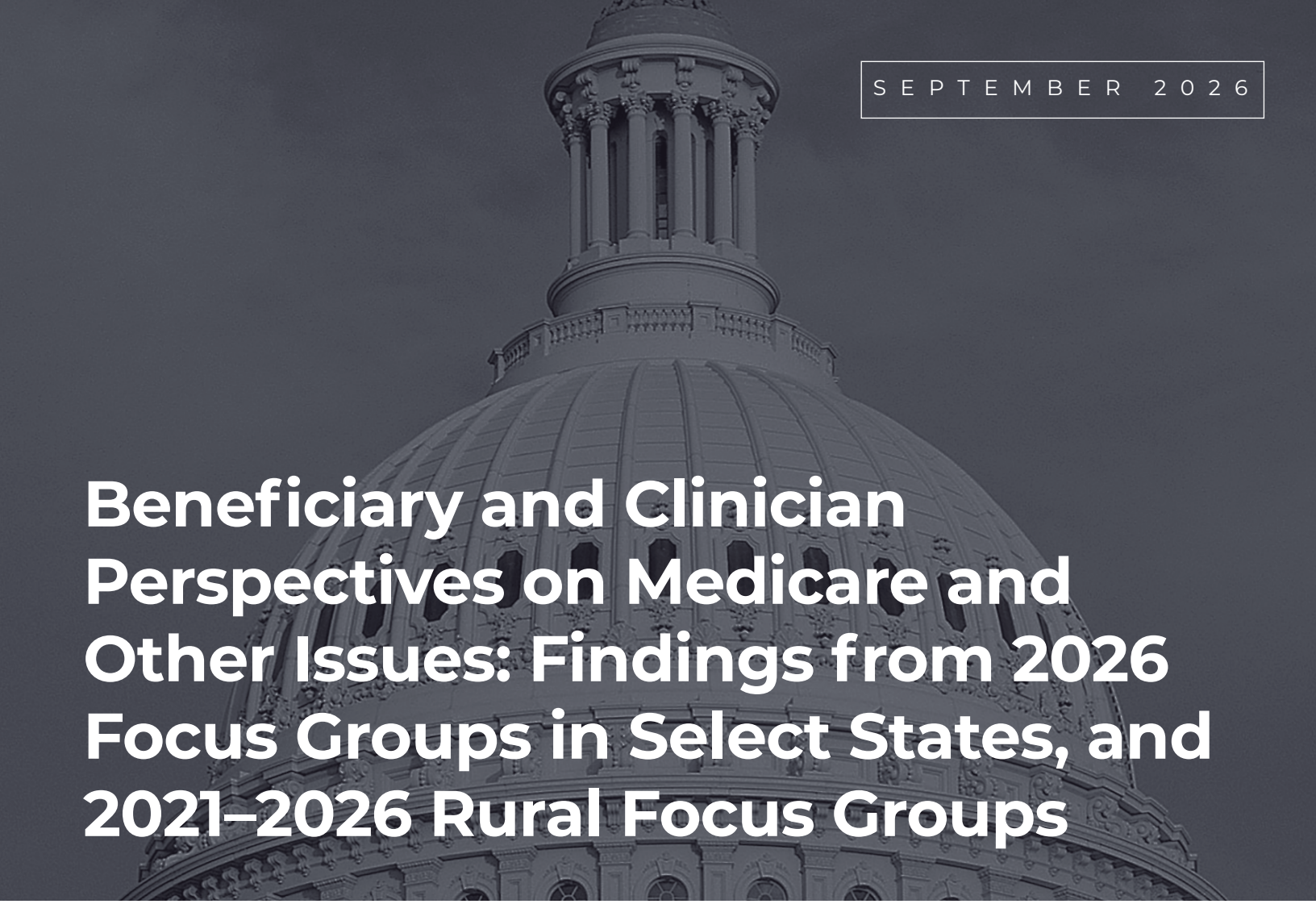


SEPTEMBER 2026

Beneficiary and Clinician Perspectives on Medicare and Other Issues: Findings from 2026 Focus Groups in Select States, and 2021–2026 Rural Focus Groups

A report by NORC at the University of Chicago for the Medicare Payment Advisory Commission



The views expressed in this report are those of the authors. No endorsement by MedPAC is intended or should be inferred.

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NORC at the University of Chicago

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Beneficiary and Clinician Perspectives on Medicare and Other Issues:

Findings from 2026 Focus Groups in Select States and 2021–2026 Rural Focus Groups

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Executive Summary

Methods

In May and June of 2026, NORC at the University of Chicago (NORC) and the Medicare Payment Advisory Commission (MedPAC) conducted 22 focus groups with Medicare beneficiaries and clinicians. Beneficiaries included those with only Medicare coverage (divided into separate groups based on enrollment in traditional Medicare versus Medicare Advantage [MA]) and those eligible for both Medicare and Medicaid (dual eligible beneficiaries). Clinicians included primary care physicians, specialist physicians, and nurse practitioners (NPs).

In this report we summarize findings from 22 focus groups completed in 2026: 21 in-person groups (7 groups per city in 3 cities) in Tampa, Florida; Iselin, New Jersey; and Seattle, Washington (n = 171); and 1 virtual focus group with Medicare beneficiaries residing in rural areas across the United States (n = 6). In total, 57 Medicare-only beneficiaries (about equal share enrolled in traditional Medicare and MA), 38 dual eligible beneficiaries, and 76 clinicians participated in the in-person focus groups. To provide additional perspectives from rural beneficiaries over time, we compile findings from 14 focus groups with 80 Medicare beneficiaries residing in rural areas between 2021 and 2026.

Due to the nature of focus group research, our sample was limited in number and is not representative of Medicare beneficiaries or clinicians in the location where we conducted this research. Therefore, findings cannot be generalized either to the studied community or to the nation as a whole. The benefit of the qualitative approach is that it allowed us to ask questions with answers that cannot be easily put into numbers to understand experience. In addition, it allowed us to understand the “how” and “why” of experiences, including deeper understanding of experiences and context, and provided personal narratives and real-life examples that policymakers may find useful as they consider potential changes to the Medicare program.

Topics discussed in beneficiary groups included the process of choosing coverage, access to primary care and specialty care, and prescription drugs. Topics discussed in clinician groups include acceptance of new patients and insurance, working with other clinicians, changing organization of medical care, working with insurance and MA plans, use of artificial intelligence (AI) in health care, quality reporting, accountable care organizations (ACOs), and prescription drugs.

All focus group procedures, screeners, and discussion protocols were reviewed and approved by NORC’s Institutional Review Board.

Key Findings from 2026 Focus Groups in Select States

The findings below highlight major themes that emerged across the focus groups.

Choosing Coverage

Understanding Medicare and Plan Choices

- Medicare beneficiaries used a range of sources when choosing their coverage. Most beneficiaries in our focus groups consulted with independent health insurance brokers or agents for individual insurance companies. Beneficiaries also attended seminars, collected brochures, researched plans on the internet, asked family and friends for their opinions of coverage, and spoke with advisors and colleagues prior to retirement.
- Beneficiaries across focus groups and locations were familiar with Medicare.gov's Plan Finder tool to compare plans, and a few beneficiaries we spoke to reported using it when choosing their coverage.
- Awareness of State Health Insurance Assistance Program (SHIP) varied across cities. Beneficiaries who used SHIPs found them to be a useful resource for coverage decisions.
- Overall, beneficiaries reported knowing about the deadline to sign up for Medicare and the penalties for late enrollment.

Factors That Affect Beneficiaries' Choice of Coverage

- Beneficiaries enrolled in traditional Medicare cited that they prioritized lack of restrictions to a specific provider network and the ability to travel without needing referrals. When deciding on supplemental plans, beneficiaries enrolled in traditional Medicare said they chose their supplemental plans based on cost of monthly premium and anticipated co-pays.
- Beneficiaries with MA cited lower co-pays and premiums than what they would have to pay for a supplemental plan to accompany traditional Medicare as their main reason for signing up for MA.
- Dual eligible beneficiaries, including those over 65 years of age, commonly described their Medicare enrollment as happening passively or automatically, rather than having to actively enroll in or choose their Medicare coverage. Among dual eligible beneficiaries who took an active role in selecting their Medicare plans, participants prioritized keeping existing providers in-network or having access to supplemental benefits. Dual eligible beneficiaries also mentioned that over the counter (OTC) and reward cards were a factor in deciding between MA plans.
- Across cities, beneficiaries with MA used the supplemental benefits offered by their plans, including OTC cards and gym memberships. Across cities, beneficiaries had positive views of financial incentives offered by MA plans, such as the rewards for healthy habits, preventive screenings, or recommended vaccines. However, some beneficiaries noted that the incentives are difficult to sign up for or receive.

Satisfaction with Overall Health Care Coverage and Prescription Drug Coverage

- Most participants (58 percent) across the groups rated their overall coverage as good. Beneficiaries who described their coverage as excellent (28 percent) noted that all of their health care needs were met, and they have yet to experience any problems such as delays in referrals or prior authorization issues. Some beneficiaries (14 percent) rated their coverage as fair due to delays with prior authorizations and provider access.
- Dual eligible beneficiaries varied on their ratings of their coverage. While a majority rated their coverage as good (42 percent across dual eligible groups), dual eligible beneficiaries were more likely than Medicare-only beneficiaries to rate their coverage as excellent (34 percent of dual eligible beneficiaries) or fair (24 percent).
- The majority of beneficiaries (89 percent) rated their prescription drug coverage as excellent or good. Most beneficiaries with traditional Medicare and half of beneficiaries with MA rated their coverage as good. Equal shares of dual eligible beneficiaries rated their coverage as excellent and as good. No beneficiaries rated their prescription drug coverage as poor.

Switching Plans

- Some beneficiaries reported revisiting their coverage decisions annually. A subset of beneficiaries reported having changed their coverage type (between MA and traditional Medicare) or switched their plans (between HMOs and PPOs or insurance companies).

Access to Care

Clinicians

Wait Times and Referrals

- We asked clinicians to estimate how long new and established patients typically must wait to get an appointment with them. Most clinicians reported that wait times were shorter for established patients compared to new patients.
- Wait times for appointments varied by specialty, with some specialists explaining that patient acuity dictated wait times. Many clinicians reported shorter wait times for patients experiencing acute concerns.
- Across all three locations, clinicians referenced psychiatry, rheumatology, and endocrinology as specialties with especially long wait times, attributing this in part to not having enough of these specialists in their geographic area to meet demand. Some clinicians reported attempting to obtain specialist appointments for their patients by using personal networks and contacting physicians directly.
- Some clinicians perceived differences in wait times between practices affiliated with large health systems and practices not affiliated with these systems. Clinicians in larger health systems reported feeling more pressure or having compensation tied to referring within their networks.

- Some clinicians described how they use patient portals to communicate with patients between visits and said that portal communication can help them determine if an appointment is needed.
- We asked clinicians to describe their experiences referring patients to specialists. Several clinicians referenced challenges referring beneficiaries enrolled in MA to specialists, which can delay care.
- Several primary care physicians described their patients seeking treatment in the primary care setting for issues that require a specialist after being unable to find specialists that accept their plan or referral. On the other hand, some specialists reported getting referrals from NPs in primary care that they believe could be addressed in the primary care setting.

Acceptance of Patients and Insurance

- Most clinicians in our focus groups (71 of 76) were accepting new patients, and of those accepting new patients, nearly all (68 of 71) were accepting new Medicare patients. Although most clinicians reported accepting new Medicare patients, some described efforts to limit the number of Medicare patients they see. Clinicians who were not accepting new patients offered reasons that included the desire to slow down in their careers as they head towards retirement and limited appointment availability.
- Most clinicians (89 percent) reported accepting MA plans, but some clinicians did not accept all MA plans in their area. Most clinicians reported that they did not participate in the decisions around which MA plans they accept but that these choices were made at an organizational level. Clinicians practicing in smaller groups described having more involvement than those in larger practices about which MA plans are accepted.
- Several clinicians reported being aware of a patient's insurance coverage, but most of them stated that it did not affect their treatment approach or documentation.
- Clinicians shared their perspectives on the advantages and disadvantages of MA and traditional Medicare for patients. Clinicians cited traditional Medicare's flexibility to choose any provider who accepts Medicare as one advantage for patients. A few primary care physicians cited MA's supplemental benefits and perceived lower costs as beneficial to patients.
- When discussing their experiences working with each payer, several clinicians expressed their preference for traditional Medicare instead of MA, citing low reimbursement rates from MA plans. In contrast, a few clinicians said they preferred MA plans because the reimbursement rates were higher.
- Some clinicians reported disadvantages of working with MA plans, including limited provider networks and onerous prior authorizations. Many clinicians noted more challenges with prior authorizations and payment approval under MA compared to traditional Medicare. Several clinicians reported challenges with prior authorizations when prescribing medication for beneficiaries enrolled in MA plans.
- Among clinicians who interacted with MA plan care managers, some found the care managers somewhat helpful. When asked whether they receive guidance from MA plans, several clinicians reported receiving both generic and case-specific guidance. In general, clinicians did not find this guidance particularly meaningful.

- Multiple clinicians reported that MA plan contract terminations are causing disruptions in patient care.

Beneficiaries

Access to Primary Care

- Most Medicare beneficiaries reported having a clinician who they see for primary care.
- We asked beneficiaries if they had looked for a new PCP in the past few years. Several beneficiaries reported the need to find a new PCP and provided a variety of reasons for doing so, including because their previous clinician was retiring, leaving the practice, or was no longer in network. When looking for a new PCP, beneficiaries attempted to find a new PCP within the practice where they were already a patient, asked friends and family for recommendations, or had their current clinician make a referral. Many beneficiaries reported that it was challenging to find a new PCP. Beneficiaries explained that clinicians were often not taking new patients or, for beneficiaries with MA, were out of network.
- Beneficiaries expressed mixed opinions and rationales for whether they would be willing to see an NP or physician assistant (PA) as their PCP. A few beneficiaries shared that they have started to see an NP or PA for primary care because it has become increasingly difficult to get appointments with their physician.
- Some Medicare beneficiaries expressed a preference for seeing an NP or PA instead of a physician because of their perception that these clinicians spend more time with patients and are more thorough. Other beneficiaries reported that they would prefer a physician to serve as their PCP because of their education and experience.
- Some beneficiaries preferred seeing their physician for regular appointments and complex issues but were open to seeing an NP or PA for acute issues so they could be seen more quickly. A few beneficiaries reported that seeing NPs or PAs at their primary care practice when they cannot get an appointment with their physician has saved them from a trip to urgent care or the emergency department. Several beneficiaries were open to seeing an NP or PA for acute issues as long as the practice was transparent about the credentials of the clinician they were seeing.
- Most Medicare beneficiaries responded that they were able to access routine primary care without issue. Beneficiaries reported that they could usually get an appointment with their PCP sooner for sick visits and urgent medical issues than for routine care.
- Beneficiaries were using telehealth for acute primary care needs. Many beneficiaries reported that their primary care practice offers telehealth services for acute issues, though it is not guaranteed they will be able to see their regular clinician.
- We asked Medicare beneficiaries about their experiences seeking care for urgent medical issues. A few beneficiaries responded that they would contact their PCP for guidance before going to an urgent care center or emergency department (ED).
- Beneficiaries reported mixed experiences with visiting urgent care for primary care needs. Some beneficiaries appreciated the convenience and access to medical equipment at urgent care facilities. However, a few beneficiaries had issues finding an urgent care facility

that accepted their insurance. Some beneficiaries reported relying on the ED for urgent medical issues when they could not get in with their PCP.

Access to Specialty Care

- Medicare-only and dual eligible beneficiaries reported seeing an average of three specialists. The maximum number of specialists that a beneficiary reported seeing was eight. All dual eligible beneficiaries reported seeing at least one specialist. A few beneficiaries with MA or traditional Medicare reported that they saw no specialists.
- Beneficiaries reported waiting weeks to many months to see a specialist as a new patient. Consistent with findings from the clinician focus groups, beneficiaries said the wait time for an appointment as a new patient was often dependent on the specialty. Many beneficiaries reported long wait times to see a specialist even if they were experiencing an acute medical issue.
- We asked Medicare beneficiaries how they found specialists as a new patient. Similar to how beneficiaries searched for new PCPs, beneficiaries asked their current provider or friends and family for referrals and recommendations to specialists. Some beneficiaries' MA plans required them to get a referral from their PCP to see a specialist.
- Beneficiaries reported that their MA plans' provider directories were often out of date or practice websites were not frequently updated, making finding an in-network specialist challenging.
- Some Medicare beneficiaries noted that they preferred to see specialists within the same practice or health system as their PCP. Beneficiaries cited multiple reasons for this, including because they knew their insurance would be accepted and that specialists had access to their health records.
- A few beneficiaries had care disrupted when their specialists became out of network or stopped accepting their insurance.
- Many beneficiaries with MA reported that they try to avoid seeing out-of-network providers and discussed the steps they took to avoid this. Several beneficiaries with MA reported needing to decide between keeping their provider or their insurance when a provider became out of network.
- In one location, multiple beneficiaries with MA reported that a major health system and large health insurance company were under contract negotiations, which may have required them to look for new clinicians or to switch insurance plans. There was some confusion about the status of the negotiations and the implications for beneficiaries.
- Many beneficiaries with MA reported challenges with prior authorizations when scheduling necessary services, which delayed care. Many also reported that the need for prior authorizations prevented them from obtaining prescriptions.

Organization of Care

Working with Other Clinicians

- Among our focus group participants, 35 physicians (63 percent) worked with NPs, and 18 physicians (32 percent) worked with PAs. Physicians described a wide range of models for working with advanced practice providers (APPs), ranging from highly autonomous practice arrangements to closely supervised, team-based relationships. Many physicians described deploying APPs to manage stable patients, routine follow-up visits, and urgent appointments, allowing physicians to focus on more complex conditions and new patient evaluations. Several physicians described how APPs help triage patient demand and absorb routine chronic disease follow-up.
- Many physicians described APPs as valuable members of the care team who improve efficiency, increase capacity, and reduce physician workload.
- Physicians described the investment in time needed to properly onboard APPs to their practice. Although many physicians valued APPs, some expressed concerns about variability in training, preparedness, and clinical decision-making.
- Physicians in all locations spoke about the value of finding experienced APPs and how increased levels of experience, mentorship, and specialty-specific training enabled APPs to practice independently. Physicians generally expressed confidence in experienced APPs who practiced within their expertise and sought physician input for challenging cases.
- NPs described working closely with physicians through a range of collaborative arrangements, from largely independent practice with consultation as needed to highly integrated, team-based care. Several NPs reported maintaining their own patient panels and managing patients, similar to their physician colleagues, while consulting with physicians on an as-needed basis.
- NPs described generally high levels of clinical autonomy, especially as they gained clinical experience, but noted that clinical complexity influences the degree of independent patient management. Several NPs described relying on physician consultation early in their careers but becoming increasingly independent over time.
- NPs discussed limits on the goods and services they can order and prescribe for patients enrolled in Medicare, including cardiac rehab and diabetic shoes. In addition, organizational administrative policies can limit APP autonomy even when clinical scope of practice authority exists.

Practice Management and Staffing

- Across all locations, there was limited physician and NP discussion on practice management and decision-making.
- Physicians reported challenges with hiring front office staff and medical assistants due to lower salaries and increased exposure to patient complaints. For the most part, physicians felt they were able to find the candidates they needed at the APP level.
- NPs spoke about switching practices for improved work-life balance, increased autonomy, and better alignment with their personal interests.

Concierge Medicine

- Physicians in all locations described some, but limited concierge medicine practices in their communities. Several concierge primary care physicians participated in the focus group discussions.
- Identifying a patient population willing to pay an annual fee was described as a potential barrier by a few physicians who considered moving to a concierge model.
- Some physicians spoke of challenges patients in their communities face accessing primary care because PCPs in their community have transformed their traditional primary care practices into concierge practices.
- Most beneficiaries across locations were familiar with concierge medicine.

