CHAMBER HILL

INSIGHTS

MedPAC November Public Meeting Day Two

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On November 6, 2026, the Medicare Payment Advisory Commission (MedPAC) met for the second day of its November public meeting, the third meeting of the 2026-2027 analytic cycle. During the meeting, Commissioners discussed findings from MedPAC's 2026 focus groups with Medicare beneficiaries, physicians, nurse practitioners (NPs), and, for the first time, pharmacists. Staff noted these findings will inform materials discussed throughout this cycle and will appear in the March and June 2027 Reports to the Congress. Next, Commissioners held a session on Medicare eligibility notification and the operations and funding of the State Health Insurance Assistance Program (SHIP). MedPAC staff presented options to close a gap in eligibility notices for people not yet receiving Social Security and to increase SHIP funding. Commissioners broadly supported both goals but split on user fees as a funding source. Several others pushed for better technology and a simpler enrollment system.

FINDINGS FROM MEDPAC BENEFICIARY AND CLINICIAN FOCUS GROUPS

This session began with MedPAC staff describing the 25 focus groups conducted with contractor NORC at the University of Chicago between May and July 2026. Staff noted that the focus groups included beneficiaries in Fee-for-Service (FFS) Medicare and Medicare Advantage (MA) as well as dually eligible and rural beneficiaries, in addition to physicians, NPs, and outpatient pharmacists. Staff cautioned that the small samples mean findings cannot be generalized. Staff shared the following highlights

- Beneficiaries. Most rated their medical and drug coverage as excellent or good, though dually eligible beneficiaries were more mixed.
- Physicians and NPs. Respondents characterized FFS as administratively simpler and named prior authorization, payment denials, and unstable provider networks as the main drawbacks of MA. Reported noticeable increase in use of artificial intelligence (AI), mostly for note-taking and drafting messages.
- Pharmacists. Respondents described rising workloads from nearby closures, low reimbursement that leads many to limit stock of high-cost drugs, and less time for medication therapy management (MTM).

Commissioner Discussion

Commissioners opened with clarifying questions. When asked whether coverage ratings differed between MA and FFS enrollees, staff said both groups were generally satisfied and differed mainly in why they chose their coverage. On concierge medicine, staff said awareness is growing among beneficiaries and physicians, but it's too early to judge any effect on access, and more detail will come with December's physician status report. Staff confirmed that dually eligible beneficiaries report more access problems in most years and that beneficiaries were not asked about Accountable Care Organization (ACO) participation this year. The Chair reminded Commissioners that the samples are not representative and cautioned against comparisons across markets or programs.

Overall, Commissioners expressed they were not surprised by the results of the focus groups and were very pleased that they validated their personal experiences. Several Commissioners said the findings point to operational problems in MA, such as slow prior authorization, inaccurate directories, and network disruptions, and urged staff to separate FFS and MA responses more clearly so any policy response can be targeted. Some suggested asking whether frustration among physicians and NPs is specific to MA or reflects utilization management across all payers, and whether beneficiaries' prior coverage shapes their views. Another Commissioner argued that MA has not delivered on its original goals and called for re-engineered Star Ratings and tighter scrutiny of prior authorization and network management. Prior authorization came up repeatedly as the most actionable cross-cutting issue.

Commissioners strongly supported continuing the pharmacist groups, possibly every two to three years. Several urged paying pharmacists for MTM separately from the drugs they dispense so they can focus on medication optimization and deprescribing, and one suggested moving enhanced MTM from plans to local pharmacists. Others called for reducing pharmacists' administrative work, giving them access to electronic health records and beneficiaries' claims data, and pushing drug pricing information into those systems. Another described the Medicare Prescription Payment Plan as convoluted and asked staff to explore how often beneficiaries bypass their Part D benefit with discount cards, which also leaves those fills out of Medicare claims data.

Dually eligible beneficiaries drew attention from several Commissioners, who asked whether lower reimbursement leads providers to drop them and suggested separating them out in network adequacy work. One Commissioner recommended dedicated focus groups for dually eligible, end-stage renal disease (ESRD), and beneficiaries with disabilities, and raised concern that some accountable care organizations (ACOs) may be steering these patients out by billing them under separate, non-ACO taxpayer identification numbers. Others focused on access, asking how long beneficiaries take to find a new primary care physician, where they get care in the meantime, and whether mid-year contract terminations could be better aligned with the plan year to prevent gaps in care.

