Medicare Advantage in 2026: Putting Changes in Context

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SUMMARY

- The Medicare Advantage (MA) market remains healthy in 2026, with a range of competitive plan offerings available to over 99% of Medicare-eligible individuals across most geographies. The average beneficiary has access to 31 zero-premium MA plans in 2026, up 37% from 2022 and 176% from 2019, though down 9% from 2025.

- The availability of special needs plans (SNPs) continues to grow. The average beneficiary has access to 15 Dual-Eligible SNPs (D-SNPs) and 7 Chronic Condition SNPs (C-SNPs) in 2026, representing cumulative growth of 153% and 259%, respectively, since 2019.

- After several years of rapid supplemental benefit expansion, benefit changes among MA non-SNPs from 2025 to 2026 are mixed. Specialty care copays are increasing by an average of 10%, while primary care copays and deductibles remain flat. Supplemental benefits remain widely available, although the share of plans offering coverage of over-the-counter non-prescription health items declined from 73% to 67%. Despite these changes, overall benefit generosity remains near all-time highs.

- We estimate that per-beneficiary federal funding for MA will increase by 8.5% in 2026, following a 2.4% increase in 2025 and a 4.5% increase in 2024. Plans appear to be using the increased funding to offset margin pressure, elevated medical cost trends, and Part D benefit enhancements required by the Inflation Reduction Act, while maintaining competitive benefits with modest targeted pullbacks, particularly for non-SNPs.

- In rural areas, the availability of MA plans has generally grown more rapidly than non-rural areas over several years. However, in certain geographies, affecting less than 0.5% of Medicare-eligible individuals and concentrated in specific counties in Vermont, Colorado, and Minnesota, reductions in MA plan options in 2026 are meaningful, with approximately 165,000 beneficiaries losing access to any MA plan.

BACKGROUND

With the 2026 contract year underway, Medicare Advantage (MA) continues to offer a broad array of plan choices and supplemental benefits to beneficiaries. This brief examines the 2026 MA landscape in the context of longer-term trends. Our analysis shows that both the number of MA options and overall benefit levels remain near all-time highs. More than half of Medicare-eligible beneficiaries are now enrolled in MA, reflecting a doubling of enrollment over the last decade, and the 2026 landscape is consistent with the Centers for Medicare & Medicaid Services (CMS) projection of continued enrollment stability.[1] [2]

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This multiyear perspective is contrary to an emerging narrative that emphasizes contraction in the 2026 MA market. Recent headlines have included "Medicare Advantage Insurers Still in Retreat," "Skinnier Benefits, Higher Premiums and Fewer Options," and "Medicare Advantage Stands on Wobbly Legs".[3] [4] [5] Insurers have highlighted that they are scaling back MA plan options, due to both rising medical costs and lower federal funding levels for MA. UnitedHealth Group, for instance, described a "generational pullback in Medicare funding, set in motion in 2023 and playing out through 2026" when discussing its termination of some preferred provider organization (PPO) offerings.[6] While we observed some reductions in plan offerings and benefits in 2026, these reflect modest adjustments within a generally healthy and well-funded market.

In our analysis, we examined 2019 to 2026 MA landscape files, plan benefit packages (PBP), and related public data. For most metrics, we show comparisons back to 2022, with 2022 reflecting a year before insurers' recent concerns about funding levels. For certain metrics, where reliably comparable data was available, we extend comparisons through 2019 to show longer-term patterns, including the years most impacted by the COVID-19 pandemic. We highlight where our findings align with the prevailing narrative, while placing the 2026 changes within broader historical trends, providing insight into how insurers respond to the financial and regulatory environment which shapes the MA market.

Despite the general stability, even modest changes on average can be meaningful for specific beneficiaries, such as those whose plans have been terminated or who may lose valued plan benefits if they remain in their current plan. While all beneficiaries can shop for new plans during the MA Open Enrollment Periods, those most affected by plan changes have the strongest incentive to switch. Our analysis identifies those beneficiaries who may be most affected by 2026 changes.

MEDICARE ADVANTAGE OPTIONS

National View

In 2026, the average beneficiary has 39 MA options, as shown in Table 1. Of these options, 31 are zero-premium plans, meaning beneficiaries only pay the standard Medicare Part B premium, and the MA plan premium is entirely federally funded through CMS. Compared to 2025, this is a reduction of 3 plan options and 3 zero-premium plan options. However, compared to 2022, there are the same average number of options (39) with 8 more of these being zero-premium plans. Compared to 2019, the number of plan options has increased 67% (from 24 to 39), and the number of zero-premium plans has increased 176% (from 11 to 31).