Software as a Service (Artificial Intelligence)

- Across all locations, many clinicians were using AI in a variety of ways, including using AI agents or tools for scribing, to answer phone calls, draft messages to patients, and for clinical purposes such as guidance or education.
- Physicians in all locations described AI scribing as a useful development. Many physicians were impressed with the accuracy of AI scribe services in capturing patient interactions. However, physicians had mixed feelings about what AI tools include in medical notes. Some praised AI tools' ability to pull the clinically relevant elements of the visit into the medical note, while others described significant omissions and the need to closely review its documentation. Several physicians were not using AI scribing tools because they did not find them appropriate for their patient population or because they felt it was more efficient to draft their own notes than to review and revise AI-generated notes.
- Some physicians spoke positively about the AI-generated emails their electronic medical records (EMRs) were drafting to patients based on patient lab results or using AI to respond to patient portal messages. They described how the AI-drafted letters included more details of the patient history and clinical references than they would normally include in their letters.
- Some physicians were using AI for clinical guidance, synthesizing medical evidence, and clinical education. Only one physician described using AI in patient procedures.

Accountable Care Organizations

- Across all groups, about a quarter of physicians reported that they were participating in ACOs. Physicians were mixed in their knowledge of ACOs. Some knew their practice participated in an ACO but did not really know what ACO participation meant to their practice. In other cases, physicians had been involved in their practice's decision to participate in the ACO and were very aware of the measures and benchmarks the ACO set for their practice and how their performance would impact the practice financially.
- Physicians participating in ACOs explained how the ACOs supported increased care coordination, enhanced quality reporting, and offered financial incentives for their practices that made participation appealing. A couple of physicians discussed how their practice used

some of the resources provided by the ACOs to hire care managers and extra help to the practice.
- Many physicians participating in ACOs had experienced financial gains, while some had experienced losses.

Quality Reporting

- Overall, clinicians expressed an appreciation for collecting and measuring quality data but felt like the measures did not always align with their delivery of quality care. Many clinicians described receiving regular quality reporting from their practice, health system, or insurers on different quality measures either in their EMRs, regular quality reporting updates, or through practice meetings.
- Some clinicians said they were reporting quality metrics because they were told to do so and some described the reporting as ticking boxes.
- Some clinicians received bonus payments from MA plans for meeting quality metrics.
- There was discussion among physicians about being held responsible for quality measures, such as preventive measures, that did not align with their specialty.

E&M Visit Complexity Add-on Code

- Physicians across all locations were familiar with the G2211 evaluation and management (E&M) visit complexity add-on code and reported using it regularly, particularly for the ongoing management of patients with chronic conditions. While physicians viewed G2211 as especially relevant to primary care, specialists in cardiology, endocrinology, rheumatology, gastroenterology, neurology, and allergy/immunology also reported using the code.
- Some physicians reported that using G2211 provided additional reimbursement and helped recognize the complexity of managing patients over time. However, experiences with reimbursement varied.
- Despite its widespread use, several participants indicated that guidance on when the code should be applied was not always clear, leading to uncertainty and inconsistent use across practices.

Prescription Drugs

Cost Sharing

- Most clinicians reported that access to certain prescription drugs were a major concern for their Medicare patients due to coverage restrictions and out-of-pocket costs.
- We asked clinicians if they noticed a change in beneficiaries' out-of-pocket costs with the implementation of the Part D Redesign, which has a $615 deductible and capped out-of-pocket costs at $2,100, and the Medicare Prescription Payment Plan, which gives beneficiaries the option to enroll in a payment plan that spreads costs over the year. While several clinicians reported that the cost-sharing cap was helping increase access to

expensive medications, many reported limitations, including that the deductible is still too high for many Medicare beneficiaries and that awareness of the Medicare Prescription Payment Plan is limited among beneficiaries.
- Several clinicians reported prescribing generic drugs or less expensive medications, or tailoring medications to their patients' insurance coverage, to make prescriptions more affordable for patients.
- Many clinicians reported that their patients use programs that reduce out-of-pocket costs, including a state prescription program, foundations, and grants, and that they help patients access these programs when they can. A few clinicians expressed frustration that Medicare beneficiaries are not eligible for other payment options, such as copay cards, coupons, and manufacturer patient assistance programs.

Medicare Drug Price Negotiation Program

- Many clinicians were generally aware of the Medicare Drug Price Negotiation Program but were not aware of the specific prescription drugs whose prices were negotiated for 2026. Clinicians had mixed responses on noticing changes in patient experience using negotiated drugs after moderators reminded them which drugs had been negotiated.

GLP-1s

- Most clinicians reported that they regularly had patients asking for GLP-1s, which often required time and energy spent on prior authorizations.
- Several clinicians expressed excitement regarding the Medicare GLP-1 Bridge program implemented on July 1, 2026, because of their perception that the program would save them time on prior authorizations and increase access to GLP-1s for their patients.
- Some clinicians reported that patients were willing to pay out of pocket for GLP-1s, including through direct-to-consumer options.

Pharmacy Use and Filling Prescriptions

- Medicare beneficiaries shared their reasons for preferring a specific pharmacy, including convenience and relationships with pharmacy staff. Several participants expressed specific reasons why they avoid certain pharmacies, including insurance barriers, experiencing errors, and expensive or seemingly variable pricing.
- While mail order and home delivery were favored by many participants to reduce the burden of picking up recurring prescriptions, several beneficiaries preferred to pick up one-off or time sensitive medications to avoid issues or delays.
- Several participants reported that closures of nearby pharmacies had forced them to switch pharmacies. When looking for alternatives, beneficiaries considered distance, store hours, delivery options, and availability of medications.
- Many participants reported that they or someone in their immediate family had attempted to fill a prescription that was out of stock. Although inconvenienced, many were able to get the prescription within a week or from another nearby pharmacy.

- Many beneficiaries noted that prescriptions' costs were increasing over time, but for most the increase in cost was described as minimal and did not affect affordability.
- Several beneficiaries who had experienced significant drug cost changes noted that they were primarily due to changes in coverage, including switching plans or medications being removed from formularies. When they could not afford the drug after changes in coverage or increases in cost, several participants reported that they switched to a cheaper alternative drug or shopped around for better prices or plans that covered their medications. Some beneficiaries reported using online tools, including GoodRx, to look up prescription costs, and chose the pharmacy that offered the best price. A few participants stated that they have skipped filling prescriptions due to the cost.

Key Findings from Rural Focus Groups 2021–2026

Choosing Coverage

- We asked rural beneficiaries how they chose between traditional Medicare and MA. Rural beneficiaries with traditional Medicare stated they prioritized the option to see any clinician who accepts Medicare, including while traveling.
- Similarly, rural beneficiaries enrolled in MA also indicated that they valued being able to see their preferred clinicians and factored provider networks into their plan choices. These beneficiaries also cited perceived lower costs and availability of supplemental benefits as factors that informed their coverage choices. However, supplemental benefits generally did not drive plan decision-making among rural beneficiaries across years. In previous years, some beneficiaries noted that their rural location limited the utility of certain MA plan supplemental benefits.

Access to Care

- Across all years, nearly all rural beneficiaries reported having local access to primary care. In 2026, sources of primary care included a physician, a nurse practitioner, a federally qualified health center (FQHC), and a clinic.
- Across years, some rural beneficiaries reported challenges finding a new PCP, including limited options and long wait times for new patients.
- Rural beneficiaries' experiences with wait times for specialty care varied, ranging in 2016 from one to two weeks to three to four months. Consistent with prior years, 2026 rural participants described seeking specialty care from clinicians in the nearest major metropolitan area, either to access care not available locally or to see specific clinicians due to perceived higher quality of care.
- Across years, we heard from rural beneficiaries who took advantage of specialists who make periodic visits to their local hospital. They see these specialists when they are at the local hospital to reduce the need to travel for specialty care.
- In 2026, one third of rural beneficiaries reported that they had used telehealth appointments.

- We asked rural beneficiaries how they would access care in different medical scenarios. If they were sick or had a time-sensitive issue to address that was not an emergency, rural beneficiaries in 2026 said they would seek care at an urgent care facility or through a walk-in appointment at their doctor's office or clinic, consistent with prior years. For an injury needing stitches, most 2026 participants said they would visit the ED, with one saying they would contact their PCP through the online portal, a telehealth visit, or an in-person visit. For symptoms of a heart attack, all rural beneficiaries in 2026 said they would seek care at the ED. For major, non-emergency care or surgery like a hip replacement, all rural beneficiaries in 2026 said they would seek care in the nearest metropolitan area.

Prescription Drugs

- Across years, rural beneficiaries generally reported having access to local pharmacies and being able to access prescription drugs through local or mail-order pharmacies.
- In 2026, several respondents said they use large retail chains or mass merchandiser pharmacies. One 2026 participant used the pharmacy at the clinic where they receive primary care. Rural beneficiaries in prior years reported that they chose or were encouraged by their insurance to use a mail-order pharmacy.
- No rural participants in 2026 had been affected by a nearby pharmacy closure.

Methods

The following bullets summarize the methods the NORC team used to conduct this qualitative research study. Methods and findings from the rural focus group are presented in a separate section at the end of this report. Additional details appear in the subsequent subsections.

- **Data collection approach**: Focus groups
- **Data collection timeframe**: May and June 2026
- **Number of focus groups**: 21
  - Seven in person in Tampa, Florida
  - Seven in person in Iselin, New Jersey
  - Seven in person in Seattle, Washington
- **Participants**: Medicare beneficiaries (grouped by enrollment in traditional Medicare and MA), beneficiaries eligible for Medicare and Medicaid (dual eligible beneficiaries), primary care physicians, specialist physicians, and NPs practicing in primary care and specialty settings
- **Moderating**: NORC senior researchers moderated each focus group
- **Topics discussed**: Enrolling in and using Medicare coverage, access to care, organization of care, use of AI in health care, and prescription drugs
- **Length of focus groups**: Approximately 90 minutes each
- **Institutional review board (IRB)**: NORC's IRB reviewed and approved all focus group procedures, screeners, and discussion protocols

Location Selection

At the beginning of this project, NORC and MedPAC worked together to choose a location from which to recruit beneficiaries and clinicians for participation in the study. The goal was to conduct research in person in three locations:

- Where MedPAC had not conducted focus groups during the past four years
- With a focus group facility that had the ability to recruit the specific profiles of participants necessary for this project

Exhibit 1 presents the city NORC and MedPAC selected based on these criteria, as well as several key characteristics related to the study.

Exhibit 1. Location characteristics

City (County)	Medicare Advantage Penetration[1]	Overall Percentage of Dual Eligibles[2]	Proportion of Population by Key Race/Ethnicity Subgroups		
			White, Not Hispanic/ Latino[3]	Black[3]	Hispanic[3]
Tampa, FL (Hillsborough)	63%	17%	44%	18%	32%
Iselin, New Jersey (Middlesex)	41%	13%	35%	13%	25%
Seattle, WA (King)	54%	15%	50%	7%	12%

Given the challenges of recruiting for and conducting in-person focus groups in rural areas, and the importance to MedPAC's work to include the experiences and perspectives of beneficiaries residing in rural areas, this project also included one virtual focus group with those beneficiaries. Methods and findings from this focus group are described in a separate section at the end of this report.

Recruitment

NORC partnered with trusted market research organizations with focus group facilities in the study locations to recruit and host the in-person focus groups. One of these organizations also had a nationwide database and performed recruitment for the virtual focus group with rural beneficiaries.

NORC worked with MedPAC to develop the screening criteria for recruitment of beneficiaries, including:

[1] Centers for Medicare & Medicaid Services. March 2026. Medicare Advantage State/County Penetration 2026 03. Available at: https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-advantagepart-d-contract-and-enrollment-data/ma-state/county-penetration/ma-state-county-penetration-2026-03.

[2] KFF. Statewide 2026 data. Dual-Eligible Individuals as a Share of Medicare Enrollment. Available at: https://www.kff.org/state-health-policy-data/state-indicator/dual-eligible-individuals-as-a-share-of-medicare-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[3] U.S. Census Bureau. QuickFacts: King County, Washington; Middlesex County, New Jersey; Hillsborough County, Florida. Available at: https://www.census.gov/quickfacts/fact/table/kingcountywashington,middlesexcountynewjersey,hillsboroughcountyflorida/PST045225.

- Details of Medicare coverage (e.g., enrollment in MA versus traditional Medicare; presence or absence of supplemental coverage) to ensure that we recruited Medicare beneficiaries who met specific coverage profiles and that we placed beneficiaries in the correct group
- Demographic information to recruit focus groups that matched as closely as possible the demographic profiles of the city (e.g., race/ethnicity)
- Experience with key discussion topics (e.g., recently looked for a new doctor, recently had help deciding on an insurance plan) to ensure groups would have participants who could speak to priority health care topics

We excluded participants whose responses to screening questions (and, in some cases, to subsequent follow-up from the focus group facility) pointed to uncertainty about their Medicare coverage situation (e.g., whether they were enrolled in traditional Medicare versus MA).

For clinicians, the screening process set out to ensure groups contained participants with:

- A mix of practice size and ownership profile
- Diversity in terms of length of time in practice
- Demographic diversity (e.g., race/ethnicity)
- A mix of specialties (for groups with specialist physicians and NPs)
- Regularly seeing Medicare patients in an outpatient setting
- A mix of practice types (e.g., solo/private, group, hospital-based)

Since their experience is less relevant to the research questions of this project, pediatricians as well as clinicians who reported that Medicare beneficiaries made up less than 10 percent of their practice population were excluded from focus groups.[4] In addition, we set out to exclude clinicians who have been practicing for more than 30 years, although in the physician groups we allowed these clinicians to participate, in order to fill the group.

When recruiting for focus groups, we often recruited more participants than needed for a discussion, as recruited individuals are often unable or unwilling at the last minute to participate. For that reason, we set out to recruit 10 participants for each in-person focus group, with a goal of conducting groups with 8 individuals. In-person groups ranged in size from 4 to 10 participants, with an average of 8 participants.

To further distinguish differences in experience based on coverage, we held separate focus groups for beneficiaries enrolled in MA and those enrolled in traditional (fee-for-service) Medicare. Input from beneficiaries was flagged by coverage type during the analysis to ensure all findings are properly attributed in this report.

[4] NORC screened providers who reported that 11–25 percent of their patients were covered by Medicare.

Focus Group Participants

We conducted discussions with the following groups:

- **Medicare beneficiaries (n = 57 across the in-person locations)**
  - Individuals enrolled in traditional Medicare (n = 29) or a MA plan (n = 28)
  - Individuals 65 years of age or older
- **Dual eligible beneficiaries (n = 38)**
  - Individuals enrolled in both Medicare (all individuals were enrolled in MA) and Medicaid
  - Included a mix of beneficiaries 65 years of age or older and beneficiaries under age 65
- **Clinicians (n = 76)**
  - Primary care physicians (n = 22), including those in family medicine and internal medicine
  - Specialist physicians (n = 34), including cardiology, oncology, psychiatry, endocrinology, rheumatology, and orthopedics
  - Primary care nurse practitioners (n = 12), including individuals who work in family medicine and internal medicine
  - Specialist nurse practitioners (n = 8) including mental health, gastroenterology, orthopedics and rehabilitation, colorectal care, and oncology

Exhibits 2 and 3 present demographic characteristics of participants in the in-person beneficiary and clinician focus groups. Diversity across demographic characteristics ensured that our focus group participants offered a range of perspectives.

Exhibit 2. Beneficiary participant characteristics

	Medicare-Only (n=57)	Dual Eligible (n=38)	Total (n=95)
Race			
Asian	3	0	**3**
Black	7	7	**14**
White	43	28	**71**
Other/Multiple Races	4	3	**7**
No Response	0	0	**0**
Ethnicity			
Hispanic	2	5	**7**
Non-Hispanic	55	33	**88**
No Response	0	0	**0**
Age (years)			
<65	0	18	**18**
65–70	30	10	**40**
71–74	12	7	**22**
75–80	9	3	**12**
>80	3	0	**3**
No Response	0	0	**0**
Gender			
Female	32	26	**58**
Male	25	12	**37**
Transgender	0	0	**0**
No Response	0	0	**0**

Exhibit 3. Clinician participant characteristics

	Primary Care Physicians (n=22)	Specialist Physicians (n=34)	Primary Care Nurse Practitioners (n=12)	Specialty Nurse Practitioners (n=8)	Total (n=76)
Race					
Asian	8	11	4	2	**25**
Black	2	2	1	0	**5**
White	8	16	6	6	**36**
Other/Multiple Races	4	5	1	0	**10**
No Response	0	0	0	0	**0**
Ethnicity					
Hispanic	2	3	1	0	**6**
Non-Hispanic	20	31	11	8	**70**
No Response	0	0	0	0	**0**
Gender					
Female	9	15	12	7	**43**
Male	13	19	0	1	**33**
No Response	0	0	0	0	**0**
Years in Practice					
<5	2	2	2	3	**9**
5–15	3	10	7	4	**24**
15–29	13	20	3	1	**27**
>30	4	2	0	0	**6**
No Response	0	0	0	0	**0**
Practice Setting					
Solo or small practice	14	8	1	1	**24**
Large group practice	5	9	4	2	**20**
Practice owned by a hospital or health system	3	17	6	4	**30**
Other	0	0	1	1	**2**
No response	0	0	0	0	**0**

Data Collection

Focus groups were scheduled for 90 minutes, with one of three senior researchers from NORC moderating each discussion. Prior to the start of each group, participants were asked to fill out a brief survey to confirm certain screening criteria (e.g., details about beneficiaries' Medicare coverage profile) and to provide the moderator some context about each group's makeup on key topics (e.g., how many participants received help choosing their plan).

A core set of research questions and topics of interest guided the development of discussion guides for all focus groups. Topics discussed in beneficiary groups included the process of choosing coverage, access to primary care and specialty care, and prescription drugs. Topics discussed in clinician groups include acceptance of new patients and insurance, working with other clinicians, AI, changing organization of medical care, working with insurance and MA plans, and prescription drugs.

Analysis

We performed our analysis using NVivo qualitative data analysis software. A summary of the analytic process is as follows:

- All focus groups were recorded and transcribed.
- NORC developed a list of topic codes based on the moderator guide for the focus groups, as well as on previous analyses and reports. (The topical codes are generally reflected in the headers of the Findings section.)
- NORC loaded transcripts and codes into an NVivo project file.
- We coded each transcript in NVivo, tagging and organizing content based on the topic codes.
- NORC researchers conducted a thematic analysis of the content within each topic code to identify themes, such as areas of agreement and disagreement among participants, and compelling quotations illustrating the identified themes.

In some of the following sections, we highlight beneficiary and clinician focus group findings by beneficiary type (e.g., dual eligible and Medicare-only; traditional Medicare and MA) to draw attention to any differences by coverage type. Due to the nature of focus group research, our sample was limited in number and is not representative of Medicare beneficiaries or clinicians in the location where we conducted this research. Therefore, findings cannot be generalized either to the studied community or to the nation as a whole.

The benefit of the qualitative approach is that it allowed us to ask questions with answers that cannot be easily put into numbers to understand experience. In addition, it allowed us to understand the "how" and "why" of experiences, including deeper understanding of experiences

and context, and provided personal narratives and real-life examples that policymakers may find useful as they consider potential changes to the Medicare program.

Findings

The following sections describe what we learned from our analyses of the 21 in-person focus groups in Florida, New Jersey, and Washington. We begin by summarizing what we heard from beneficiaries about their experiences with choosing coverage and then discuss beneficiary and clinician experiences with access to care, organization of care, and prescription drugs.

Choosing Coverage

Understanding Medicare and Plan Choices

Overall, beneficiaries reported knowing about the deadline sign-up for Medicare and the penalties for late enrollment. Many participants mentioned that there are widespread campaigns on the deadline to sign up for Medicare via TV, phone, and mail. One beneficiary enrolled in traditional Medicare noted "If you have a TV, you can't miss the deadline," while another said they were "bombarded" with information before they turned 65. Others were aware of the deadline and penalties based on information in Medicare seminars, from health insurance brokers and agents,[5] from their financial advisors, and by word of mouth in their communities. One Medicare beneficiary mentioned speaking to their local State Health Insurance Assistance Program (SHIP) office to clarify questions about timing and penalties.

Beneficiaries who delayed Medicare enrollment because they were covered by their or their spouse's employer coverage at the time they turned 65 were generally familiar with the process to delay enrollment. One beneficiary noted that their employer's benefits managers assisted with completing the paperwork to submit to Medicare. Another traditional Medicare beneficiary said, "My husband worked for a major company, so it wasn't a problem: [he] just called the benefits people and said, 'OK, I need this.' They provided [the paperwork] and submitted it." Another Medicare beneficiary who was employed when they turned 65 reported confusion about the exact timing of signing up in relation to their birthday but did not report any issues with the sign-up process when they did retire.