Self-referral within health systems drew a sharp response. One Commissioner objected to large health systems tying physician compensation to referrals within the system, calling it inconsistent with limits on physician self-referral and arguing the same rules should apply to all market participants. Another cited evidence that referral patterns shift toward higher-cost settings after physicians join health systems, while a third said in-network referral can be appropriate but should never be forced.

Commissioners requested the following additional analyses and context:

- Questions on what would lead MA enrollees to switch back to FFS, why FFS enrollees avoid MA, and how brokers influence plan choice
- Provider perspectives on whether lower payment drives clinicians to drop dually eligible patients
- Clinician views on quality measures and payment adequacy
- Focus groups with consistently high-performing ACOs and MA plans
- Questions tied to other workstreams, including hospice enrollment, rural health clinic cost sharing, and how beneficiaries learn about Medicare eligibility
- Presenting beneficiary survey results and focus group findings together in future cycles
- Proposed sorting AI uses into back-office tasks, clinical workflow tools, and patient-facing diagnostic tools, with the last most relevant to payment policy

The Chair closed by stressing that the focus groups are not meant to drive policy development because the findings cannot be generalized. The Chair also explained that NORC's recruitment panels and limited resources constrain how groups can be built (for example, by prior coverage) and said focus group findings are already woven into other chapters. NORC's full reports will be posted on the MedPAC website.

MEDICARE ELIGIBILITY NOTIFICATION AND SHIP OPERATIONS AND FUNDING

The session began with MedPAC staff explaining the notification gap. Currently only people receiving Social Security by age 64 and 8 months get a mailed notice and automatic enrollment in Medicare. Many individuals eligible for Medicare are now working longer and delaying Social Security since the full retirement age is now 67. So, these individual now receive neither a mailed notice nor automatic enrollment. Using 2023 survey data, staff estimated that up to 2.6 million people age 64 were not receiving Social Security. Excluding those who may get an email from a joint Social Security Administration (SSA) and CMS outreach campaign, about 2 million may receive no notice at all. Staff said 1.4% of Part B enrollees and 5.3% of Part D enrollees currently pay late enrollment penalties.

Staff then reviewed the SHIP, which awards grants to 54 grantees. Just over 10,000 counselors provided one-on-one counseling to nearly 1.2 million beneficiaries in the second half of 2025. Beneficiary focus groups showed limited awareness of the program, and grantees described persistent capacity limits, with one stopping appointments three weeks into the 2025 Annual Enrollment Period (AEP). SHIP received $55.2 million in discretionary funding and about $15 million in mandatory funding in 2026. Adjusted for inflation, funding per beneficiary fell 34%, from $1.82 in 2009 to $1.20 in 2026. Staff also found that lower discretionary funding per beneficiary is associated with weaker grantee performance on client contacts.

Staff noted that MA and Part D plan user fees once funded the SHIP. CMS redirected those fees to Part D education in 2005, and they now fund 1-800-MEDICARE, Medicare.gov, and other outreach. In 2026, the fees were assessed at 0.021% of plan expenditures, or $120.3 million.

Staff presented the following potential policy directions:

- Requiring SSA or CMS to mail a notice at age 64 and 9 months to people not receiving Social Security, with appropriated funding of about $2.86 million for postage (roughly $1.10 per mailing) plus administrative costs
- Indexing SHIP funding to growth in Medicare enrollment, Medicare spending, or another measure
- Establishing a dedicated, stable SHIP funding source, such as MA plan fees

Commissioner Discussion

Commissioners opened with several clarifying questions:

- One Commissioner asked why Ohio scores “excellent” on performance while receiving $0.66 per beneficiary, 9% below the $0.72 national average. Staff said Ohio’s program is closely integrated with the state and receives substantial state support, and that they would look into it further.
- Another Commissioner asked what funding level would end the AEP capacity crunch. Staff said current data are limited and that greater access could itself raise demand but agreed to attempt an order-of-magnitude estimate.
- One Commissioner contrasted SHIP funding with the roughly $9.5 billion plans spend on agent and broker compensation and asked why user fees apply only to MA plans. Staff clarified that Part D plans also pay the fees, but a statutory cap that has not been updated in years leaves the fees short of covering even CMS’s current uses. Another Commissioner noted the federal government has no direct financial relationship with Medigap insurers, which may explain their exclusion.

- A Commissioner asked why a state's discretionary funding per beneficiary varies so widely. Staff said beneficiary counts are only one factor in the allocation formula. The Commissioner suggested revisiting the formula, with adjustments for rural and dually eligible beneficiaries.
- One Commissioner asked whether mailed notices are legally required. Staff said no statute requires mail, and that SSA emails only people whose addresses it has. The same Commissioner asked which options would need congressional action. Staff said both raising the user fee cap and changing the discretionary allocation would require Congress.