The number of Special Needs Plans (SNPs) continues to increase steadily in 2026. The average number of dual-eligible SNP (D-SNP) options is increasing from 14 to 15 in 2026, and is up from 9 in 2022 and 6 in 2019. The integration of Medicare and Medicaid administration within a single plan, known as Applicable Integrated D-SNPs (AIPs), has been gaining traction since CMS created the designation for 2021. The transition of Financial Alignment Initiative (FAI) demonstration plans to AIPs in 2026 is contributing to further growth, with, on average, 4 of the 15 D-SNPs options being AIPs in 2026.[7] SNPs for those with chronic conditions (C-SNPs) have grown steadily, up 92% since 2022 and 259% since 2019.

TABLE 1: AVERAGE MEDICARE ADVANTAGE OPTIONS, BY PLAN TYPE, 2019-2026

	non-SNP		D-SNP			
Year	Any	$0 Premium	Any	AIPs	C-SNP	I-SNP
2026	39	31	15	4	7	3
2025	42	34	14	2	6	3
2024	44	29	13	2	5	3
2023	43	26	11	2	4	3
2022	39	23	9	2	4	3
2021	33	18	8	1	3	2
2020	28	14	7	-	2	2
2019	24	11	6	-	2	2
2026 vs 2022	+2%	+37%	+56%	+142%	+92%	+6%
2026 vs 2019	+67%	+176%	+153%	-	+259%	+80%

Notes: Source is authors' analysis of CMS Landscape Files and Plan/County Penetration.[8] [9] D-SNP Integrated plans are those which meet CMS requirements for an Applicable Integrated Plan.[10] Averages are weighted by county-level eligible Medicare beneficiaries. Counties outside of the 50 states and Washington D.C. are excluded, as are counties without FIPS-level eligibility data (typically related to county definition changes). Abbreviations: SNP: Special Needs Plan; D-SNP: Dual-Eligible SNP; C-SNP: Chronic SNP; I-SNP: Institutional SNP; AIP: Applicable Integrated Plan.

The number of parent organizations (POs) from which beneficiaries can choose has remained roughly flat, with the average beneficiary having access to plan options from 8 POs in each of the last 3 years (not shown in table). This indicates that the recent reduction in MA options is primarily driven by a reduction in the number of plan variations that POs are offering, rather than a reduction in the number of POs. For example, CVS Health is offering an average of 5.2 plans per market in 2026, down from 5.9 in 2025.

Less-Served Geographies

Geographies that historically had fewer MA options have experienced even faster growth over several years than the national average. The three panels of Table 2 show the number of plan offerings in remote counties and for the 10% and 1% of eligible beneficiaries with the fewest options. In remote areas (Panel 2A), there are more than double the number of options and 6 times more zero-premium options in 2026 than in 2019, despite the small reduction since 2025.

Ninety percent of beneficiaries have access to 17 options (Panel 2B) and 99% of beneficiaries have access to at least 2 options (Panel 2C). However, in 2025, 99% of beneficiaries had access to at least 5 options, indicating there is a small tail of the distribution in which beneficiaries lost access to most of their already limited choices (see the County Distributions discussion, below).

TABLE 2: MEDICARE ADVANTAGE OPTIONS IN LESS-SERVED GEOGRAPHIES, BY PLAN TYPE, 2019-2026

	Panel 2A: Remote Areas			Panel 2B: 10th Percentile of Beneficiaries			Panel 2C: 1st Percentile		
Year	non-SNP	$0 non-SNP	D-SNP	non-SNP	$0 non-SNP	D-SNP	non-SNP	$0 non-SNP	D-SNP
2026	23	18	10	17	11	4	2	2	-
2025	26	21	9	20	14	3	5	4	-
2024	26	15	8	21	11	3	5	2	-
2023	25	13	6	21	9	3	5	1	-
2022	21	9	5	18	6	2	3	-	-
2021	17	6	3	13	4	1	2	-	-
2020	13	4	2	9	2	1	1	-	-
2019	11	3	2	8	1	-	-	-	-
2026 vs 2022	+11%	+93%	+120%	-6%	+83%	+100%	-33%	-	-
2026 vs 2019	+118%	+515%	+504%	+113%	+1000%	-	-	-	-

Notes: Source is authors' analysis of CMS Landscape Files and Plan/County Penetration. Remote is defined as counties with a Rural-Urban Continuum Code (RUCC) score between 7-9. Averages and percentiles are weighted by county-level eligible Medicare beneficiaries. Counties outside of the 50 states and Washington D.C. are excluded, as are counties without FIPS-level eligibility data (typically related to county definition changes). Abbreviations: SNP: Special Needs Plan; D-SNP: Dual-Eligible SNP.

County Distributions

The nationwide average number of MA options remains high, and 66.8 million beneficiaries (99.5%) have access to multiple MA plans, as shown in Table 3. Counties in which selections either remain or are becoming limited in 2026 are rare exceptions: 32 counties (165,000 beneficiaries) had an MA option in 2025 and are losing MA access in 2026.