[5] A Medicare broker is someone who works with multiple insurers who can provide beneficiaries with a variety of options. An agent works with one insurer and can only offer beneficiaries plans from that insurer. Beneficiaries reported working with both brokers and agents, but we are unable to differentiate between the two in our findings because some beneficiaries used the terms interchangeably. Source: HealthCare.gov. Agent and Broker (Health Insurance). Available at: https://www.healthcare.gov/glossary/agent/.

Dual eligible beneficiaries, including those over 65 years of age, commonly described their Medicare enrollment as happening passively or automatically, rather than having to actively enroll in or choose their Medicare coverage. One MA beneficiary said, "I was just enrolled in the Medicare when I became disabled…I was automatically enrolled." Multiple dual eligible beneficiaries mentioned that they did not know about having to sign up for Medicare but that "it just happened." One participant said they received information about Medicare a few months before turning 65 and completed their Medicare enrollment over the phone. Dual eligible beneficiaries reported receiving enrollment assistance from their Social Security office, caseworkers, or state insurance agency. Most of the dual eligible participants in our focus groups were in MA plans; only three dual eligible participants across locations were in traditional Medicare. One beneficiary mentioned that they "don't recall seeing traditional [Medicare]" as an option.

Medicare beneficiaries used a range of sources when choosing their coverage. Regardless of ultimate Medicare coverage profile (i.e. traditional Medicare versus MA) and both Medicare-only and dual eligible beneficiaries spoke to agents and brokers, attended seminars, collected brochures, researched plans on the internet, asked family and friends for their opinions of coverage, and spoke with advisors and colleagues prior to retirement. Some participants also mentioned wanting to stay with the same insurance carrier they had prior to retirement or disability. A few beneficiaries who were former state employees noted that they had to take the MA plan that the state offered them. Dual eligible beneficiaries consulted additional sources when learning about their Medicare coverage options, including doctors, case managers, and social workers.

Beneficiaries across different groups and locations were familiar with Medicare.gov's Plan Finder tool, and a few beneficiaries we spoke to reported using it when choosing their coverage. Some Medicare beneficiaries used the site to confirm independent research they did on insurance websites or other resources, especially to confirm inclusion of specific doctors or prescription drugs in a plan. Across cities, participants described the site as "overwhelming" and "frustrating" because of how many options there are to sort through. A couple of beneficiaries said they prefer the *Medicare & You* handbook over the website to compare plans and lay out all of the available information.

Most beneficiaries in our focus groups spoke to agents or brokers—both independent brokers or agents for individual insurance companies. Some beneficiaries talked to brokers through national organizations or via the resources they found online. Some beneficiaries spoke with multiple brokers before choosing one they felt comfortable with. One beneficiary who had switched from traditional Medicare to MA said:

> *The first guy, I guess it was just when I turned 65. I had no really knowledge about anything to do with Medicare. Tried to talk to him a little bit, tried to tell him about the payments on the medications, what the costs would be. He was kind of going wishy-washy, back and forth, look this up, look this up, look this up.... I asked him about*

> *Medicare Advantage, and he immediately said, "No, Medicare Advantage is not for you." I said, "Why?" "Oh, look, this thing, it's not for you.'"… Well, I wasn't happy with the first program. The second guy who I went with was very good. He explained everything, explained all the different programs. And I was happy with them.*

A few people mentioned speaking to their agents or brokers throughout the year if they experienced issues with their plan, but most people who had an ongoing relationship with a broker reported speaking to them once a year when they wanted to revisit their plan options at open enrollment time. One beneficiary enrolled in MA noted that their broker sends monthly newsletters to "keep in touch," which keeps the broker in mind for coverage changes.

Awareness of SHIP varied across cities, with awareness being highest in Seattle. Fewer than 10 beneficiaries across groups in Tampa and Iselin were familiar with SHIPs, while most beneficiaries in Seattle either mentioned using Statewide Health Insurance Benefits Advisors (SHIBA), Seattle's SHIP, when deciding on their coverage options or had general awareness of the office. Medicare beneficiaries reported hearing about SHIP from the library, notices in the newspapers, and friends and family. One dual eligible beneficiary enrolled in MA went to the SHIP office that had helped a family member, saying, "Before I was ready for Medicare, I was helping my sister who had dementia, and at that point I met with [local SHIP] and got all of the information for her. So when it became my turn, I just went with the same people." Two beneficiaries with MA, one dual eligible, said that they thought SHIP was only for people who were eligible for Medicaid.

Beneficiaries who used SHIPs found them to be a useful resource for coverage decisions. The beneficiaries who had spoken with SHIPs reported they were extremely helpful with coverage decision-making and the advisors presented all the options for traditional Medicare, Medigap plans, and Medicare Advantage. One beneficiary with MA said, "It made the book [*Medicare & You* handbook] just obsolete for us because they went over everything that we needed to know."

Factors That Affect Beneficiaries' Choice of Coverage

Below we describe the factors that affected beneficiaries' Medicare enrollment.

Consideration of Coverage Options

Beneficiaries enrolled in traditional Medicare cited that they wanted the ability to travel without needing referrals or being restricted to a specific provider network. They also mentioned that when they spoke to family and friends who had MA plans, they heard about issues with getting referrals to specialists, long wait times to see clinicians, and prior authorization delays. One beneficiary said they signed up for traditional Medicare because MA "[is] too much like regular insurance. When my knee acted up, I had to get a pre-approval for an MRI. I'm going around the floor in agony, waiting for these fools to check the box." One

beneficiary mentioned their primary reason for choosing traditional Medicare was that they heard from family and friends that they would not be able to change to traditional Medicare with a supplemental plan in the future if they signed up for MA first.[6] One traditional Medicare beneficiary said, "I have a lot of friends who've had not good experiences with the Advantage plans. As much as I'd love to get $1,200 a month, I don't see it in the long run being a positive."

When deciding on supplemental plans, beneficiaries enrolled in traditional Medicare said they chose their plans due to cost. One beneficiary noted: "Well, my understanding is that all the plans cover the same thing.[7] So it's just a question of cost. And customer service, I guess. So I took the difference: in Plan N you have a copay. So I took the difference between Plan G, plan N annually, and then figured out how many times I had to use a copay to make it worthwhile." One primary care NP noted that their patients with traditional Medicare and Medigap plans are informed about coverage: "But I think the people that have a secondary seem to be more up on what they need, especially because they've navigated what their options are. And especially if they need pharmaceutical coverage. So, I'd say they're more informed."

Beneficiaries with Medicare Advantage cited lower co-pays and premiums as their main reason for signing up for Medicare Advantage. One beneficiary said, "I signed up for it because I didn't have to pay a premium, it was free, and I don't mind that because over the year I'm just not going to spend that much." When asked whether MA plan supplemental benefits factored into their coverage choice, some beneficiaries said they liked these benefits, but they were not the deciding factor for choosing their plan.

Among dual eligible beneficiaries who took an active role in selecting their Medicare plans, participants prioritized keeping existing providers in-network or having access to supplemental benefits. Dual eligible beneficiaries preferred to keep their current clinicians, and they used those clinicians as information sources when deciding on their coverage options, including to confirm the clinician accepted their intended MA plan. One dual eligible beneficiary enrolled in traditional Medicare said, "I thought about [Medicare Advantage], but I felt I like—I don't like to be a pigeonholed. I like to have the freedom of choosing what doctors.… I've seen the lists and the doctors—specialists that I go to are not on there."

Dual eligible beneficiaries also mentioned that OTC and reward cards were a factor in deciding between MA plans. A dual eligible beneficiary with MA said, "And then, the Advantage plan, the reason I actually, I chose was for the extra care card because I did need the extra help, you know, with an eight-year-old son. And the fixed income that I'm living on, as well as two grandchildren, so it does help. You know, I can purchase food with it and stuff."

[6] Beneficiaries can only switch Medigap policies within a six-month Medigap open enrollment period, based on a specific eligibility situation, or have guaranteed issue rights. For more information, see: https://www.medicare.gov/health-drug-plans/medigap/ready-to-buy/change-policies

[7] Medigap plan benefits vary. For more information, see: https://www.medicare.gov/health-drug-plans/medigap/basics/compare-plan-benefits

Medicare Advantage Supplemental Benefits

Across cities, beneficiaries with MA used the supplemental benefits offered by their plans, including over the counter (OTC) cards and gym memberships. Beneficiaries used OTC cards for various pharmacy items such as pain relievers and bandages. A smaller number of beneficiaries mentioned vision and dental care as supplemental benefits, and one beneficiary explained that their plan "seems to cover all of my attachments [for my hearing aid] so far." One beneficiary mentioned that it was an "expectation" that MA plans offer these benefits.

Across cities, beneficiaries had positive views of financial incentives offered by MA plans, such as the rewards for healthy habits, preventive screenings, or recommended vaccines. However, some beneficiaries noted that the incentives are difficult to sign up for or receive. One dual eligible beneficiary said, "Mine says it does [have incentives], but they make it almost impossible to—they don't give you the money for stuff you've already done. You have to sign up ahead of time and ... they just basically make it kind of difficult." A Medicare-only beneficiary noted that it is a process to get these incentives: "I get about $200 a year back in gift cards. Give or take, yeah. But it's work to sign up for you. You have to put a lot of time into it. To get that money." Another dual eligible beneficiary noted that the rewards are less flexible than they used to be. This beneficiary was previously able to use their card for food items but now are restricted in what they can use it for. They explained, "In the past [I received] $50, $25; they used to actually give you a gift card. And [I could] use that. But now they put it onto your account."

Though we did not explicitly ask about transportation benefits, a few beneficiaries, mostly dual eligible, mentioned using transportation offered by their plans. Beneficiaries often noted that the rides are limited in quantity per year. Some beneficiaries said the transportation coverage was done by rideshare now. Beneficiaries did not report any issues with rideshare services but mentioned that these services were not always helpful for surgery, as they need someone they know to help after discharge. One dual eligible beneficiary noted that their plan got rid of transportation benefits in the last year, but they were able to use a city-sponsored program for transportation.

Beneficiaries enrolled in MA reported that over the last year, the OTC cards or reward amounts offered by their plans decreased between $50 and $100 per year. One beneficiary with MA mentioned that their plan "doesn't have any OTC at all anymore." A dual eligible beneficiary with MA said the decreases "[are] not that much, but with the cost of living, it hurts a little bit." A dual eligible beneficiary said, "You know, they do the OTC funds, but they recently lowered it for a PPO provider, recipients, and that's actually hurt me more recently than ever before.… But they raised it for HMO beneficiaries, which I felt was extra insulting. You know, as if to encourage people to switch to a lesser plan."

A few participants experienced home visits from their MA plans. A couple of dual eligible beneficiaries who had participated in MA plan home visits appreciated the financial rewards offered by their plans, which ranged from $50 to $100, and one beneficiary found it very helpful

to see a provider in person for a longer amount of time than they see their PCP. However, some beneficiaries found home visits duplicative of care they receive in their PCP's office. One beneficiary with MA said: "I did it once and it was so long, and they keep calling me from [insurance company], and when I see it on caller ID, I don't even answer." One beneficiary noted that: "I don't think it's for my benefit; it's for [the insurance company's] benefit." Another beneficiary explained:

> *I had one [visit from a] nurse, and I said it's a waste of insurance money, so don't call again. Because they're taking blood pressure and everything, but you don't really know [why], so what is the point on that?... They're paying them money, the insurance company is wasting money, and we don't get any benefit from it.*

Satisfaction with Coverage

Exhibit 4. Beneficiary satisfaction with overall coverage

	Traditional Medicare Only n (%)	Medicare Advantage Only n (%)	Dual Eligible[8] n (%)	Total n (%)
Excellent	7 (24%)	7 (25%)	13 (34%)	27 (28%)
Good	21 (72%)	18 (64%)	16 (42%)	55 (58%)
Fair	1 (3%)	3 (11%)	9 (24%)	13 (14%)
Poor	0 (0%)	0 (0%)	0 (0%)	0 (0%)

We discussed how beneficiaries rated their health coverage "overall" in 8 of 12 focus groups.[9]

Beneficiaries who described their overall coverage as excellent (28 percent across all groups) noted that all of their health care needs were met, and they have yet to experience any problems such as delays in referrals or prior authorization issues. A couple of beneficiaries noted that they "rarely rate anything excellent anyway." One beneficiary explained, "I put excellent … because it covers what I need at this present time in my life. I know that it's not perfect, but for me, everything, you know if I need to get a procedure done, they do give an authorization. It's easy to find doctors that accept the plan."

Most participants (58 percent) across the groups rated their coverage as good. One beneficiary noted that they have limited costs other than their copay. Another beneficiary noted that, "I really don't have any problem with Medicare. I rated it good, not excellent, because it—it does keep me from pulling money out of a savings account."

[8]Given the relatively small number of focus group participants, percentages should be considered directional only and not interpreted as statistically representative of the broader Medicare population.

[9] This topic was not covered in the other groups due to time constraints.

Some Medicare beneficiaries (14 percent) rated their coverage as fair due to delays with prior authorizations and provider access. One beneficiary said that they spent a significant amount of time waiting for an MRI. Another beneficiary noted some issues with finding nearby, in-network providers:

> *I rated mine fair. In the first couple years it was good, and now that I'm getting older, and I'm needing different doctors … I can't find the doctors that are close to me. They want me to drive 15, 20 miles away, and I'm not doing it.… And the other thing was that you'll go to the doctor's office, and they'll say, "Oh, no one informed you that we're out of network, so you're going to have to pay." I walk out. I'm not paying. I'm on a fixed income, you know?*

Dual eligible beneficiaries varied on their ratings of their coverage. While a majority rated their coverage as good (42 percent across dual eligible groups), more dual eligible beneficiaries than Medicare-only beneficiaries rated their coverage as excellent (34 percent) or fair (24 percent). Beneficiaries who rated their coverage as excellent or good cited the lack of copays and that their coverage offers them a wide range of benefits with one noting that their plan covers "a tremendous amount of stuff."

Dual eligible beneficiaries who rated their plans as good or fair cited copay costs, accessing care, and administrative obstacles as reasons for their ratings. One dual eligible beneficiary with traditional Medicare said:

> *I said good because with my Medicare, I would have to pay $35 or $40 copay for specialists—like for my mental health and my neurological disabilities. It can be a burden. It can be a burden, especially if you're ... low income, paying rent because I live in an apartment. You're paying rent, you're paying the utilities, paying the cable bill. It's a lot, and it accumulates, too.… I don't know if [Medicare] covers that, too, but when I was on just Medicaid, I didn't have any copay or anything like that.*

Administrative issues contributed to lower ratings among dual eligible beneficiaries. One beneficiary mentioned they received a number for a representative they can call with issues but waited on the phone longer than expected when they had an issue. A few beneficiaries mentioned that they have to "jump through hoops" to get care and waited six months to see a provider they were referred to. Another dual eligible beneficiary explained:

> *Fair, I put, because it's hard to find specialists that will even take it [MA plan]. And then it got to the point where, you know, they were saying we had to get special permission to go out of the 50-mile range or whatever to find a doctor. Who wants to travel out of 50-mile range to go to a doctor? You know what I mean? And then you got to see them every month or every three months or whatever. No one wants to travel that far.*

Switching Plans

Some beneficiaries reported revisiting their coverage decisions annually. Beneficiaries with MA generally did not revisit their coverage choices each year but would revisit their

coverage if their health needs changed. Some beneficiaries with traditional Medicare said they revisit their coverage decisions annually in anticipation of Medigap plan rate changes, but most reported not revisiting these decisions. A few beneficiaries noted that they do not pay attention to their plan changes annually.

Beneficiaries across coverage types noted that the process of switching is daunting. One beneficiary with traditional Medicare said, "The analysis is sitting down and plugging all this information in, being sure that I understand what it's telling me and just the unknown of going to a different company." A dual eligible beneficiary noted that they want to switch insurance companies but are hesitant, saying, "I would love to have it be assessed by somebody, help me go through [the current plan], have [the new plan] be the best that it could be for me." They noted that they would follow up with their local SHIP during open enrollment.

Approximately 10 percent of beneficiaries reported having changed their coverage type (between MA and traditional Medicare) or switched their plans (between HMOs and PPOs or insurance companies). Beneficiaries with MA who switched from traditional Medicare were driven by premium costs. One beneficiary who switched from traditional Medicare to MA found the $0 a month premium of an MA plan appealing compared to the costs of a Medigap plan, which they reported as "[seeming] like a lot of money."

Beneficiaries in Seattle had more experience with switching from Medicare Advantage back to traditional Medicare compared to beneficiaries in Tampa or Iselin.[10] One beneficiary said that they were able to change their Part D plan due to its Star Rating being too low.[11] Another beneficiary with traditional Medicare who had previously been enrolled in MA explained their process of switching due to issues with finding providers:

> *I started out on a Medicare Advantage program.… And after a year, I was having trouble finding the right [health care providers]. I switched to [insurance company], getting a great dog and pony show there. Stayed with them several years, and then I escaped. And went back to standard Medicare at the time I was told that you could do that, but [insurance company] was the only one that didn't require a physical for it. And I knew I wasn't going to pass the physical with others or something, so I went with them. So I have stayed with them.*

A few beneficiaries cited not needing referrals from their PCPs as the reason they switched to or stayed with their current MA plan. One dual eligible beneficiary with MA explained:

> *I don't want to ever change. They always send me something to change to the HMO for extra benefits, the OTC things, but I don't want to change because … I do see lots of specialists, and I'm not going through all that—with the having to get referrals, and …*

[10] Washington has expanded guaranteed issue rights to sell Medigap policies and cover pre-existing health conditions if their MA plan changes. For more information, see: https://www.insurance.wa.gov/sites/default/files/2025-05/shiba-workbook-june%202025-ce-medigap.pdf

[11] There is a special enrollment period to switch MA or Part D plans if their Star Rating is fewer than three stars for three straight years. For more information, see: https://www.ncoa.org/article/medicare-star-ratings/

this way, it's just such an easy thing for me. To not have to have the referrals and things like that … it's not worth it to change.

Another beneficiary who switched MA plans described, "I did change this year ... and that was because the plan I was on...it was [insurance company], and they no longer [offered] the [specific HMO] plan any longer... And their prices for a PPO skyrocketed, which was so totally out of line with [other PPOs]. So, therefore I did go with a different company." A dual eligible beneficiary described a similar situation where they reported a time when they were no longer eligible for the PPO plan offered by one insurance company and reported switching to an HMO within the same company. This beneficiary noted that there were issues with more paperwork for prior authorizations with their HMO compared to their PPO.

Beneficiaries who switched insurance companies said they were happy with their decision. One dual eligible beneficiary said: "I've never had a problem [at all], and they're so nice on the phone. Any problem, and—and if I need a new doctor, you just go on the website. I'm good with that, and [I can] call up what [doctors I] want."

Access to Care

We spoke with clinicians about their perspectives on topics related to access to care, including wait times for appointments, acceptance of new patients and insurance, acceptance of MA plans, and working with MA plans. We spoke with beneficiaries about access to primary care, including their regular source of primary care, receiving care from NPs and PAs, their access to specialty care, experiences looking for new primary and specialty clinicians, and experiences with MA plan networks and prior authorizations.

Clinicians

Wait Times

We asked clinicians to estimate how long new and established patients typically must wait to get an appointment with them. Most clinicians reported that wait times were shorter for established patients compared to new patients. Primary care physicians reported wait times for new patients ranging from a few days up to six months. Specialists' responses also varied widely, ranging from 1 week to 12 months. NPs across specialties reported wait times between a week to six months. Clinicians also shared that follow-up appointments, such as after a hospital discharge, are scheduled in more defined increments, ensuring that patients can see their clinicians when there is need for regular engagement.

Wait times for appointments varied by specialty, with some specialists explaining that patient acuity dictated wait times. One specialist explained, "For cardiology, you can't get away with that…. I have patients that are calling, and technically I don't have openings until October or December, although we fit them in and there's ways to get around it. So, I don't

know, it probably depends on the specialty and placement." Another cardiologist expressed similar sentiments, stating, "Someone calls with a chest pain, I'll see them right away."

Across all three focus group locations, clinicians referenced psychiatry, rheumatology, and endocrinology as specialties with especially long wait times. One NP explained, "I'd say that most of my referral specialties are probably one to three months out, other than endocrine, rheumatology, and neurology, which are either closed to new patients or six months out or declined … but I would say endocrinology and rheumatology are still very difficult to get." A PCP noted, "Psychiatry is difficult.... I mean, it really has its whole own model of care because so many providers just don't accept insurance and so that's difficult."