Commissioners then turned to discussing the merits of the possible policy directions outlined by staff. Most Commissioners called the mailing an easy fix, with one describing a $1.10 stamp versus a lifetime penalty as "the easiest call we'll make this year." Several suggested ways to refine it. Three Commissioners supported a phased approach, with email first and a mailed letter to those still not enrolled a few months later. Another Commissioner warned that a generic "you must enroll" message could push people with employer coverage into Part B, triggering retroactive Part A enrollment and tax penalties on health savings account (HSA) contributions. A Commissioner who leads a SHIP coordinating site in Durham, North Carolina, said notices should list unbiased help such as the local SHIP and 1-800-MEDICARE alongside agents and brokers, disclose that brokers are paid by commission, and explain the Part D low-income subsidy and income-related premiums. Another Commissioner asked staff to examine auto-enrollment itself, since the chapter noted the discrepancy but focused only on notices.

One Commissioner, while still supporting the recommendation, questioned whether MedPAC should micromanage agency mailings. They noted that SSA and CMS could likely find the money on their own and that the Commission has criticized MA plans for relying on paper forms. The same Commissioner questioned the $2 million estimate, given how often employers raise Medicare enrollment, and asked that it be qualified. Another Commissioner called SSA's claim that its email campaign beats marketing benchmarks weak, noting typical open rates near 31%, that 54% of U.S. adults read below a sixth-grade level, and that readability should come before any decision about who pays for or sends notices.

Commissioners largely agreed SHIP funding should increase but disagreed on how to pay for it.

- Supportive of user fees: One Commissioner backed expanding the existing MA and Part D fees, and adding Medigap if legally possible, without pulling funds from 1-800-MEDICARE. Another proposed combining a per-beneficiary funding floor with rural and low-income add-ons, indexing to Medicare enrollment, and restoring SHIP's share of the user fees while indexing the cap. A third supported increased funding, enrollment indexing, and a dedicated source.

- Skeptical of user fees: One Commissioner called the fees a tax passed on to MA and Part D enrollees while fee-for-service and Medigap enrollees get the same service for free. This Commissioner proposed spreading the cost across all of Medicare. They recommended an initial funding step-up for both staff and technology, followed by enrollment indexing with a cap and review every three years. A second Commissioner opposed taking money from Medicare.gov, Plan Finder, or 1-800-MEDICARE and cited growth in FDA user-fee-funded staff without matching performance gains. This Commissioner challenged the framing of SHIP as unbiased, noting that counselors are paid by the government, which runs its own insurance program. They pointed out that appropriators have repeatedly chosen not to raise SHIP funding and that states could fund their own programs but generally do not. The SHIP site director disagreed on bias, saying volunteers have no stake in which plan a beneficiary chooses and asked staff to drop the word "free" because local governments and fundraising heavily subsidize the program. Her site receives about $65,000 through four to five grants, which she said covers roughly 10% of its costs.

Several Commissioners asked that any funding increase be tied to accountability. Suggested measures included wait times, how often grantees reach capacity during the AEP, penalties avoided, Extra Help and Medicare Savings Program enrollments, and beneficiary satisfaction. One Commissioner also asked staff to learn where SHIPs get their other funding and how much they actually need.

Many Commissioners called for better tools. One Commissioner recommended federal investment in technology at scale, pointing to three grantees already building AI chatbots for counselors and beneficiaries. Another proposed a CMS-built AI tool to handle basic questions and route complex cases, such as dually eligible beneficiaries and Medicare Savings Program enrollees, to in-person counselors. A third Commissioner urged CMS to build a beneficiary app using Blue Button claims data that would list drugs in plain English, track preventive care, and pre-populate plan comparisons. Other Commissioners agreed technology helps but said many beneficiaries will still need one-on-one help, particularly those with dementia, limited incomes, or low literacy. One Commissioner noted that general AI tools can already walk users through complex processes at a sixth-grade reading level.

Several Commissioners said the underlying problem is the complexity of the enrollment system itself and urged further work on standardizing benefit design, with one noting she faces 32 plan choices in her area. Another suggested CMS develop toolkits for employers to educate workers before retirement. One Commissioner suggested requiring MA non-renewal and network change notices to include local SHIP contact information.

Staff said the Commission will return to this work in the spring.

At the conclusion of the session, MedPAC opened the floor for public comment.

- Akshay Venkitasubramanian, founder of DearBill, said his company has struggled to work with SHIPs because no national framework exists for private technology companies to partner with grantees. He asked the Commission to consider one.

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