19	24	22	21	26
6 weeks or more	30	22	18	35	32	31
I have not scheduled an appointment	9	16	12	15	10	12
Specialist						
0 to 2 weeks	33 ^a	43	44 ^b	26 ^a	39 ^b	34
3 to 5 weeks	28	20	30	30	25	24
6 weeks or more	32 ^a	27	22 ^a	40 ^a	21 ^b	37 ^a
I have not scheduled an appointment	4	7	4	4	11 ^b	4
Forgoing care: “During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?”						
Yes	17 ^a	14 ^a	17 ^a	26 ^a	26 ^a	26 ^a

Note: “Hispanic” refers to Hispanic respondents of any race. Survey completed by 4,788 Medicare beneficiaries and 5,079 privately insured individuals. “Overall share” refers to share of all respondents of the respective race/ethnicity and insurance type. Totals may not sum to 100 percent due to rounding and the exclusion of the following responses: “I don’t remember” and “Refused.”

^a Statistically significant difference between Medicare beneficiaries and the privately insured within the same race/ethnicity category (at a 95 percent confidence level).

^b Statistically significant difference between White and Black or White and Hispanic respondents within the same insurance group (at a 95 percent confidence level).

Source: MedPAC’s 2025 access-to-care survey, conducted July 18 to September 8, 2025.

(Chart continued next page)

Chart 7-23 In MedPAC's 2025 survey, there were few differences in White, Black, and Hispanic beneficiaries' access to care (continued)

> Our survey found only a few differences in Medicare beneficiaries' access to care by race and ethnicity. For example:

>> A slightly lower share of Hispanic beneficiaries reported receiving any health care in the past year (92 percent) compared with White (95 percent) and Black (94 percent) beneficiaries.

>> A higher share of Black beneficiaries reported being satisfied with their ability to find providers that have appointments when they need them (95 percent) compared with White (89 percent) and Hispanic (91 percent) beneficiaries.

>> A much higher share of White beneficiaries looked for a new specialist in the past year (35 percent) compared with Black (20 percent) and Hispanic (25 percent) beneficiaries. A lower share of White beneficiaries reported waiting only two weeks or less for their first appointment with a new specialist (33 percent) compared with Black (43 percent) and Hispanic (44 percent) beneficiaries.