Across locations and specialties, many clinicians reported shorter wait times for patients experiencing acute concerns. Several physicians described using NPs and PAs in their practices for urgent visits when their schedules were full. Some specialists reported reserving slots in their schedule for urgent cases. Similarly, one NP shared that their office allots a certain number of hours for walk-in appointments, which enable patients to be seen the same day. Clinicians working in larger practices shared that if they do not have availability to see a patient with an acute need, someone else in their office is likely to have an opening. Several clinicians reported that they can see a patient via telehealth if the patient cannot make it to the office or wants to be seen quickly. Most clinicians shared that in instances where they cannot fit in a patient with an acute issue, they recommend the person go to an urgent care or the emergency department.

Some clinicians perceived differences in wait times between practices affiliated with large health systems and practices not affiliated with these systems. A specialist in a practice not affiliated with a health care system explained, "I think with some of the larger health care systems, they're coming up with a lot of different pathways of how to expedite these appointments. And there are a lot of practitioner appointments. There's going to be somebody at a different location also with the same subspecialty of practice." Clinicians in practices not affiliated with a health system reported they have longer wait times because they have fewer providers in their practice available to see patients. These clinicians reported hiring additional physicians to help reduce wait times. One specialist in a practice not affiliated with a health system said, "Three months is average, but it's gotten better to like two to three weeks because we've hired somebody new."

Some clinicians described how they use patient portals to communicate with patients between visits and said that portal communication can help them determine if an appointment is needed. One NP explained, "If someone's having like a side effect to a medicine or something like that, and then you can just kind of respond back saying like stop it or try this, and it can save a phone call in." Another specialist shared that they were more likely to fit a patient in for an appointment if they messaged the clinician through the portal instead of contacting their scheduling call center.

Changing Organization of Medical Care

We asked clinicians to describe their experiences referring patients to specialists. Several clinicians referenced challenges referring beneficiaries enrolled in MA to specialists, which can delay care. A PCP explained, "[Finding providers in MA networks to refer a patient] leads to a delay in patient care.… It's frustrating for you, it's frustrating for them, and it just feels like there's always delay in care with the Advantage plans." When asked if they check to see if a referral will be in-network, one physician explained, "We can. Because otherwise it'd be to the patient's cost, which is outrageous. They won't be able to afford it."

Several primary care physicians described their patients seeking treatment in the primary care setting for issues that require a specialist after being unable to find specialists that accept their plan or referral. One explained:

> *I think a lot of them [specialists] that don't accept certain insurances that we take, some of the not-so-desirable insurances.… So, you can't find one in the city; they have to travel, maybe a different town, different county. And so, you a lot of times end up having to bear the burden because the patient can't go … who are they going to go to? They come back to you. You end up having to do things that you're not comfortable with, that are out of your real expertise. How long you keep telling them, "No, follow up with orthopedics?" They come back to say, "I can't find them."*

One NP described challenges with specialists sending patients to primary care after initially accepting a referral from a PCP, stating, "Endocrine, rheumatology, and neurology, which are either closed to new patients, or six months [wait] out or declined, seeing certain types of patients that maybe would still be somewhat appropriate. But they push back to be handled in primary care." **Some specialists reported getting referrals from NPs in primary care that they believe could be addressed in the primary care setting.** They implied that NPs do not have enough training or understanding some of issues that they believe should not be referred to them. For example, an allergy specialist stated, "I'm doing a lot of primary care.… It's a whole good chunk of my day," when discussing receiving referrals from NPs.

Across locations, clinicians cited many of the same specialists as being partially hard to refer to because there were not enough of each to meet demand in their geographic area. These specialties included rheumatology and endocrinology. One NP said, "Rheumatology is probably the one we use the most. Several months out, there's not enough providers in the area." An NP in a different city stated, "Endocrinology, rheumatology … it's a very long waitlist just because there's not enough providers." One specialist explained that it is challenging for patients in their location to get appointments with specialists because there has been an increase in people moving to the area. The specialists explained, "There's more people in this

area [than] I think that the medical infrastructure can address: just many migration, people moving here permanently."

Some clinicians reported attempting to obtain specialist appointments for their patients by using personal networks and contacting physicians directly. One primary care physician working in a practice not affiliated with a health system reported texting specialist friends to try to get appointments for patients. The physician explained, "When I work in a traditional system, I wouldn't do that. But my boutique practice, that's what I feel like people are paying me for these connections." One NP provided examples of messaging a specialist using MyChart to ask if they could accommodate their patient or making calls on behalf of a patient to a specialist's clinic. Another NP shared that building relationships with specialists may result in patients being seen sooner: "It really takes that personal relationship. And it can take a very long time to establish that, and it sucks that we have to rely on that."

We asked clinicians if they felt pressure to refer to specific clinicians in particular networks or health systems. **Clinicians in larger health systems reported feeling more pressure to refer – or having compensation tied to referring – within their networks.** One physician employed by a health system stated, "They watch us. It's part of our bonus structure. It's part of the system." Similarly, other clinicians described receiving grades based on whether they refer within or outside of the system. In a different group, one clinician explained, "I think even if you are not … not forced to refer within their system, there are other financial incentives to stay within the system." Clinicians in smaller or independent practices described less pressure to stay within certain networks. One PCP whose practice participates in an ACO explained their office's reasoning: "We prefer to avoid large groups of specialty because we want to have control of our patients. So, we—if we have to refer to a large group, we pick and we contact several providers [who] … will work with us.… Otherwise we lose control of the patient, and the cost can go really high."

Acceptance of Patients and Insurance

In our pre-group surveys, we asked clinicians if they were accepting new patients generally and accepting new Medicare patients (Exhibit 5). Most clinicians (71 of 76) were accepting new patients and, of those accepting new patients, nearly all (68 of 71) were accepting new Medicare patients.

Exhibit 5. Clinician acceptance of new patients

Clinician Group	Accepting New Patients n (%)	Accepting New Medicare Patients n (%)
Primary care physicians	20 (91%)	20 (91%)
Specialist physicians	31 (91%)	29 (85%)

Clinician Group	Accepting New Patients n (%)	Accepting New Medicare Patients n (%)
Primary care nurse practitioners	12 (100%)	12 (100%)
Specialist nurse practitioners	8 (100%)	7 (88%)

Although most clinicians reported accepting new Medicare patients, some described efforts to limit the number of Medicare patients they see. For example, one specialist discussed recent limits set by their organization for Medicare patients, stating, "Ideally, no more than 10 percent of your payable volume." When asked why they limit the number of Medicare patients, another clinician explained, "It's both reimbursement and administrative costs. So, they're linked. They're not independent of each other." In one case, a primary care physician spoke about how at her previous employer she saw many Medicare patients and enjoyed that patient population, but at her current employer she is no longer seeing Medicare patients.

A few clinicians reported accepting patients enrolled in Medicare but not accepting those enrolled in Medicaid. Across groups, several clinicians reported not accepting patients enrolled in Medicaid. One specialist stated, "Medicaid is just too hard to deal with. If you talk about the coverage access to Medicare, just triple that with Medicaid." Of the few clinicians that reported accepting patients enrolled in Medicaid, most reported capping the number of Medicaid beneficiaries they would accept. One specialist affiliated with a large health system described how his organization would limit the number of Medicaid patients the organization would accept. In addition to restricting acceptance of new patients based on insurance type, the organization was narrowing the number of organizations they would accept referrals from and were favoring an "in-network style referral approach."

We asked clinicians who were not accepting new patients for their reasoning. Clinicians offered a mix of responses as to why they are not accepting new patients, including the desire to slow down in their careers and limited appointment availability. One specialist reported, "At this point, I'd like to slow down. The other thing is that I'm sort of transforming the practice into a purely consultation practice from outside. So, I won't throw anybody out, but I don't really want anybody new." One specialist explained why their practice was not accepting either new Medicare patients or patients covered by other insurance sources, stating "There's not that many neurologists, and the population is aging so there's a lot more cognitive issues as well. The patients are very complex, especially the Medicare patients, and so it just kind of comes down to there's just not enough space on the schedule."

Clinicians' Acceptance of Medicare Advantage Plans

Most clinicians (89 percent) reported accepting MA plans (Exhibit 6), but some clinicians reported that they do not accept all MA plans in their area.

Exhibit 6. Clinician acceptance of Medicare Advantage plans

Clinician Group	Accepting Medicare Advantage Plans n (%)
Primary care physicians	19 (86%)
Specialist physicians	31 (91%)
Primary care nurse practitioners	11 (55%)
Specialist nurse practitioners	7 (35%)

Most clinicians reported that they did not participate in the decisions around which MA plans they accept but that these choices were made at an organizational level. One NP explained this decision was made at the "executive level," while another NP explained, "I think the ACO has something to do with it." Similarly, a physician clarified, "Management makes that decision," when asked if they are involved in the decision about which plans to accept. Many clinicians attributed the reasoning for accepting certain MA plans to favorable reimbursement rates. One NP stated, "Reimbursement. I think that's like the only thing that they look at," going on to explain, "I think they cut the reimbursement significantly a couple years ago," when describing an MA plan their practice no longer accepts.

Clinicians practicing in smaller or independent groups described having more involvement than those in larger practices about which MA plans are accepted. One clinician stated, "We just discuss with the office manager and figure out what works for the group." The clinician further explained that the demographic makeup of the area affects their decision about which MA plans to accept: "Specifically where we're located there's mostly elderly patients in the area, so we can't really [not accept MA]." One clinician shared their perspective that MA is more beneficial for large institutions, explaining, "It favors large institutions. So, they need to be able to scale, have a big enough scale to enable those efficiencies that then allow you to take advantage of Medicare Advantage."

Two physicians in small or solo practice described MA plans that they cannot accept because the insurance company decided not to include them in-network. One specified: "[insurance company] has kicked out a lot of providers for no real reasons. They kicked out a lot of the surgery centers. They're doing weird things."

Working with Insurance and MA Plans

Several clinicians reported being aware of a patient's insurance coverage, but many stated that it did not affect their treatment approach or documentation. Several clinicians reported that they do not look at a patient's insurance unless it is needed. One specialist said, "I never really pay attention on, oh, is this patient on Medicare.… It only comes up when I want to

write for a certain drug, and it's like, oh no, I can't because I have to go through the formulary. So that's when I'm aware of it. Prior to that, I don't think about that." One NP shared that differing treatment approaches or documenting practices based on insurance coverage goes "against what we were taught." In contrast, one NP stated, "[Insurance] is one of the first things I look at when I open the chart. Just to remind myself like, what am I going to be able to get covered?"

Clinicians shared their perspectives on the advantages and disadvantages of MA and traditional Medicare for patients. Clinicians cited traditional Medicare's flexibility to choose any provider who accepts Medicare as one advantage for patients. One primary care physician stated, "They love it [MA] until they have to go into a nursing home or they need any specialist care or any extended care, like the ability to choose." An NP agreed, sharing, "I've heard patients complain and say there's no advantage to Advantage." Clinicians also cited frequent MA provider network changes as challenging for patients seeking care. One primary care physician explained, "Some Advantage plans are taking care of them [patients] and then they would drop in the middle. So, patients are left without any coverage. Either they pick a primary care [provider] or they kick them off it.… So [the patients are] very upset on that. They only have a month notice to figure those things out, and they have to find a new provider in three months."

In contrast, **a few primary care physicians cited MA's supplemental benefits and perceived lower costs as beneficial to patients**, stating, "In primary care, they get better. I'm not sure how they deal with a specialist, but in primary care they get better value with Medicare Advantage." Another primary care physician agreed, "They get some vision coverage, they get some free eyeglasses … they get like $300 credit every quarter to buy over-the-counter drugs … and medical supply; they get some dental money."

We asked clinicians about their experiences working with MA and traditional Medicare. **Several clinicians expressed their preference for traditional Medicare instead of MA, citing low reimbursement rates from MA plans.** One physician said, "In terms of reimbursements, [Medicare Advantage is] terrible." One primary care physician who also preferred working with traditional Medicare stated, "I think in the beginning we used to think of [traditional] Medicare as not paying well, but now it's probably the best paying. And probably the least hassles, actually." When discussing reimbursement rates, one specialist reported, "For a specialist, traditional Medicare is far superior [to] Advantage."

In contrast, a few clinicians said they preferred MA plans because the reimbursement rates were higher. One primary care physician explained, "I prefer to take Medicare Advantage … because they pay more money than just Medicare, especially if you're eligible. Medicare, they pay like 80 percent, and then you can charge 20 percent because Medicare is giving nothing. So, Medicare Advantage, much better." Some clinicians highlighted that MA plans encourage more coding than traditional Medicare and attributed this to financial motives. One

primary care physician stated that this practice was to "make the patient look as sick as possible." Clinicians also reported receiving incentives from MA plans for attributing more codes to a patient.

Some clinicians reported disadvantages of working with MA plans, including limited provider networks and onerous prior authorizations. For example, one primary care physician shared, "There's always issues in terms of Medicare Advantage with coverage, getting them [patients] either seen by specialists if they need to or medications that they need. It just feels like you're jumping through more, more hoops with the Medicare Advantage plans." Some clinicians reported preferring traditional Medicare because of the lack of provider network restrictions and no requirement for referrals from primary care physicians to see specialists. One primary care physician said, "One of the issues that … I see in Medicare Advantage is when [MA plans] have a network of providers and … don't have the capability to refer to other providers because they don't take their insurance.… [The network is] very limited in certain [MA plans]."

Many clinicians noted more challenges with prior authorizations and payment approval under MA compared to traditional Medicare. One specialist explained, "It's [MA prior authorizations] not easy. It's very difficult. Medicare, straight Medicare is a lot easier." Clinicians reported their prior authorizations are frequently denied with MA, resulting in clinicians needing to spend additional time submitting appeals and further delaying care for beneficiaries. One physician said, "We have cardiac imaging tests denied at times. They [patients] do their stress test, echocardiograms, and that doesn't happen with traditional Medicare, but it does happen with the Advantage plans. We have to get on the phone. We have to explain the rationale." A few clinicians reported that MA plan prior authorizations require specific documentation to prevent denials. One NP explained, "It has to be written a certain way, or they will reject it."

Several clinicians reported challenges with prior authorizations when prescribing medication for beneficiaries enrolled in MA. One clinician described the additional steps that she and her patients must take for MA documentation when prescribing certain medications, specifying that they must engage in step therapy, which creates a burden for the clinician and patient and prolongs treatment. A few clinicians said prior authorization for biologics was particularly difficult. One specialist explained how biologics have revolutionized care for irritable bowel disease but noted, "It's a shame that we have to go through this process to get them approved, because patients … that need these medicines need them now. And a lot of times it's being delayed even by two weeks, which could make the difference between keeping your colon and losing your colon." Another specialist agreed, stating:

> *Good luck getting any of these [biologics] approved.… We have more and more options, but in the years I've been in practice, it's more of a struggle to get people on things. People could be on Enbrel for three years, then January rolls around, and their insurance is, "Oh, it's not on our formulary." And then they're kind of right back where*

they started after they cycle through other medicines, which is more of a waste and a cost to the system. So, I don't know where anybody's saving any money.

Another specialist expressed frustration at having to constantly seek prior authorizations for lifetime therapies, such as medications for HIV, explaining that it felt redundant and delayed care when these medications are not meant to be taken for short periods of time. Additionally, GLP-1s were often cited as a medication requiring prior authorization. When asked if their appeals are ultimately successful, one physician said, "It depends … what kind of plan they have and what kind of drug it is. Like HMO, Medicare Advantage, the new drugs … they all get denied until you go through all the process. If plain Medicare, it's easier to get all the new drugs."

We asked clinicians how much time they spend completing prior authorizations. Clinicians' responses varied and were dependent on whether they personally complete prior authorizations or if someone else in their office is responsible for them. Accordingly, **clinicians completing prior authorizations themselves reported spending more time on prior authorizations than clinicians who had support submitting them.** One NP responded, "So much [time], because we don't have a biologics coordinator, like someone who does it [prior authorizations].… So, most of the time, I have to do it myself.… It's a lot of work." One NP working in a primary care practice reported that their practice has a dedicated prior authorization team to reduce the burden on clinicians. The NP stated, "They're offsite. but they're very busy.… They'll run through their process, but then they send it back to us for more information, which I probably do a handful of those a day."

Multiple clinicians reported that MA plan contract terminations are causing disruptions in patient care. One clinician explained what happened when a plan was terminated, stating, "We stopped accepting their insurance the middle of the year.… They have to change provider[s], or they pay out of pocket." Another clinician described the burden it creates for patients who are already dealing with health challenges: "And also just especially Medicare age patients, when you've got 20 problems and 15 medications and specialists all within one organization and now you're having to find a new organization, that's extremely difficult."

When asked whether they receive guidance from MA plans, several clinicians reported receiving both generic and case specific guidance. Clinicians stated that guidance often comes as a fax and brings attention to potential medication hazards or reminds the clinician to perform certain services such as eye and foot exams. Clinicians did not find the guidance particularly meaningful. One clinician stated, "Sometimes," when asked if the guidance was helpful.

Among clinicians who interacted with MA plan care managers, some found the care managers somewhat helpful. A few clinicians, typically PCPs, had experience with MA plan care managers. One primary care physician explained that care managers can be helpful for

Medicare beneficiaries, stating, “I think sometimes it does help us because patient has not come into my office for six months. They’re elderly. At least the nurse went to their home, and they did some of the things that is required for the betterment of health. So, I think it’s working together. I don’t think they could have done anything more than that but try to get them healthy.” Another primary care physician described their interaction with care managers: “If it’s a long-standing case or there was a surgery or something, they’ll call the patient at home on their phone to see if there’s anything they can do to help the situation. That might come in good with an appeal or something, but other than that, they’re not coordinating with us.”

Beneficiaries

We asked beneficiaries about their experience accessing primary care services, including their source of primary care, if they would be open to seeing an NP or PA as their PCP, and their experiences finding new PCPs. Additionally, we spoke with beneficiaries about their perceptions and experiences accessing timely primary care services and where they go for acute issues.

Access to Primary Care

Regular Source of Primary Care

Most beneficiaries reported having a clinician who they see for primary care. A few beneficiaries explained that while they technically do have a PCP listed on their insurance card, they have never seen them, do not have a relationship with them, or are looking for a new clinician. Similarly, some beneficiaries described having a designated PCP but stated that they do not seek primary care services often. Several beneficiaries enrolled in MA noted that their plan requires them to name a PCP during the registration process. Other beneficiaries enrolled in MA indicated that their plan assigned them a PCP; however, it is not the clinician they see for primary care. One beneficiary with MA explained, “You have to have a primary doctor on the plan I’m on.... I haven’t even met the doctor yet.… But, when I signed up, they just automatically gave me someone, and that person was not acceptable to me, and I called up and I said I want this [other] person. And they said no problem.”

Seeing NPs and PAs for Primary Care

Beneficiaries expressed mixed opinions and rationales for whether they would be willing to see an NP or PA as their PCP. Several beneficiaries reported that the practices where they receive primary care employ a variety of clinicians, and they will often see whoever is available. One dual eligible beneficiary explained, “With my primary care, I don’t actually mind if I don’t get to see [a physician] [be]cause I trust everyone there.” Some beneficiaries expressed willingness to have an NP or PA as their PCP. **A few beneficiaries shared that they have started to see an NP or PA for primary care because it has become increasingly difficult to get appointments with their physician.** One beneficiary with traditional Medicare said, “I’ve been to a nurse practitioner when my primary care doctor was unavailable. And I’m finding it harder

and harder to get appointments with my physician. So yeah, that's why I ended up going to see the nurse practitioner."

Some beneficiaries expressed a preference for seeing an NP or PA instead of a physician because of their perception that these clinicians spend more time with patients and are more thorough. One beneficiary with MA said, "I can tell you is these nurse practitioners, in my opinion, are better than any regular doctors for care. They'll listen to you, they'll talk to you, they'll explain to you about everything that's going instead of just checking a box.…" Another dual eligible beneficiary with MA explained, "I feel that they [NPs and PAs] work really hard, and I feel that they try to prove themselves a little more because I have not been happy with my current physician.… I do feel that some of, like, the practitioners or the PA really do go above and beyond. I do. And I've been very impressed." One beneficiary with traditional Medicare believed that NPs and PAs were more open to trying new treatment options than physicians, which other participants in the same group agreed with:

> *[Nurse practitioners] seemed to be really interested in pursuing options, and a lot of times the doctors would just, like, look down and see what has happened in the past and continue on that path, even if it was not necessarily working. I felt like the nurse practitioners were more up to date on new things and more willing to try new things.*

Other beneficiaries reported that they would prefer a physician to serve as their PCP because of their education and experience. One beneficiary with MA stated, "I do a lot of research on the doctors … before I make an appointment, … but honestly, I prefer an MD because of the education, the background, the experience. I mean I just think that says a lot.…Some people are fine with whoever, but I'm not." A few beneficiaries responded that their desire to see a physician as their PCP is not about their level of training or quality of care, but due to their established relationship with their current PCP. One beneficiary with traditional Medicare said, "I'm sure the nurse practitioners are great. I'm sure they do what they do. I've been with the same doctor for 15 years. I don't see a need to switch. She knows my history."

Some beneficiaries were open to seeing an NP or PA for acute issues, so they could be seen more quickly than getting in with their PCP—but prefer their physician for regular appointments and complex issues. One beneficiary with traditional Medicare explained, "Kind of run-of-the-mill things, if I feel like I'm getting the flu or whatever, she [NP or PA] can prescribe medication just as well as the doctor.… But yeah if it's something that I want to talk to the doctor about, more in depth.… [If] I want to see the doctor, I make that clear."

Several beneficiaries reported that they would be open to seeing an NP or PA for acute issues as long as the practice is transparent about the credentials of the clinician they are seeing. One dual eligible beneficiary stated, "I don't have a problem seeing a physician's assistant. What I have a problem with is if they don't disclose that." Another beneficiary with traditional Medicare said, "When I think I'm going to see the doctor … I don't want to substitute

when I get there." One dual eligible beneficiary with MA stated, "I don't mind, because I know [the physician is] going to see all the notes that they put in anyway."

A few beneficiaries reported that seeing NPs or PAs at their primary care practice when they cannot get an appointment with their physician has saved them from a trip to urgent care or the emergency department. One beneficiary with MA stated, "I couldn't get in.… And they told me that they had a PA available that day for a telephone conference and asked if I wanted to do that, which was a whole lot better than going to the ER or urgent care, and they handled it."

Finding a New Primary Care Provider

We asked beneficiaries if they had looked for a new PCP in the past few years. Several beneficiaries reported the need to find a new PCP and provided a variety of reasons for doing so, including because their previous clinician was retiring, leaving the practice, or was no longer in network. One beneficiary enrolled in MA explained, "We're all in that same age range where it used to be we'd have a physician for life, almost, until they retired. Well, guess what? They've all retired." One beneficiary with traditional Medicare shared that their former PCP transitioned to a concierge model, and the beneficiary was able to find a new PCP within the health system of their previous PCP's practice.

When looking for a new PCP, beneficiaries attempted to find a new PCP within the practice where they were already a patient, asked friends and family for recommendations, or had their current clinician make a referral. Several beneficiaries reported that transitioning to a new clinician in the same health system was less burdensome, as the new PCP was able to access their health records with their health history. One beneficiary with traditional Medicare explained how their previous physician referred them to their current PCP:

> *My doctor that retired, I kept questioning him [about whether he knew another PCP that would be a good fit] and so he gave me a recommendation, and I actually called and spoke with [the new PCP's] office and set up an appointment with him—a consultation to see if he would work out for me, and [he] did. And I've had [the new PCP] now for probably about three years."*

One beneficiary with traditional Medicare described posting in their neighborhood social media group to find a new PCP, explaining, "I asked who... they use for their primary care, and I would write down the names and if I kept seeing the name. I went with the one that had the most.… And she is fabulous."

Many beneficiaries reported that it was challenging to find a new PCP. Beneficiaries explained that clinicians were often not taking new patients or, for beneficiaries with MA, were out of network. One beneficiary with traditional Medicare said, "I had been seeing the same doctor for literally 50 years. He retired.… But it's not easy finding them now … especially

a physician to take on a new patient. It's very difficult." **Several beneficiaries expressed concerns about their clinicians' availability because of their large patient panels.** One beneficiary with MA reported being committed to their current PCP but felt reservations about the number of patients he sees, sharing, "But I asked him how many patients he had that were his patients, and I thought he'd say 250. He said 2,000. I was astonished: 2,000 people are his patients." One beneficiary with MA reported paying out of pocket to stay with their current physician who recently left their plan's network, but they said they plan to search for a new PCP.

Timely Access to Routine and Urgent Care

We asked Medicare beneficiaries about their access to primary care, including whether they were able to get timely care for routine and sick visits and urgent medical issues. **Most beneficiaries responded that they were able to access routine primary care without issue.** Some beneficiaries reported that they were able to be seen immediately or within the week, while others said they had to wait months for a routine primary care appointment. Some Medicare beneficiaries said they could sometimes be seen sooner if they were willing to see a different clinician in the practice, including NPs and PAs. Several beneficiaries reported that scheduling their next visit during the current visit or setting appointments at regular increments ensures they are able to see their PCP for routine care. One beneficiary with traditional Medicare explained, "The trick is when you leave, you make the appointment for next time. If it turns out that you don't need it two, three months ahead, cancel: somebody else gets a vacant spot."

Beneficiaries reported that they could usually get an appointment with their PCP sooner for sick visits and urgent medical issues than for routine care. One beneficiary with MA explained, "I see [my PCP] every six months. But if I get a cold or I have to see somebody right away, they put me with the nurse practitioner, and she gets me in usually the next day." Several beneficiaries reported using the patient portal to communicate with their PCP about acute issues, stating that they often get a response sooner than if they tried to make an appointment. One beneficiary with traditional Medicare responded that they prefer the patient portal to calling because when you call, "You don't always get directly to the doctor. There is a gatekeeper." A beneficiary with MA stated, "I'll do MyChart.…That's what my doctor likes to do.…If I call the office, I'm told [go to urgent care]. But if I do [MyChart], she'll say to me, 'How high is your temperature?'" Other beneficiaries reported success calling their primary care practice to obtain prescriptions for acute issues. One dual eligible beneficiary with MA explained, "If I call them and tell them what's wrong, they'll actually prescribe something. Now, you don't have to come in."

Medicare beneficiaries were using telehealth for acute primary care needs. Many beneficiaries reported that their primary care practice offers telehealth services for acute issues, though it is not guaranteed they will be able to see their regular clinician. One beneficiary with traditional Medicare said, "If it's not anything serious ... I find that [if] you leave a message and say I need to see somebody or talk to somebody, they'll respond with telehealth, which is fine

under most circumstances." Another beneficiary with traditional Medicare said, "I had telehealth from my doctor. And usually, I get him. But if I can't get him, and it's something I need somebody to see then I'll take his PA." Similarly, other beneficiaries noted that their primary care practices offer walk-in hours for acute issues. One beneficiary with MA explained that care was so readily available that they even use the walk-in hours for their annual physical.

We asked beneficiaries about their experiences seeking care for urgent medical issues. A few beneficiaries responded that they would contact their PCP for guidance before going to an urgent care center or ED. One beneficiary with MA explained, "I call first. You call first. And see what happens. If they can get me in, I'll go there. But if they can't, then I'm [going to] urgent care." Some beneficiaries reported that they go directly to urgent care for urgent medical issues because they know they would be seen sooner than if they were to contact their PCP or because an urgent care center was close to their home. One beneficiary with MA said, "Just go to urgent care. [Be]cause by the time they put you on hold or whatever, you could already be there." One beneficiary with traditional Medicare explained, "I just go to the closest one [urgent care]. It's close to my house. I've been there a million times."

Medicare beneficiaries reported mixed experiences with visiting urgent care for primary care needs. Some beneficiaries appreciated the convenience of urgent care facilities and that they had access to more medical equipment than their regular clinician's practice. One dual eligible beneficiary with MA explained, "I love that going to [urgent care].…That's because they have all the equipment the emergency room has." One beneficiary shared that they preferred going to an urgent care in the same health system as their PCP because their PCP has access to the notes from their visit. One dual eligible beneficiary with MA said,

> *I just start going to [urgent care]. I don't go to the doctor. I don't even call my doctor. I just go to [urgent care] real quick and then the next morning or late that night I get a call saying … 'I see you went to [urgent care] this afternoon.'*

A few beneficiaries had issues finding an urgent care facility that accepted their insurance. One dual eligible beneficiary with MA said, "All the ones in my area … none of them take the insurance anymore. The ones that did before, they all said no. I had to go to four different ones." Other dual eligible beneficiaries responded that they did not like using urgent care because the visits often result in a bill. One dual eligible beneficiary with traditional Medicare stated, "If I have to go to an urgent care, I would have to pay them a co-pay. So, I don't usually go to urgent care anymore because I got a bill in the mail maybe two months ago [after] going to urgent care."

Some beneficiaries reported relying on the ED for urgent medical issues when they could not get in with their PCP. One dual eligible beneficiary explained, "They [PCP] couldn't see me.… I had to go to emergency because they couldn't … do the ultrasound. And so, I had to go to the ER to do it." Other beneficiaries shared that they did not like going to the ED because they knew they would likely spend hours waiting to see a clinician. One dual eligible beneficiary with traditional Medicare said, "I've had issues, and I didn't go to urgent care. I went to the

emergency room in the hospital, and the wait there is ridiculous. So, I should have gone to urgent care."

Access to Specialty Care

In the brief survey we asked beneficiaries to fill out prior to focus groups, we asked how many specialists they were seeing. Medicare-only and dual eligible beneficiaries reported seeing an average of three specialists. The maximum number of specialists that a beneficiary reported seeing was eight. All dual eligible beneficiaries reported seeing at least one specialist. A few beneficiaries with MA or traditional Medicare reported that they saw no specialists.

Beneficiaries reported waiting weeks to many months to see a specialist as a new patient. We asked approximately how long they waited to get an appointment with a specialist as a new patient. Beneficiaries provided a range of responses ranging from a few weeks up to nine months, with an average wait time of around three months. When asked if they can get appointments to see their clinicians, one beneficiary with MA said, "It's the specialists that take a long time, two months maybe sometimes." Several beneficiaries noted that they experienced longer waiting times to see a specialist as a new patient than with a primary care physician. One dual eligible beneficiary with MA shared, "My primary care physician, he just closed down permanently.... I found another one right away. But with my endocrinologist, I cannot find one without having an appointment eight months out."

Beneficiaries reported that the wait time for an appointment as a new patient was often dependent on the specialty. For example, one beneficiary with MA explained, "It depends on the specialty.… Like orthopedics can be really difficult unless you've got a compound fracture and you're in the hospital, but some of them are very quick." One dual eligible beneficiary shared:

> *You see, pain clinic's not a problem to get a specialist. There's easy. A migraine doctor, that's when you need a neurologist, that's three months. If you're going to see a neuro spinal, that's six months to a year.… It all depends on what specialty you're looking for. Gastrointestinal … I have a regular GI doctor, but I still have to make my appointments six months to a year beforehand.*

Another dual eligible beneficiary with MA said, "Cardiologist is probably worse, but the neurologist, they're booked like three, four months out." Beneficiaries reported endocrinology, dermatology, and rheumatology as other specialties with long wait times.

Many beneficiaries reported long wait times to see a specialist even if they were experiencing an acute medical issue. A dual eligible beneficiary with MA shared that their PCP referred them to a specialist after an acute incident, and the specialist did not have appointment availability for months. The beneficiary said, "They said it would take, like, a couple of months.… A couple of months, I'm going to be dead."

We asked beneficiaries how they found specialists as a new patient. Similar to how beneficiaries searched for new PCPs, beneficiaries asked their current provider or

friends and family for referrals and recommendations to specialists. One dual eligible beneficiary with MA stated, "And sometimes with referrals, even if I don't need them, the doctor sometimes knows who would be better suited for my particular case. So, [the doctor is] like, this is who I recommend. I'm going to give you a referral that you don't need, but it's a good starting point." Beneficiaries also reported using their health system or health insurance website to search for specialists. One dual eligible beneficiary with traditional Medicare explained, "I just go onto the [health plan] website, and I just search in my area, and it's easy doing it like that instead of calling and going through the automated voice and then getting transferred, which can be very tedious and time-consuming."

Some beneficiaries' MA plans required them to get a referral from their PCP to see a specialist. Several beneficiaries shared that these referrals need to be renewed for each new appointment or annually, which can disrupt care. One dual eligible beneficiary with MA explained, "But after the referral expired, every time that I have to go … to the cardiologist, I need a referral from them. It's an ordeal now." Another beneficiary with MA shared that if the referral from their PCP is not completed properly, the beneficiary must pay out of pocket for specialty care. A dual eligible beneficiary with MA described how needing a referral from their PCP delayed their ability to see a specialist for an acute medical issue: "I had to see a neurologist. And the one thing that my doctor's office did was to get it approved for the referral. But then the communication between the offices took me almost four weeks to get in. And I mean, and I was in excruciating pain. I kept calling every day."

Some beneficiaries noted that they preferred to see specialists within the same practice or health system as their PCP. Beneficiaries cited multiple reasons for this, including because they knew their insurance would be accepted and that specialists had access to their health records. One beneficiary with traditional Medicare stated:

> *I found [health system] is like one-stop shopping.… You walk in the door, they know everything about you.… And it's made it incredibly easy to see people because they're like, it's our guy, it's our people. It's our practice, so, yeah, that's convenient … You're seeing somebody who's in their network. That makes it really easy to see [a specialist].*

Another beneficiary with traditional Medicare shared similar reasoning, stating, "I'm in the [health] system, and whether I love it or not, I want to stay there because your records are all in one place, and you hope that they [see] each other's notes." One beneficiary with MA said, "And part of the [health] system, which is really big down here … and with that system you go in the portal, and everything is there. It's not like you have to give all your documents [to] every single doctor you go to, so it makes a real big difference." Beneficiaries also reported appreciating when specialists were located in the same building or near their PCP as a result of being a part of the same practice or health system. One dual eligible beneficiary explained, "That's another reason why I wanted you stick with [health system] because my primary doctor refers me to whoever I need to be referred to. And in the general same … [geographic] area."

A few beneficiaries had care disrupted when their specialists became out of network or stopped accepting their insurance. One dual eligible beneficiary stated, "At one point, I had all my doctors at [the same hospital] … and then they called me one by one. We don't take your insurance. They all dropped me, every one of them. I have not … found new doctors as of yet,

still, it's been a good six months." One beneficiary with MA said, "I had a specialist that stopped taking insurance completely.… He was a pain doctor.… And so, he says we're no longer carrying insurance.… It's hard to find a pain specialist that takes insurance."

Beneficiaries reported that their MA plans' provider directories were often out of date or practice websites were not frequently updated, making finding an in-network specialist challenging. When asked if they use their provider directory to find specialists, one dual eligible beneficiary with MA responded, "I have, and I've also noticed some issues with that. Some of those doctors aren't in network. So, you have to double check." Another dual eligible beneficiary with MA stated, "The insurance [company is] saying that these doctors take your insurance, no. Maybe 50 percent is correct of their list."

Access Specific to Beneficiaries Enrolled in Medicare Advantage

We asked beneficiaries with MA to describe their experiences seeing providers outside of their plan's network. Many beneficiaries reported that they try to avoid seeing out-of-network providers and discussed the steps they took to avoid this. For example, one dual eligible beneficiary with MA explained that they review their plan's website to ensure a provider is in network but noted the website is not always accurate. Another dual eligible beneficiary with MA reported asking their PCP for referrals to providers in the same health system to ensure that they are in network.

Several beneficiaries with MA reported needing to decide between keeping their provider or their insurance when a provider became out of network. One beneficiary with MA chose to see a new clinician that accepts her insurance rather than switching plans to stay with her physician. The beneficiary said, "For me, it was just easier to switch to someone that other people have used in a different office."

In one location, multiple beneficiaries with MA reported that a major health system and large health insurance company were under contract negotiations, which may have required them to look for new clinicians or to switch insurance plans. There was some confusion about the status of the negotiations and the implications for beneficiaries. One dual eligible beneficiary with MA shared, "I won't be able to go without my primary I've had it for so long." Another beneficiary with MA said, "I was to get 12 treatments a year under the coverage that I had under the PPO. And I found out after about halfway through the year that he hadn't received any payment.… I just stopped going because I can't feel comfortable going into a doctor's office and know I'm not paying them."

Many beneficiaries with MA reported challenges with prior authorizations when scheduling necessary services, which delayed care. One beneficiary with MA shared, "I needed an MRI. And they made me jump through a ton of hoops and then denied it. Then we had to appeal that denial.… And so when I finally got my MRI ... my issue was almost 16 weeks out." The beneficiary reported being in pain and was required to engage in physical therapy while waiting for the MRI to be approved. A dual eligible beneficiary with MA said, "They might

eventually approve it, but you don't get the care when you need it." Another dual eligible beneficiary with MA reported that they completely forewent treatment after receiving a denial.

Many beneficiaries explained that the need for prior authorizations prevented them from obtaining prescriptions. One dual eligible beneficiary reported that their plan required step therapy, stating, "My psychiatrist wanted to put me on a specific drug, but because it's a newer one and more expensive, my insurance company wants me to try this one first and then that one." Another dual eligible beneficiary with MA reported having to pay for a prescription out of pocket after a denial, despite the medication previously having been approved.

Several beneficiaries expressed appreciation for their providers and practices for appealing denials and ensuring they eventually received care. One dual eligible beneficiary shared, "My doctors have all been really good about if I get a letter from the insurance company saying they're not going to cover this prescription anymore. My doctors have always been really good about writing a letter and getting it taken care of."

Organization of Care

We asked clinicians about aspects of the organization and processes of their practices, including referrals, roles of NPs and PAs, practice acquisition, quality reporting, and ACOs. Nurse practitioners were also asked about their experiences working with other clinicians.

Physicians: Working with NPs and PAs

In our pre-group survey, we asked physicians whether they worked with NPs and PAs in their practice. Thirty-five physicians (63 percent) worked with nurse practitioners, and 18 physicians (32 percent) worked with PAs.

Physicians described a wide range of models for working with advanced practice providers (APPs), ranging from highly autonomous practice arrangements to closely supervised, team-based relationships. Across specialties, APPs were commonly used to expand access to care, manage follow-up visits, and help physicians focus on more complex patients. Many physicians reported that experienced NPs maintained their own patient panels and managed routine care independently, consulting physicians when questions or unusual clinical situations arose. One family medicine physician described this model, explaining, "My nurse practitioner has a whole panel of patients, and some of them I haven't personally seen in years. I have my patients. She's just working hand in hand with me." Similarly, an endocrinologist noted, "They function autonomously. So they're specialized in diabetes specifically, but they basically run their own practices." While physicians described varying levels of oversight, many emphasized that collaboration remained important, with NPs seeking guidance when needed.

Many physicians described deploying APPs to manage stable patients, routine follow-up visits, and urgent appointments, allowing physicians to focus on more complex conditions and new patient evaluations. In several specialty practices, physicians preferred to see new patients themselves while relying on APPs for established patients. A dermatologist explained, “I would prefer her not to see new patients. I would prefer her to see a routine follow-up that’s been established and the person needs follow-up, but I’ll want to see the new patient and she’ll follow up with whatever plan I have in place."

Several physicians described how APPs help triage patient demand and absorb routine chronic disease follow-up. One specialist explained that in his practice, physicians see all new patients, and after this initial visit, an APP could manage follow-up visits. An endocrinologist explained that NPs were brought into the practice to help manage diabetes care because “we were getting overwhelmed with diabetes,” allowing physicians to focus on less common or more complicated endocrine concerns. Similarly, a pulmonary critical care physician noted that NPs manage the majority of routine sleep medicine cases: “The nurse practitioner group will handle the majority of the routine cases, which is probably like 70 percent. So without that, I don’t think we can manage.”

Many physicians described APPs as valuable members of the care team who improve efficiency, increase capacity, and reduce physician workload. Physicians reported that trusted APPs could manage routine patient care, support care coordination, and provide coverage when physicians were unavailable. One primary care physician explained that employing NPs allowed physicians to devote more time to medically complex patients: “It’s giving me more time to spend with my existing patients.... We’re transitioning those urgent care issues to the mid-level providers, which opens us a little bit more time to see chronically ill patients that require more time.”

A cardiologist noted that APPs improve the quality of physician-patient interactions by taking on administrative responsibilities, stating “[AAPs allow for] more quality time [with the patients I see] because a lot of the grunt work is being taken off the books. It’s more time to actually sit down and talk and interact rather than typing up notes.” Physicians also discussed the role APPs play in reducing burnout and maintaining continuity of care. A rheumatologist explained, “When you have a nurse practitioner or a PA that you trust, when you go on vacation, you don’t feel like you always have to constantly check your inboxes because someone else can look it over for you.”

Physicians described the investment in time needed to properly onboard APPs to their practice. This is particularly true for recent graduates who may not have the specialty-specific training needed to operate independently. In some cases, these APPs spend anywhere from four weeks to six months in training before being able to see a patient independently. One endocrinologist described an extensive onboarding process, explaining, “We don’t let them touch a patient for six months. So shadowing, training, a six-month ramp up after that.” Some

physicians similarly described a prolonged training period where the APP worked alongside physicians and gradually assumed greater responsibility for patient care. Physicians frequently stressed the importance of self-awareness and knowing when to seek consultation.

Physicians in all locations spoke about the value of finding experienced APPs and how increased levels of experience, mentorship, and specialty-specific training enabled APPs to practice independently. Many physicians reported providing formal onboarding, shadowing, and ongoing mentorship to help APPs develop specialty expertise and clinical judgment. Several participants emphasized that the effectiveness of APPs depends heavily on experience and their willingness to seek guidance when needed. Physicians generally expressed confidence in experienced APPs who practiced within their expertise and sought physician input for challenging cases.

Although many physicians valued APPs, some expressed concerns about variability in training, preparedness, and clinical decision-making. Physicians noted that newly graduated APPs often require significant mentoring and supervision before practicing independently. A primary care physician argued that APPs primary care “training is severely lacking**"** and described having to **"**clean up after**"** less experienced APPs. A few physicians described differences in referral patterns and clinical management. A cardiologist observed, “I see the difference in the quality of referral. A lot of the docs will take care of it themselves,” while a neurologist noted that physician referrals tended to be more thorough than referrals originating from NPs. Other participants expressed concern that less experienced NPs may rely too heavily on referrals or have difficulty managing atypical presentations.

Nurse Practitioners: Working with Physicians

Some NPs noted primarily working independent of a physician while leading a clinical team. In these cases, the NPs were frequently in touch with their physician colleagues. Most NPs described their collaborative arrangements with physicians as having their own patient panels while seeking consultations with collaborating physicians on unusual cases. One NP explained:

> *For the most part, I work by myself. That’s me, my two medical assistants and the front desk. But in other offices in our company, there will be maybe four or five providers. It all depends on which building you’re in. And then I hadn’t seen my collaborative physician in the flesh since before COVID. So, I mostly work by myself. But sometimes another provider will come in and train someone new. We have a pretty good working relationship.*

Several NPs reported maintaining their own patient panels and managing patients, similar to their physician colleagues, while consulting with physicians on an as-needed basis. In these settings, NPs described relationships characterized by mutual respect, shared responsibilities, and clinical autonomy. One NP noted, **“**I have my own patients, but that doesn’t

mean that no one else will ever see my patients. If I'm out, if something urgent comes up and the patient calls and I'm not in the office that day**."** Another NP shared:

> *So we have our own independent practice, our own patient panel. They're available if we need to collaborate. Oftentimes we're on site by ourselves, but we can secure chat if we need consult. And then the other part of the time in the hospital inpatient consulting we are running the entire service. The APP or the physician on call is available and in-house scoping. So again, if we have something urgent that needs attention, we can certainly go and grab them or ask for some input or some assistance, but that's how we work.*

While another NP shared, "So we have our own panels, we're completely independently, shoulder-to-shoulder in the hallways with people. And we take the same call shifts and leadership. I'm assistant medical director and so I usually manage all of the APPs but can also be doing management of some of the physicians as well."

Most NP participants felt that physician collaboration serves as a resource for managing complex cases rather than a mechanism for routine oversight. One NP in a small primary care practice explained how she works with the physician in her practice: "I have my list of patients. I'll chip in with her if she needs help. And then if I don't have a full day of patients, I do the office work. So the authorizations, phone calls, prescription ordering, and she does the televisits. So we split it.". The effectiveness of these relationships often depended on physician trust, communication, and organizational culture. Participants frequently noted that they turn to physician colleagues when faced with particularly challenging diagnoses, uncommon presentations, or highly specialized clinical questions. One NP explained how they work with their collaborating physician, "If I have more difficult cases, I'll text them or call and I'll show pictures, that kind of thing." Many NPs described working "shoulder-to-shoulder" with physicians, sharing patient care responsibilities, leadership roles, call schedules, and clinical decision-making.

NPs reported variation in how physicians approach collaboration. Some physicians were described as highly hands-off and trusting of NP judgment, while others preferred close oversight, frequent communication, and review of clinical decisions. In some practices, physicians evaluate new patients and establish treatment plans while NPs provide ongoing management and follow-up care. Other models involve shared visits, joint decision-making, or consultation-based support.

Communication and accessibility are critical to successful collaboration. NPs valued physician partners who were readily available for consultation, responsive to questions, and supportive of shared decision-making. Regular communication helped ensure continuity of care and prevented issues from "falling through the cracks." One NP explained how they communicate with their physician colleague,

> *I work with one physician and so he's really laidback, and so I pretty much do my own thing. We send each other emails every day like, 'Hey, here's who I saw, here's what's*

going on' because we're both seeing the same patients a lot of times—yeah, so it's very laid back, and I never feel bad about asking some dumb question. He's always very kind about it if something comes up.

NPs described generally high levels of clinical autonomy, especially as they gained clinical experience. However, participants noted that autonomy can be shaped by specialty, organizational policies, physician relationships, and the complexity of patients' conditions. Many emphasized knowing when to manage patients independently and when to seek consultation or refer to specialists is an important skill.

Several NPs described relying on physician consultation early in their careers but becoming increasingly independent over time. Participants reported that after several years of practice, they felt comfortable managing most routine and moderately complex cases without physician input. One NP shared, "I'd say at the four- or five-year mark, I didn't really need to ask so many questions at all. And if it's really bad, refer to rheumatology, refer to [health system], something like that." Rather than viewing referrals or physician consultation as a limitation, participants described them as an important part of safe, collaborative practice.

Clinical complexity influences the degree of independent patient management. Many NPs felt confident managing complex patients independently and engaging specialists when cases exceeded their expertise or required highly specialized care. Participants reported managing many complex conditions themselves but noted that particularly challenging cases may require escalation to subspecialists. In some settings, specialist physicians serve primarily as consultants, while in others they assume responsibility for patient care.

NPs discussed limits on the goods and services they can order and prescribe for patients enrolled in Medicare. One NP in cardiology explained, "APPs can't order a cardiac rehab. It has to be a physician, which is wild because patients with certain procedures and certain diagnoses are required to have cardiac rehab, and we are just not allowed to do it." Multiple NPs corroborated that Medicare requires an MD to prescribe diabetic supplies, including non-pharmaceutical items, like therapeutic footwear.

Organizational administrative policies can limit APP autonomy even when clinical scope of practice authority exists. One acute care NP described a recently implemented organizational policy requiring physician co-signatures for discharge medications, including routine prescriptions. Participants questioned the rationale for such requirements, particularly when NPs were authorized to manage the same medications during hospitalization without physician approval. A few participants expressed interest in expanding their responsibilities to include maintaining their own patient panels, viewing an independent panel as a pathway to greater professional independence.

Staffing and Hiring

Physicians reported challenges with hiring front office staff and medical assistants due to lower salaries and increased exposure to patient complaints. For the most part, physicians felt they were able to find the candidates they needed at the APP level. A number of physicians spoke about hosting internships for NPs and PAs and how they use those interns as a valuable pipeline for potential candidates who could eventually be hired at their practices. One physician described the challenge of hiring the first APP for his practice because his practice was not sure what functions the APP would take on for the team and how they would work together.

NPs spoke about switching practices for improved work-life balance, increased autonomy, and better alignment with their personal interests. Several NPs spoke about leaving hospitals or acute care settings to improve their quality of life. Other NPs sought opportunities where they would have great autonomy over their patient panels or schedules. One NP shared:

> *I worked in a cardiac ICU …. for many years, so I've always had just a love for cardiology and I wanted to get to a point I wanted to manage the care rather than provide, rather than deliver the care, and so that's why I chose to go back for a nurse practitioner, so I could start managing the care*.

Practice Management and Acquisition

Across all locations, there was limited discussion on practice management and decision-making. One primary care physician described how some of their peers joined hospital-owned practices and then returned to private practice after a year because they preferred to practice on their own terms. As an alternative to the hospital-owned model, this physician embraced being in private practice and hiring a management company to provide administrative support:

> *The private practice that I am in, I manage—actually, there's a management company there I'm a part of now, which is great. There's a management fee I pay, and I own it. I just pay them the management fee, 5 percent billing and a little above it. It works really well because what I'm getting is the hospital base in my practice, which benefits tremendously. I think that works very well because any time I decide to leave it, I can leave that management company and retain everything back. I think that's working and why I felt that it was a better decision. It worked out very good for me, actually.*

Concierge Medicine

Physicians in all locations described limited concierge medicine in their communities.[12] Despite this overall perception, several concierge physicians participated in the focus group

[12] Concierge practices charge patients a monthly or annual membership fee and may continue to accept insurance plans and government programs. Concierge practices cater to higher income populations. Direct primary care is a model that charges patients a monthly membership fee for most or all primary care services. Direct primary care practices do not accept insurance or participate

discussions. One physician in a concierge practice discussed why they chose to join a concierge practice:

> *A little bit of seeing what the potential future of medicine would be. I didn't want to be so bottled down by the time constraints with patients that I wasn't getting at that prior facility. I have this discussion all the time. I was with my boss, and I was there for a year and he's like, "OK, you're seeing three to four patients an hour. How do we get you to four to five?" You don't. Like, I'm not going to—it's just not going to provide good care to patients. So that was one thing. It allowed me time and space and effort to—since I've made the jump [to concierge medicine], it really—I see that I'm providing better care for the patients. Yes, it might not be as many per day, but in my aspect, it just allowed me to feel more comfortable with my treatment.*

In Florida, a couple of physicians discussed colleagues and friends who left traditional practices for concierge practices. Another physician in Florida discussed how a fellow physician opened a concierge practice where he sees only 8–10 patients a day since his patients pay an upfront $5,000 to join the practice as well as annual membership fees. This physician felt that knowing a lot of people in the area was essential to establishing a concierge practice because not everyone will have enough patients willing to pay the upfront membership fee.

Identifying a patient population willing to pay an annual fee was described as a potential barrier by a few physicians who considered moving to a concierge model. Physicians in New Jersey and Florida discussed an interest in moving to a concierge model, but they did not believe their patient populations would support their practice moving to the concierge model. Some physicians mentioned colleagues who tried the concierge medicine model. They discussed having the right socioeconomic mix in their patient population to support the transition to concierge. Some participants shared how physicians in their communities may experiment with a concierge model to see if it is sustainable. Specialists across all three locations explained that the concierge model is not as well suited to specialty practice.

Some physicians spoke of challenges patients in their communities face accessing primary care because PCPs in their community have transformed their traditional primary care practices into concierge practices. Some physicians described the difficulties their patients faced when practices became concierge, had much smaller patient panels, and required a membership fee unaffordable to many Medicare beneficiaries. One physician shared, "Yeah, there have been quite a few primary care [practices] that have shifted to concierge, so patients are, like, then abandoned, right? Like, where do they go? It's a big—that's a loss."

Physicians spoke about what might drive their patients to concierge medicine practices. One specialist noted:

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in government programs. Source: American Academy of Family Physicians. Direct Primary Care. Available at: https://www.aafp.org/family-physician/practice-and-career/delivery-payment-models/direct-primary-care.html

> *I do have patients who see concierge doctors for primary care and also because they know that they'll be seeing a doctor and probably their doctor, because they think a lot of primary care practices are now using PAs and NPs, and you'll be lucky if you see your doctor once in two years. So, that's some of the feedback I've been getting back from patients: that either, "I need a new primary care doctor because mine's retired" or "I'm just seeing the NP or the PA, and I want to see a doctor." I think maybe that's ... why somebody would pick a concierge practice.*

A specialist discussed receiving referral requests from concierge physicians asking to see their patients on the same day, an expectation that this physician does not feel when receiving referrals from physicians in traditional practices. Some physicians felt that when patients pay for concierge medicine, they expect total access that includes being seen right away and seeing specialists that they would not be able to access through traditional avenues.

In Washington, there were several primary care physicians who participated in the focus group discussions who were in nontraditional practice arrangements other than concierge medicine. One physician's practice was contracted to care only for employees at one business. Another described a variation on the direct primary care model; a third physician expressed her desire to go to an all-cash model.

Most beneficiaries across all locations were familiar with concierge medicine. Some were familiar because their family members were patients of concierge practices, while others knew about it because their primary care practice had moved to the concierge model. One beneficiary spoke about her decision to leave her primary care physician when the practice moved to a concierge model:

> *You don't typically have to see a doctor about maybe once or twice. The math doesn't math. So I chose not to, but not because I didn't love her, I did. And I was even willing to come from where I lived to—she was up here close to [location]. So I was like, I'll go because I just loved her. But at that point I made the decision not to.*

Another beneficiary in Florida described a similar experience of her primary care practice switching to concierge and what factored into her decision to leave the practice.

> *My husband, his mom, and myself were patients of a doctor in [location]. We really liked him because he was young enough, not too young, but he was, you know, he was marvelous. Yeah, he was just—he wanted to get to the bottom of everything. And the next year we get a letter from them saying, you know, we're moving to concierge, so that was the end of that because we weren't willing to shovel out two memberships.*

In Florida, a couple of Medicare beneficiaries discussed how their primary care practice attempted to move to a concierge model, but in the end did not switch because there was not sufficient interest from patients to sustain the concierge model.

Software as a Service (Artificial Intelligence)

Across all locations, many clinicians were using AI in a variety of ways, including using AI agents or tools for scribing, to answer phone calls, draft messages to patients, and for clinical purposes such as guidance or education. AI use among focus group participants appeared to have increased in 2026 compared to prior years. In some cases, physicians spoke about their offices moving to AI agents answering patient calls or AI tools drafting portal messages to patients based on lab results that had been uploaded to the EMR. One physician whose office implemented an AI agent for answering patient calls shared her unique frustration with the AI agent having the same name as her, which led to confusion.

> *We have this AI robot that answers the phone that everybody complains about. And its name is the same as mine, which is so frustrating because people get confused. They're like, "Did you schedule this?" I'm like, "No, that's the AI robot. Do I sound like the AI robot?"*

Physicians in all locations described AI scribing as a useful development. Many physicians were impressed with the accuracy of AI scribe services in capturing patient interactions. One physician described how the AI scribing service enables her to be more engaged during the patient visit. She was happy to be able to face the patient and not be distracted by the EMR.

Some physicians spoke positively about the AI-generated emails their EMRs were drafting to patients based on patient lab results or using AI to respond to patient portal messages. Other physicians mentioned how AI has helped them draft effective prior authorization letters to insurance companies**.**

> *The one thing I use AI for is I use it for my PA letters for getting expensive drugs covered, and I can do it very succinctly and put in the age of the patient, what they've tried, why the drug that is—I'm having to go through steps. Isn't this ridiculous? And I will ask them to cite the literature, and I can write—I can ask it to write a very stern letter, and this will be the last letter that I write exclusively to the insurance company. 100 percent approval for the drugs. And you know when they say you have to use this biologic, and it's in the same category, it's a TNF inhibitor and they've already failed that, and I want to get an IL-17? Just sort of AI will generate a letter that is, like, fantastic that if I had to do that, it would take me an hour to cite the specific literature for this particular patient for this particular problem.*

Physicians spoke of how the AI-drafted letters included greater details of the patient history and clinical references than they would normally include in their letters. These more detailed letters were viewed by physicians as helpful. Another physician explained how an AI generated letter to a patient included more details and clinical history than they would have normally included in a patient letter:

> *Today was the first time that I got my results with the proposed letter. And AI already went to the chart and checked their previous LDL. And it's like, "You did a great*

> *improvement in your LDL, continue with your lifestyle." And it's like, I would have never gone back. I just write very succinct things and make an appointment to discuss, because I don't have time to go to the chart. But AI went to the chart and gathered everything.*

Physicians had mixed feelings about what AI tools include in medical notes. Some physicians valued the AI agent's ability to only pull the clinically relevant elements of the visit into the medical note, while other physicians described how the AI scribe did not include in its documentation the social and occupational information from patient conversations and the physicians were frustrated by these omissions in the clinical note:

> *But, for instance, you said something social and occupational. For pulmonary, occupational is very important. It will knock off the occupational no matter what. I ask the patient every single time. It's never in there. And I have to. Because chemicals, what have you. For us, it's an important piece. So these are the minor nuances. I feel like it's not trained to do so. Where they eliminate all the unimportant information that we're chatting with the patient. They decide what's important. AI decides what's important.*

One said, "It does speed up the whole interaction. But you're right. You have to look at the diagnosis code they give you. And the other aspects of it. […] But I think it does make it more efficient." Another explained:

> *I'm a believer. I think it has just sort of completely changed delivery of care for me. I was just commenting to a friend that you go through the same number of patients, but my notes would be terrible. Now they're not terrible. Or you have to slow down to have a more complete documentation.*

Although many clinicians found AI scribing tools helpful, several physicians described why they do not use an AI scribing tool. One physician described his patient population as having dementia and was not comfortable asking them for permission to use AI, so he instead used voice-to-text software. A couple of physicians felt that they had refined their approach to drafting patient notes and that the AI notes required more review and revisions, and it was more efficient to draft their own notes.

Some physicians were using AI for clinical guidance, synthesizing medical evidence, and clinical education. They appreciated the way the resources can be quickly summarized by AI but emphasized their critical evaluation of the summarized text is essential:

> *I actually use it more for personal education. Let's say I'm trying to decide on a course of treatment. And I want just a very quick summary of the evidence for one versus the other. It would have taken me an hour to go through PubMed reading papers. Now I'll be very easily summarized. It's not through my hospital system.… And I think I make better decisions. And just as importantly, I know why I'm making decisions because I'm being presented with the pros and cons.*

Only one physician described using AI in patient procedures. He appreciated the AI tool's ability to identify polyps that he would not see, but he also shared that it creates false positives. For him, it was a fair balance to catch items he could have missed, despite spending more time on false positives:

> *During colonoscopy, obviously we're looking for polyps. So it puts a box around a polyp that may not be picked up by the physician. So it's not supposed to, you're not supposed to fully rely on it, but it may help pick up subtle polyps that some or most physicians may miss, increases quality, increases adenoma detection rate.*

Accountable Care Organizations

ACOs are groups of doctors, hospitals, and other clinicians who provide coordinated care to their Medicare patients. There are several Medicare ACO programs, including the Medicare Shared Savings Program.[13] In each clinician group, we asked if clinicians were familiar with ACOs, and if they were participating in an ACO. To those with ACO experiences, we asked if they were involved in the decision to join, how the ACO affected their practice processes, financial rewards, and leaving an ACO (if applicable).

In New Jersey and Washington, three physicians in each state participated in ACOs; in Florida, eight physicians participated in ACOs. Physicians were mixed in their knowledge of ACOs. Some knew their practice participated in an ACO but admitted they did not really know what ACO participation meant to their practice. In other cases, physicians in Florida in small practices had been involved in their practice's decision to participate in the ACO and were very aware of the measures and benchmarks the ACO set for their practice and how their performance would impact the practice financially.

In Florida, one physician discussed how his practice decided to join an ACO and how they received financial rewards in the first year, but after the first year they just broke even and ultimately left the ACO after looking ahead and projecting they would lose money. Shortly after leaving the ACO, they were approached by another ACO and decided to join that one because they felt they had learned from their initial ACO experience and thought some of the EMR features offered by the new ACO were worthwhile.

Physicians participating in ACOs explained how the ACOs supported increased care coordination, improved tracking of quality data, and offered financial incentives for their practices that made participation appealing. A physician in Washington shared how the ACO kept an eye on measures like eye exams and physicals which the physician found helpful. One physician helped create an ACO as the next step to systematically incorporate quality improvement into their organization. They noted, "It was a huge upside to, you know, our organization, and it was something that like we've always been doing quality improvement and

[13] For more information, see: Centers for Medicare & Medicaid Services. Shared Savings Program. Available at: https://www.cms.gov/medicare/payment/fee-for-service-providers/shared-savings-program-ssp-acos

projects, so we just continued on and, you know, presented it to first to an insurer, and it just kind of progressed from there." Another physician in Washington saw benefits for their practice participating in an ACO:

> *If they're [patients] assigned to me, they automatically go into the ACO, and which is kind of—it's easy to bill, they pay better, and they give us money, like, at the end of the year. They give us money for, like, office remodeling or for patient care, for this, for that, and I would say it's better. And they keep an eye on our Medicare benchmarks. They keep an eye on meaningful use and some other things. And they keep an eye on what—so many physicals, so many eye exams, so many—so the percentage of performance. So they keep an eye on that, and it's pretty nice.*

A couple of physicians discussed how their practice used some of the resources provided by the ACOs to hire care managers and extra help to the practice. One physician explained how the ACO suggested the practice could continue to grow their quality improvement efforts with the support of the ACO and that in the beginning they received financial benefits, but they are no longer receiving any financial benefits: "The money's pretty much dried up." Many physicians participating in ACOs had experienced financial gains, while some had experienced losses.

When asked about whether participating in an ACO changed how they practice, two physicians in Washington shared how their ACO encouraged them to refer to specific practices in their systems and how challenging it became to make referrals outside of the system.

Quality Reporting

We asked physicians and NPs about their experiences with and opinions about quality reporting.

Overall, clinicians expressed an appreciation for collecting and measuring quality data but felt like the measures did not always align with their delivery of quality care or their specialty. Many clinicians described receiving regular quality reporting from their practice, health system, or insurers on different quality measures—either in their EMRs, regular quality reporting updates, or through practice meetings. There was a general understanding among the physicians we spoke with that physician accountability is important and quality measure are one piece of that accountability. One primary care physician shared:

> *They report out on it [quality scores] monthly and, like, your quality scores compared to all the other providers that practice are available for everyone. Actually organization-wide, you can see what everybody's quality score is if you really wanted to take the time to do it, and you're evaluated on 20 different metrics, and then they choose one a month that's going to be the important one. And so you have competitions going to see who can do, like, the most—get most blood pressures in range, do the most A1Cs, have the most Medicare physicals scheduled for the next year. It's constant. And then now it's new in a part of our compensation package that in July, they will determine if your quality*

> *scores were above the 95th percentile or something, and you qualify to get $1,000 or something.*

Not all physicians received updates on their quality scores. In some cases, they knew there was quality reporting happening at their organization, but they were not aware of their quality scores or how they compared to their peers.

Some clinicians said they were reporting quality metrics because they were told to do so and some described the reporting as ticking boxes. For some physicians, they felt quality reporting was not meaningful, and it amounted to "ticking boxes." One gastroenterologist described how if their patients have high blood pressure or depression, they received less reimbursement even though those are conditions he considers outside of his scope of practice. In some cases, his patients have normal blood pressure readings throughout the year only to have one out of range reading at the end of the year that throws off his quality score. One physician described how their quality measures "are typically based on things that I can't control. Like, I can do my own foot exam, but I can't, like, get them to an eye doctor. Like, we just don't have that even within our health system that you can get in to someone closer than September. So, like, I don't like that I'm dinged on that."

Some clinicians received bonus payments for meeting quality metrics. One physician felt like these payments were "payment for paperwork, not pay for quality." Another physician was happy to receive quality payments from an insurance company and hospital system for achieving certain quality benchmarks. One physician described his institution's efforts to capitalize on quality payments:

> *Well, in terms of behavior at our institution, I know the tail wags the dog, and so they're chasing after nickeled and dimed, and we are doing metrics that are even germane to my specialty, and I mean there could be glass on the floor and they'd be more concerned about, are you checking the boxes on the intake.*

There was discussion among physicians about being held responsible for quality measures, such as preventive measures, that did not align with their specialty. Some physicians discussed how their practices surveyed patients on their visit experience. One physician spoke about her quality scores being impacted by changes to the parking garage, front desk, or traffic; she expressed frustration as these issues are outside of her control. Some physicians also raised struggles with the moving target of measures. Physicians noted one month their practice was focused on blood pressure and the next month something else, which made it hard to prioritize what measures mattered most for their patients.

E&M Visit Complexity Add-on Code

Most primary care and specialty physicians across all locations were familiar with the G2211 E&M visit complexity add-on code and reported using it regularly, particularly for the ongoing management of patients with chronic conditions. The G2211 code is an add-

on billing code that can be used with an office visit when a physician or other clinician is providing ongoing care for a patient over time, particularly for chronic, serious, or complex health conditions. The code is intended to recognize the additional work involved in managing a patient's long-term care needs, coordinating treatment, and serving as a continuing source of care. While physicians viewed G2211 as especially relevant to primary care, specialists in cardiology, endocrinology, rheumatology, gastroenterology, neurology, and allergy/immunology also reported using the code. Physicians explained that G2211 is most appropriate for patients receiving ongoing, relationship-based care and for visits involving complex, long-term conditions. As one physician noted, the code is used for patients requiring "high-complexity long-term care," while another explained that "it's based on what the diagnoses are.... Something that you're seeing a patient longitudinally for."

Some physicians reported that using G2211 provided additional reimbursement and helped recognize the complexity of managing patients over time. However, experiences with reimbursement varied. One physician described why he stopped using the G2211 codes: "Many times when you use those, you find yourself audited.…They won't pay that so better off not getting involved with that can of worms." Several physicians, particularly in primary care, reported using the code but not consistently receiving the additional payment. Physicians learned about G2211 through a variety of sources, including practice administrators, billing specialists, and EMR systems where the code was automatically suggested or added. **Despite its widespread use, several participants indicated that guidance on when the code should be applied was not always clear, leading to uncertainty and inconsistent use across practices.**

Prescription Drugs

We asked beneficiaries to rate their prescription drug coverage and spoke to them about the rationale behind their ratings, drug costs, pharmacy use, and ability to fill prescriptions. We also talked to clinicians about their experience in prescribing, including prescribing GLP-1s,[14] the Medicare Drug Price Negotiation Program, and the cost of drugs for their patients.

Clinicians

Cost of Medications

We asked clinicians if they noticed a change in beneficiaries' out-of-pocket costs with the implementation of the Part D Redesign, which has a $615 deductible and capped out-of-pocket

[14] Glucagon-like peptide-1 (GLP-1) agonists are a class of medications that mainly help manage blood sugar (glucose) levels in people with Type 2 diabetes. Some GLP-1 agonists can also help treat obesity. Source: Cleveland Clinic. GLP-1 Agonists. Available at: https://my.clevelandclinic.org/health/treatments/13901-glp-1-agonists

costs at $2,100,[15] and the Medicare Prescription Payment Plan, which gives beneficiaries the option to enroll in a payment plan that spreads costs over the year.[16]

While several clinicians reported that the cost-sharing cap was helping increase access to expensive medications, many reported limitations. Most clinicians were at least somewhat aware of the cost-sharing cap, and those who regularly prescribe expensive drugs reported firsthand experiences and anecdotes. One rheumatologist shared that the $2,100 cap on out-of-pocket costs has opened options to more expensive medications that were not previously feasible for some patients, explaining, "With biosimilars and things that weren't even remotely possible to prescribe, at least I can have them on a potential option at $2,000 out. I used to have to do infusions for everybody, but now I can talk about injectables." A primary care NP described fewer patients skipping doses of medications due to the cost-sharing cap.

At the same time, an internal medicine physician initially described the amount patients needed to spend out-of-pocket as "something that has gotten better," but later in the conversation noted that "the majority of them do not reach that amount" and that they "only know of one or two [patients] that would benefit from [the 12-month payment plan], only because of the drugs that they're on." Many other clinicians shared similar sentiments about how the $615 deductible was still too high for most patients. For example, one general practice NP noted, "They'll never hit the deductible unless they're on really big-time meds," and another rheumatologist described, "In general, for older patients who are maybe limited resources, if they're going to have to pay a certain amount per month, they're just going to say, I'm not going to pursue this." A couple of clinicians noted that they hear fewer concerns about costs after the summer, when more patients have hit their deductible and are paying less for each prescription.

A couple of clinicians reported concerns that patients were not aware of the Medicare Prescription Payment Plan option. One primary care physician described, "They don't realize they can spread it out over the year because, you know, the Medicare didn't tell them that you could do that. They all think they have to pay all of the money for it."

Several clinicians reported prescribing generics or cheaper medications, or tailoring medications to their patients' insurance coverage, to make prescriptions more affordable for patients. When asked if they have changed how they talk to Medicare patients about drug costs after the implementation of the Part D redesign, one internal medicine physician explained that their prescribing decisions continue to be dictated by plan formularies, explaining, "I think for our Advantage patients who are on a limited budget for Medicare, we've started treating

[15] The CY 2026 annual out-of-pocket threshold of $2,100, which is the original 2025 out-of-pocket cap of $2,000, adjusted based on the annual percentage increase in average expenditures for covered Part D drugs in the U.S. for Part D eligible individuals in the previous year (API). April 2025. Available at: https://www.cms.gov/newsroom/fact-sheets/final-cy-2026-part-d-redesign-program-instructions

[16] Beginning in CY 2025, the statute requires Part D sponsors to provide all Part D enrollees the option to pay their out-of-pocket prescription drug costs in monthly amounts over the course of the plan year, instead of paying out-of-pocket costs at the point-of-sale. February 2024. Available at: https://www.cms.gov/files/document/medicare-prescription-payment-plan-final-part-one-guidance.pdf

them that way—that this [coverage of these certain drugs] is all you have, so … these are the medicines I'm going to use.… And I would say, no, we haven't changed that. Even though the limit has gone up."

Many clinicians noted that costs vary widely at different pharmacies and that patients shop around for deals. One NP shared their experience, saying, "One month, I'm supposed to send this drug to this pharmacy, but then the next month they come in and tell me to send it to this pharmacy because now they have another deal."

A few clinicians also reported patients ordering drugs internationally, especially from Canada, to get lower prices. One clinician in Seattle explained, "We have a full-time social worker who helps set people up for Canada because otherwise they can't get it."

Many clinicians reported that their patients use programs that reduce out-of-pocket drug costs and that they help patients access these programs when they can. One clinician in New Jersey highlighted the state prescription program for low-income older adults and individuals with disabilities,[17] noting, "A good amount of medicines are capped at $5, but some are a little bit more, but it's a very good program. It has helped a lot of my patients."

A couple of clinicians mentioned foundations or grants that could assist with prescription drug payment. One NP described that "January 1 was a rush to see who we could get people—like grants and foundation coverage to cover January 1's bill of that med so that they would be covered for the rest of the year.… We're always trying to find ways, but we need to get a little creative with hitting that $2,000 and then after that we're good because then everything's covered." A couple of NPs who worked in outpatient settings mentioned that their clinics use the 340B program[18] to get discounts on very expensive medications for all patients, including Medicare beneficiaries.

A few clinicians expressed frustration that Medicare beneficiaries are not eligible for other payment options, such as copay cards, coupons, and manufacturer patient assistance programs.[19] One NP noted, "One thing that's unfortunate is that when there is a medication that

[17] The Pharmaceutical Assistance to the Aged and Disabled (PAAD) program is a state-funded program that helps eligible older adults and individuals with disabilities save money on their prescription drug costs. The federal Medicare Plan and/or PAAD will pay any costs above the PAAD copayment of $5 for each covered generic drug or $7 for each covered brand name drug, including premiums. However, if a Medicare Part D plan does not pay for a medication because the drug is not on its formulary, PAAD beneficiaries will have to switch to a drug on their Part D plan's formulary, or their doctor will have to request an exception due to medical necessity directly to their Part D plan. Available at: https://nj.gov/humanservices/doas/services/l-p/paad/

[18] In the 340B Program, manufacturers participating in Medicaid agree to provide outpatient drugs to covered entities at significantly reduced prices. To participate in the 340B Program, eligible organizations/covered entities must register and be enrolled with the 340B program and comply with all 340B Program requirements. May 2026. Available at: https://www.hrsa.gov/opa

[19] Federal statutes, including an anti-kickback law, limit the use of coupons and manufacturer donations in conjunction with federal health care programs, including the Medicare Part D prescription drug benefit. Source: Congressional Research Service. June 2017. Prescription Drug Discount Coupons and Patient Assistance Programs (PAPs).Available at: https://crsreports.congress.gov/product/pdf/R/R44264/5.

has like a copay card, but it's only able to be used by commercial insurance, not by Medicare or Medicaid. So, that can price a lot of people out."

Most clinicians reported that access to certain prescription drugs was a major concern for their Medicare patients due to coverage restrictions and out-of-pocket costs. When asked what comes to mind when treating Medicare beneficiaries, one rheumatologist reported, "What first comes to my mind is my expensive medications and rheumatology, and having Medicare as an insurance is very limiting in treating my Medicare patients when they need expensive meds." Others described it as a "struggle," a "pain," and "challenging" to find coverage for the medications they want to prescribe to their Medicare patients.

Medicare Drug Price Negotiation Program

We asked clinicians if they were aware of the Medicare Prescription Drug Price Negotiation Program[20] and if they had noticed or heard from patients about any difference in their experience accessing and paying for negotiated prescription drugs such as Eliquis or Enbrel.

Many clinicians were generally aware of the Medicare Drug Price Negotiation Program but were not aware of the specific prescription drugs whose prices were negotiated for 2026. Most clinicians indicated familiarity with the program, but several clinicians asked follow-up questions about which prescription drugs were being negotiated and when these prices were implemented.

Clinicians had mixed responses about changes in patient experience with negotiated drugs after moderators reminded them which drugs had been negotiated. Some had not noticed any changes in patient access. One cardiologist reported, "We use a ton of Eliquis, and I haven't noticed a difference in people's willingness to pay or not." Others were seeing some improvements. For example, another cardiologist noted, "I would say I've noticed more people being willing to transition from Warfarin to Eliquis.… I feel like I've had less pushback from patients on Eliquis."

GLP-1s

Most clinicians reported that they regularly have patients asking for GLP-1s, which often requires time and energy spent on prior authorizations. One NP reported, "Everyone's on it. I feel like [in] one day I have like more than half of my patients … on GLP-1s." Another NP noted, "I would agree that probably most of my prior auths are GLP-1s, but I probably have two to three prior auths a day." One endocrinologist described how they would work to justify the

[20] In August 2022, President Biden signed the Inflation Reduction Act of 2022 (P.L. 117-169) into law. The law provides Medicare the ability to directly negotiate the prices of certain high-expenditure, single-source drugs without generic or biosimilar competition. CMS selected 10 drugs covered under Medicare Part D for the first cycle of negotiations for initial price applicability year 2026 and engaged in voluntary negotiations with the drug companies for the selected drugs: Januvia, Fiasp, Farxiga, Enbrel, Jardiance, Stelara, Xarelto, Eliquis, Entresto, Imbruvica. August 2024. Available at: https://www.cms.gov/files/document/fact-sheet-negotiated-prices-initial-price-applicability-year-2026.pdf

prior authorization for GLP-1s: "You look for other ways of getting it approved. In my practice, they're obese and if they have diabetes and if they have metabolic syndrome and they have something else. So, you just can't use the diagnosis of obesity. You use something else." However, a cardiologist reported that the time and energy costs were too high: "I don't prescribe [GLP-1s] because it's too much of a pain."

Several clinicians expressed excitement regarding the Medicare GLP-1 Bridge program[21] implemented on July 1, 2026, because of their perception that it will cut down on back-and-forth regarding prior authorizations and increase access to GLP-1s. One NP explained the new program to other NPs and noted, "There's, of course, different requirements than the FDA covering requirements. But it's really exciting. I prescribe a lot of GLP-1s, so a lot of prior auth for GLP-1s and a lot of prior auths [where I] actually pick up the phone."

Some clinicians reported that patients were willing to pay out-of-pocket for GLP-1s, including through direct-to-consumer options. For example, one primary care physician reported that when coverage is available, patients are willing to pay the high cost prior to hitting their deductible:

> *A lot of patients are talking about the GLP-1, particularly the Medicare population, and they're willing to pay for the first two, 500, 500 to meet the deductible because they know after that they'll get eight months free or a very low cost. They have no problem. Before they would complain to me about every little thing, but when it comes to GLP-1, it's really good actually.*

Clinicians reported that patients are still interested in GLP-1s even when they are not covered by insurance. One rheumatologist, when asked if they can get their patients GLP-1s, reported, "I tell everybody about [pharmaceutical company's direct-to-consumer pharmacy]." Another endocrinologist estimated that 50 percent of their patients use direct-to-consumer programs for GLP-1s.

Not all clinicians felt positively about the uptake of direct-to-consumer options, with one primary care physician saying, "I don't send anyone that way." An endocrinologist, when asked if they were worried about patients getting prescriptions online from direct-to-consumer options, reported, "I've had patients on GLP-1s prescribed by me and another doctor and insulin and a DPP-4, and it's been—it's a mess sometimes. You have to clean up.…There are some good direct-to-consumer, though."

[21] Starting July 1, 2026, Medicare GLP-1 Bridge covers Foundayo, Wegovy, and Zepbound. The cost is $50 per month, no matter your income level. It doesn't count toward Medicare drug plan deductibles or the yearly out-of-pocket limit. You are eligible if you: 1) have Medicare Part D drug coverage, 2) you're not eligible to receive a GLP-1 through your drug plan, 3) you don't have type 2 diabetes, sleep apnea, or fatty liver disease, and 4) you're at least 18 and meet BMI and health risk criteria. June 2026. Available at: https://www.medicare.gov/publications/12234-medicare-glp-1-bridge-glp-1-drugs-for-50-a-month.pdf

Beneficiaries

The majority of Medicare beneficiaries (89 percent) rated their prescription drug coverage as excellent or good (Exhibit 7). Most beneficiaries with traditional Medicare and half of beneficiaries with MA rated their coverage as good. Equal shares of dual eligible beneficiaries rated their coverage as excellent and as good. No beneficiaries rated their prescription drug coverage as poor.

Exhibit 7. Beneficiary satisfaction with prescription drug coverage

	Traditional Medicare Only†	Medicare Advantage Only	Dual Eligible	Total*
Excellent	3 (10%)	13 (46%)	16 (42%)	32 (34%)
Good	22 (76%)	14 (50%)	16 (42%)	52 (55%)
Fair	4 (14%)	1 (4%)	6 (16%)	11 (12%)
Poor	0 (0%)	0 (0%)	0 (0%)	0 (0%)

*Percentages do not sum to 100% due to rounding.

We discussed ratings for drug coverage in 5 of 12 groups. Among beneficiaries with traditional Medicare, issues included that they have seen drug costs go up in the last few years, they cannot use rebate coupons, and they are frustrated with the wait time for prior authorizations. One beneficiary said, “I put fair. I’m new to this, just a few months. And the specialist ordered eye drops for me, and I ran out. And then it was for glaucoma, so I wanted to get it refilled immediately. And they were telling me “you can’t get it; you got to wait 10 days” and blah, blah. I’d say, “Hell, I could go blind.” A beneficiary with MA noted the same issue of delays when refilling controlled substances. A dual eligible beneficiary with MA explained that recently they have dealt with appeals for prior authorizations that have been denied:

> *This has just started that I have to do appeals quite a bit. All of a sudden, I will be—for instance, I get Botox for my migraines, and they have been a miracle, but all of a sudden, they did the prior authorization, and [insurance company] was just flat-out not—what’s the word? Not approving it. And that’s not the first time this has happened.... And then it took about three months between the appeal, and then they send it to a company to review. So I was three months behind, and I was in agony. And I just kept calling them. I’m like, "What are you people doing to me?” So that’s a big issue.*

Pharmacy Use

Focus group participants shared their reasons for preferring a specific pharmacy, including convenience and relationships with pharmacy staff. Some participants primarily chose their pharmacy based on the convenient location. For example, one participant with MA

explained, “Convenience. It’s like less than a mile.” Several participants preferred a pharmacy where they had built a relationship with the pharmacists or trusted the staff to look out for them. One participant with MA described, “I know the couple of pharmacists, and I then I greet them with their name and remember their name. Because they always remember me. And anytime I say I have a prescription, I say, ‘Look, I need as soon as possible.’ … I’ll wait for 10 minutes.… If you make a good relationship, it works very well.” Another dual eligible participant with MA was appreciative of the knowledge-sharing that pharmacists would provide: “I use the [pharmacy name], and I love it. I know pharmacists by first name. When I come and pick up prescriptions, they tell me about interactions and make sure that I’m doing the right thing. Like take things 12 hours apart or some things four hours apart. I learn more from my pharmacist than I do from my doctor.”

A few participants noted that they chose a local pharmacy to give business to smaller pharmacies or avoid giving business to large chain companies. One participant with traditional Medicare stated, “Mine is local. Even though [chain pharmacy] is across the street, I go to a local pharmacy.” In another focus group, a participant with MA noted, “I don’t like the fact that they own health care and non-health care, that same thing, and [insurance company], they both own their own pharmacy, mail order pharmacy. I don’t know. I don't like being pressured into using—it’s probably more cost efficient for everybody, but I don’t want to be pressured into using your pharmacy.”

Several participants expressed specific reasons why they avoid certain pharmacies, including insurance barriers, experiencing errors, and expensive or seemingly variable pricing. One participant with traditional Medicare shared a recent experience that drove them away from their pharmacy, explaining:

> *Albuterol … [is a] … $5 a month refill. My Trelegy … was supposed to be $253. And I went in, and I picked them up, and I got charged $29 from [pharmacy 1, for the albuterol alone]: and $496 for my Trelegy… Not knowing what the formulary cost was, I paid. […] I reported them after it was all done, and then I went to [pharmacy 2].*

Several participants reported insurance coverage as the primary reason for choosing their pharmacy. For example, one participant with MA reported that they have to stay with their insurance company’s specialty pharmacy despite having dealt with frequent errors at this pharmacy, explaining, “They have the [name] specialty pharmacy, so with the immunosuppressive medications, I had to stay with them.” Another dual eligible participant said, “[Pharmacy 1] stopped taking my insurance. So I switched to [pharmacy 2].”

Several participants reported that closures of nearby pharmacies had forced them to switch pharmacies. When looking for alternatives, beneficiaries considered distance, store hours, delivery options, and availability of medications. One dual eligible participant with MA reported, “All my pharmacies went out of business.… I had [pharmacy 1]; they went out of business.…Then … I had this other one, [pharmacy 2], and they, they sold the business to

other people. So, now I'm with [pharmacy 3], … but they do deliver." When asked if closures affected their access to the pharmacy, a dual eligible beneficiary said:

> *Yes, definitely…. I switched to [pharmacy 1] temporarily because they were close by, but they aren't very good. They're good for getting your vaccines, but for me to actually be able to get the meds I need, I had to go to the [pharmacy 2] one, which is better service. You're guaranteed to get your meds. Only problem with that is that they close at five o'clock in the evening as opposed to nine o'clock.*

While mail order and home delivery were favored by many participants to reduce the burden of picking up recurring prescriptions, several beneficiaries preferred to pick up one-off or time-sensitive medications to avoid issues or delays. Several participants favored pharmacies that allowed mail order or delivery so that they could avoid the obstacle of physically going to the pharmacy. One participant with MA said, "Well, it's also a matter of how you want to spend your time and mileage. I mean, you've got to evaluate the energy and effort it takes to do something, so mail order makes it easy." Another dual eligible participant with MA explained, "I like the whole delivery aspect of it. Because a lot of times I can't leave the house, you know, or I'm sick, so they have to deliver it."

Several participants noted that, while they prefer having their prescriptions delivered most of the time, they reserve delivery for long-term, recurring prescriptions and make exceptions for prescriptions that are short-term or more urgent. For example, one participant with traditional Medicare, "If I need the medicine right away, I go to a close-by pharmacy. Otherwise, I get everything else on mail order." Another beneficiary with MA similarly stated, "Mail order unless it's an emergency or something unusual." Another dual eligible participant noted that they use delivery, but "if I was getting like something that was a narcotic … or something like that, I wouldn't trust [delivery]." Some beneficiaries avoided delivery altogether, citing concerns about delays and errors in deliveries. For example, one dual eligible participant exclaimed:

> *They're always asking me, but when it gets delivered to the wrong address, and you can't do it anywhere but online, and you can't figure it out and no one can help you, it's like, 'No, I'll just call you and tell you when I need it.' And then they, they give you like 10 bottles of this, and I always get my standard statin, all of it. "You need some statin." No, I don't need that for another six months.*

Ability to Fill Prescriptions

Many participants reported that they or someone in their immediate family had attempted to fill a prescription that was out of stock, but many, although inconvenienced, were able to get the prescription within a week or from another nearby pharmacy. For example, one participant with MA noted that they have experienced prescriptions not being available and reported, "So they say you can either go to that store … or you can wait … and it will be here sometime tomorrow." Several participants reported that they could usually get their prescription within a few days at their pharmacy, but a few others stated that it would take about a week for the pharmacy to have their prescription back in stock. Several participants noted that they would

wait unless it was something urgent, in which case they would go to another pharmacy to get the prescription sooner. For example, one participant with traditional Medicare stated, “If I … had a surgery that I had to take something last minute, and they didn’t have it, I just went to a different pharmacy, but it was a pain in the butt.”

A couple of participants reported that their pharmacy provides workaround options to ensure that patients can get access to their medications. For example, one dual eligible participant with MA reported, “Well, now the other day, they only had 73 of my steroids.… I was due for 90. He said, ‘We’ll give you the 73, and then we'll deliver the rest when we get the rest.’ That’s fine.” Another traditional Medicare participant’s pharmacy told them that they don’t stock their medication, but that the beneficiary should “let [the pharmacy] know two weeks before you’re running out, and … I can go get it.”

Many beneficiaries noted that prescriptions costs were increasing over time, but for most the increase in cost was described as minimal and did not affect affordability. One dual eligible participant noted, “Yes. One of mine went up just $5.” Another dual eligible participant with MA outlined the slight increases they were seeing: “I do notice it’s gone up a little bit. I mean like 50 cents here, 85 cents. But I noticed that my husband paid very little, like 85 cents or $1.65. $1.65 has now gone up to $2.05.”

Several beneficiaries who had experienced significant drug cost changes noted that they were primarily due to changes in coverage, including switching plans or medications being removed from formularies. For example, one participant with MA reported, “They changed the price at the beginning of the year. Like, the one medicine I had taken was, it was no cost at all. Then in January I went to get it, it was $199.”

When they could not afford the drug after changes in coverage or increases in cost, several participants reported that they switched to a cheaper alternative drug or shopped around for better prices or plans that covered their medications. For example, one participant with MA described how they worked with their doctor when they could not afford a medication, “Well my doctor [said], they no longer cover this. She says, “Well, I’ll switch you to something else. It’s going to be, not quite as good, but it, it’ll be sufficient for you.” Another participant with traditional Medicare noted “There’s always another drug that you can substitute for the one that’s pricey.”

Some beneficiaries reported using online tools, including GoodRx, to look up prescription costs and choose the pharmacy that offered the best price. For example, one participant with traditional Medicare stated, “Each time I get a prescription now, I go on GoodRx, and I swear to god, it’s like $52 here, $390, $186, all different prices for the same exact drug with the same exact dosage, and the same exact amount.” Another beneficiary with traditional Medicare noted, “[For] my regular ones ... I deal with Express Scripts, and [for] short term things that my doctor is

prescribing, I'll just run up to CVS. But I do check online first to see if there's going to be any difference in cost."

Some beneficiaries described shopping around for prescription drug coverage that best suits their needs. For example, one beneficiary with traditional Medicare noted that they switched plans to one that covered their medications with a lower out-of-pocket cost: "I was getting charged the $50 a month. So I did change plans. In the long run, it's going to be better that I changed plans because I just don't really understand why that drug would be so expensive and on a different tier."

A few participants stated that they have skipped filling prescriptions due to the cost. For example, one dual eligible participant explained, "I have two inhalers. When I had to switch to Humana … they filled one, but they didn't fill the other.… [The doctor] fought it for like three months, and they finally said, 'You can pay for it. It's $489.' I said I'll just have to go without it." One participant with MA reported, "Yeah, it was $27, and then it went to $141. Well. Good grief. I didn't pick it up. I said I'm not paying that much." One dual eligible participant clarified that they would often skip their medication temporarily until they had funds or were able to find a substitute: "Well, usually, if I have to go without, it won't be for long. I probably just didn't have the funds then." When asked if their doctor helped with substitutions, they explained, "They've changed it a couple of times, but a couple of times there was no substitute either. And I would just still have to come up with the money."

Findings from Focus Groups with Medicare Beneficiaries in Rural Areas, 2021–2026

Introduction

This section of the report summarizes findings from virtual focus groups that were conducted from 2021 to 2026 with Medicare beneficiaries residing in rural areas of the United States. We present findings in three areas: rural considerations in choosing Medicare coverage; access to care in rural areas; and prescription drug access in rural areas. We focus on findings where there were specific considerations for beneficiaries, given their rural location or where there were differences between rural and non-rural beneficiaries.

Methods

From 2021 to 2026, we held a total of 14 focus groups with 80 participants who resided in rural areas of the United States (Exhibit 8). Focus groups were held annually in the spring or summer. All focus groups were conducted virtually using a videoconferencing platform. We used the same recruitment process as described in the Methods section above (i.e., using a screener and aiming for representation across demographic characteristics). To best moderate

the virtual focus groups, we set out to recruit eight participants, with a goal of having six to seven participants in each group.

Exhibit 8. Overview of rural focus groups, 2021–2026

Year	Participants (n)	Number of Groups (n)	Recruitment Region	Recruitment Partner
2021	11	3	Beneficiaries residing in Idaho, Montana, Nebraska, North Dakota, South Dakota, and Wyoming	National recruitment firm and NORC's AmeriSpeak panel
2022	16	3	Beneficiaries residing in Alabama and Mississippi (two groups) and West Virginia (one group)	Local recruitment firms
2023	21	3	Beneficiaries residing in rural areas nationwide, defined as a ZIP code not in a metropolitan or micropolitan statistical area[22]	National recruitment firm
2024	19	3		
2025	7	1		
2026	**6**	**1**		
Total	**80**	**14**		

All rural focus groups were recorded and transcribed. We coded and analyzed transcripts using the approach described in the Methods section above. Findings from the 2021 to 2024 rural focus groups were summarized in reports to MedPAC each year. We used the 2021 to 2024 reports and the 2025 transcript to develop a standalone rural report section in 2025. To develop this year's rural report section, we used the 2021 to 2025 reports and the 2026 transcript, supplemented by targeted review of 2021 to 2024 transcripts.

Choosing Coverage

We asked rural beneficiaries how they chose between traditional Medicare and MA.

[22] Metropolitan statistical areas must have at least one urban area of 50,000 or more inhabitants. Micropolitan statistical areas must have at least one urban area of at least 10,000 but fewer than 50,000 population. Source: U.S. Census Bureau. July 2023. Metropolitan and Micropolitan: About. Available at: https://www.census.gov/programs-surveys/metro-micro/about.html

Traditional Medicare

Rural beneficiaries with traditional Medicare prioritized the option to see any clinician who accepts Medicare, including while traveling. One 2026 participant explained:

> *We spend five months of our year in Colorado. So that was another reason we went with a supplemental plan, because if we were with an Advantage plan and trying to figure out a primary in Wisconsin and then primary in Colorado. This way, with the supplemental, the few times that we've had to do anything in Colorado, you could basically go anywhere.*

A 2023 participant described similar reasons for choosing traditional Medicare, noting that their decision was also influenced by contract disputes between their local hospital system and insurance plans:

> *I also like to travel to various U.S. parks and things. So I wanted full coverage anywhere I go. And the Advantage plans didn't. Plus where I am right now, the hospital system is frequently in disputes with the insurance companies. And in fact for an entire year they did not accept [plan name]. So I just decided to go with basic Medicare and the supplemental G, just to be sure that I could get coverage wherever I am.*

Medicare Advantage

Rural beneficiaries enrolled in MA also valued being able to see their preferred clinicians and factored provider networks into their plan choices. One 2026 participant with MA explained that clinician access, including while traveling, was their primary reason for choosing a PPO:

> *I also have a PPO, and I'm very happy. I would not select any that limits me way too much to what's going on locally. […] That's exactly what I chose, the PPO, because I could basically go anywhere. I mean, we still have ties at upstate New York, so if anything happens to either of us, you know, we're pretty much covered. [Plan name 1] and [plan name 2] both were touting their nationwide coverage. And it was really, you know, one of the big reasons.*

A 2025 participant explained how they selected their MA plan based on the inclusion of their preferred physician:

> *Well, because I'm in a rural area, I'm very limited to a physician.… That was one of the things that really make me go [plan name] because we don't have very many doctors in this area. And I did check to see if she was going to be on that list of people, and luckily she was. So that was something that really made me determine who I was going to go with for my health care.*

MA plan supplemental benefits

Rural beneficiaries with MA also cited perceived lower costs and availability of supplemental benefits as factors that informed their coverage choices. Although

supplemental benefits generally did not drive decision-making among rural beneficiaries across years, one 2026 participant explained how costs and supplemental benefits were key considerations in their plan selection:

> *For me, there was a number of reasons. One was the 20 percent copay with the Medicare Advantage was essentially removed except for specialists. And that helps a lot. The other reasons were there was vision and dental coverage. And there was even a card that you could use to help with copays or so much each month that you could get. Or in my case it was a quarter. And so that's helped pay for glasses, and you know, there's just—there was just more features than just basic Medicare and, and there was also no cost. You know, it also gave me some money back on my Medicare premiums. So, it just seemed like it was one of those things that's too good to be true. but it's, it's proved out for almost a year and a half now, and I've been really pleased with it.*

In previous years, some beneficiaries noted that their rural location limited the utility of certain MA plan supplemental benefits. For example, in 2023, a participant explained: "The reason I didn't go with an Advantage plan was that all of the advantages they offered, such as the fitness center and so forth, all of the advantages are 90 minutes away because there's just nothing out here where I am. So it just wasn't worth it to me. Plus all of the requirements that you pre-qualify for everything." Another 2023 participant shared similar sentiments, reporting:

> *I used the dental, I used the vision, and we have Silver Sneakers on my plan, which I have used in the past, but the problem is that the nearest facility is a 25-mile drive each direction for me. […] I would like them to have maybe something more available: maybe in a high school or in an elementary school gym for people in the rural area that there would be something that would be more accessible to us.*

Access to Care

We asked rural beneficiaries about their access to primary and specialty care and what they would do in various medical scenarios.

Primary care

Across all years, nearly all rural beneficiaries reported having local access to primary care. In 2026, beneficiaries reported seeing physicians, NPs, and PAs for primary care, with several seeing whichever clinician was available at their preferred clinic or federally qualified health center (FQHC). One 2026 participant explained, "We have a clinic... here in our small town, and there's a number of doctors there and no appointment's even required. You just go in and see who's on call that day, and there's always somebody available to help." In past years, wait times for primary care ranged from same-day appointments to several weeks or a month; wait times were not discussed in 2026.

In past years, travel times to primary care ranged from a few minutes to up to an hour; estimates were similar in 2026, with a maximum of over an hour reported by one participant:

"Well, I live in a rural area. So, everything's really, big type of cities are far from me. So it takes me about an hour and 10 minutes to get to my nurse practitioner, is what I use."

Across years, some rural beneficiaries reported challenges finding a new PCP, including limited options and long wait times for new patients. In 2024, one participant reported paying a monthly fee for a direct primary care model in which their physician does not accept insurance. This beneficiary explained of the local landscape, "I am in a rural area and health care is seriously lacking, and I have friends who've—they can't even find a doctor around here that's accepting new patients. One had to drive 65 miles to find a doctor who was accepting new patients." In 2026, one participant who had recently looked for a new PCP said, "There's not a lot of choices where we live," citing the rural area, and explained that they access primary care at a local clinic.

Specialty care

Consistent with prior years, 2026 rural participants described seeking specialty care from clinicians in the nearest major metropolitan area, either to access care not available locally or to see specific clinicians due to perceived higher quality of care. One 2026 participant said, "We're like an hour and 45 minutes, two hours from the Twin Cities. So, for specialized care, we usually go in there, Minneapolis/St. Paul." This participant later explained, "I don't want to change my provider, so I don't mind driving." Another 2026 participant said, "I'm going to the closest place [for specialty care]. It's still 40, 45 minutes." Similarly, a third 2026 participant said, "My pulmonologist is like 45 minutes away. […] And, I, all my specialists basically are a good hour and a half up in Charlotte." This participant explained how these clinicians in Charlotte "seem to be far and above anybody that's local here" and that closer specialists are not all located in the same place, so they would have to travel between locations no matter what.

Across years, we heard from some rural beneficiaries who took advantage of specialists who make periodic visits to their local hospital. They see these specialists when they are at the local hospital to reduce the need to travel for specialty care. A 2026 participant explained:

> *And I see an orthopedic guy, and they actually are about an hour from our house, but they make time slots available at our local hospital like once a month. And we can go see them during those office visits. So it's kind of nice; they have the specialist come in, like an eye guy will be there one day, you know, and surgeons are there one day, and you just can kind of schedule local visits, and they come to us.*

Rural beneficiaries' experiences with wait times for specialty care varied. Two rural beneficiaries in 2026 said that they could get timely access for specialty appointments, reporting wait times of one to two weeks. Another said they make regular specialist appointments every two to six months, but for unplanned specialist appointments, wait times are one to two months. A fourth participant said that they can be seen quicker if their regular physician thinks they need

to be seen and helps them get an appointment. One 2026 beneficiary was trying to schedule a neurology appointment and faced wait times of three to four months.

Telehealth

In 2026, one third of rural beneficiaries (n = 2) reported that they had used telehealth appointments. One explained how they use telehealth to reduce the burden of traveling for appointments: "If she [primary care NP] has me two appointments in a week, sometimes I try to do them virtual because like, you know, gas now gone up to 5 [dollars] a gallon. So I'm going to do as many virtual as I can." The other described using telehealth to stay in touch with their PCP between scheduled visits: "I go to his [primary care physician's] office, but I also have a portal that I can message or video on demand anytime I need to. And so we communicate a lot via that mechanism, and then I see him once a quarter."

Medical scenarios

We asked rural beneficiaries how they would access care in different medical scenarios. If they were sick or had a time-sensitive issue to address that was not an emergency, rural beneficiaries in 2026 said they would seek care at an urgent care facility or through a walk-in appointment at their doctor's office or clinic, consistent with prior years. Some beneficiaries in past years also noted they would use the ED, message their clinician online, or seek a telehealth visit in this situation.

For an injury needing stitches, most 2026 participants said they would visit the ED, with one saying they would contact their PCP through the online portal, a telehealth visit, or an in-person visit. Urgent care locations ranged from local to 50 miles away, and ED locations ranged from local to 30 minutes away. Rural beneficiaries in past years likewise reported they would visit the ED, urgent care, a walk-in clinic, or their PCP for an injury requiring stitches.

For symptoms of a heart attack, all rural beneficiaries in 2026 said they would seek care at the ED. One explained that they would like be transferred to the nearest city: "ER, they'll probably send me to Missoula, which is quite a ways away, but my hospital is half an hour from my house." Rural beneficiaries in past years also reported that they would seek emergency care at the nearest hospital and likely be transferred to a hospital in an urban area.

For major, non-emergency care or surgery like a hip replacement, all rural beneficiaries in 2026 said they would seek care in the nearest metropolitan area. Similarly, in prior years, rural beneficiaries said they would travel to a larger hospital where they could receive high-quality care.

Local clinician landscape

In 2026, two rural beneficiaries had clinicians who had recently moved away or retired, and one beneficiary had a new outpatient facility associated with a large health system open closer to

their location. In prior years, some rural beneficiaries described how their area was affected by provider shortages. This finding was echoed by a participant in 2026 who explained how other clinicians have helped meet their community's needs when faced with physician shortages: "But, you know, the lack of doctors, which has been going on for a while. That, and nurses now, thank God we do have PAs and so on to help us out."

Prescription Drugs

Pharmacy access

Across years, rural beneficiaries generally reported having access to local pharmacies. In prior years, rural beneficiaries noted certain limitations to local pharmacies, including longer wait times to fill prescriptions, certain drugs not being stocked, and lack of access to specialty medications. Despite these limitations, rural beneficiaries across years were generally able to access prescription drugs through local or mail-order pharmacies.

In 2026, several respondents said they use large retail chains or mass merchandiser pharmacies, with one explaining, "I use [mass merchandiser pharmacy] because that's really the only place we have here in town." One 2026 participant used the pharmacy at the clinic where they receive primary care (an FQHC). Another 2026 participant noted local pharmacy hours as a reason they use a mail-order pharmacy instead: "Mine is through [insurance company] and the little pharmacy in [small town]. It's the closest town to me, has really erratic hours, so I can't ever get there when they're open. So I depend on [mail order pharmacy through insurance company]." Rural beneficiaries in prior years reported that they chose or were encouraged by their insurance to use a mail-order pharmacy.

No rural participants in 2026 had been affected by a nearby pharmacy closure. In 2025, several rural beneficiaries had experienced pharmacy closures.