The availability of D-SNPs, and particularly integrated D-SNPs, continues to grow. A total of 143 counties (493,000 dual-eligible beneficiaries) are gaining access to D-SNPs, compared to only 48 counties (15,000 dual-eligible beneficiaries) losing access. Access to AIPs is growing as well, with 425 counties (2.5 million dual-eligible beneficiaries) gaining access. While there remain 164 counties (165,000 dual-eligible beneficiaries) without any D-SNPs, non-SNPs with $0 premiums for low-income beneficiaries are available in 114 of those counties (not shown in table).

Counties with meaningful reductions in MA plan availability in 2026 are concentrated in a few states (not shown in tables). Of the 32 counties (165,000 beneficiaries) that lost access to MA, eight (108,000 beneficiaries) are in Vermont. Six counties in Colorado and three in Minnesota, with roughly 40,000 beneficiaries, account for most of the remaining areas where beneficiaries are losing access to MA. These localized changes are not associated with corresponding funding reductions. For example, in the Vermont counties which lost MA access, we estimated that 2022 to 2026 benchmark increases of 16.2% for these counties were consistent with national-level average benchmark changes of 16.3% for the same period (see Table 5). This suggests insurer strategies unrelated to 2026 funding may be driving the access reductions in these counties.

TABLE 3: DISTRIBUTION OF NUMBER OF MA OPTIONS, 2026

	Number of Counties						Number of Eligible Beneficiaries (000s)			
	non-SNP		D-SNP				non-SNP		D-SNP	
	Any	$0 Prem.	Any	AIP	C-SNP	I-SNP	Any	$ 0 Prem.	Any	AIP
0 Plans	86	97	164	2,098	775	1,033	269	405	165	5,247
1 Plan	6	82	83	91	416	536	73	348	161	485
2-9 Plans	391	591	1,080	753	1,845	1,541	2,756	5,914	4,071	5,090
10+ Plans	2,630	2,343	1,786	171	77	3	64,035	60,465	8,619	2,193
Dropped to 0 Plans	32	43	48	-	30	45	165	302	15	-
Dropped to 1 Plan	5	51	20	1	4	65	51	286	23	1
Increased from 0 Plans	4	4	143	425	68	-	23	23	493	2,457
Increased from 1 Plan	-	5	23	19	283	134	-	7	33	70

Notes: Source is authors' analysis of CMS Landscape Files, Plan/County Penetration, and the Medicare Beneficiary Summary File (MBSF). Dropped to 0 Plans are areas which had at least 1 option in 2025 and have no options in 2026. Dropped to 1 Plan are areas which had at least 2 options in 2025 and have 1 option in 2026. Increased from 0 Plans are areas which have at least 1 option in 2026 and had 0 in 2025. Increased from 1 Plan are areas with at least 2 options in 2026 and had 1 option in 2025. Counties outside of the 50 states and Washington D.C. are excluded, as are counties without FIPS-level eligibility data (typically related to county definition changes). Abbreviations: SNP: Special Needs Plan; D-SNP: Dual-Eligible SNP; C-SNP: Chronic SNP; I-SNP: Institutional SNP; AIP: Applicable Integrated Plan.

MEDICARE ADVANTAGE BENEFITS

After several years of rapid benefit expansion, benefit changes from 2025 to 2026 are generally modest and mixed. Certain benefits, especially among non-SNPs, are declining slightly, while other benefits, especially among SNPs, have improved. Overall, benefit levels remain near all-time highs, and MA continues to offer substantial additional value relative to traditional Medicare for beneficiaries who prioritize lower out-of-pocket costs or supplemental benefits. Tables 4a and 4b show average benefit amounts and changes for non-SNPs and D-SNPs, respectively.

Within non-SNPs, maximum out-of-pocket (MOOP) amounts are increasing 5%, which follows a 7% increase in 2025. However, the average annual increase from 2019 through 2024 was less than 1% (not shown in table), well below average medical inflation of 2.7% over the same period.[11] This suggests that plans may have been aggressive in maintaining benefit generosity in prior years, with the recent increases representing a correction toward underlying cost growth.

Other cost sharing measures are flat to slightly increasing: primary care copays remain $0 for most plans and specialist copays are rising from $30 to $33. Deductible amounts and prevalence are changing little in 2026, following an increase in the prevalence of deductibles in 2025.

Common supplemental benefits remain strong, with 99% of plans offering vision and 98% offering dental benefits. The portion of plans offering a fitness benefit is decreasing from 95% to 93%. There is a more pronounced pullback in over-the-counter (OTC) benefits, which include non-prescription drugs and everyday medical supplies, with 67%

of plans offering OTC benefits in 2026, compared with 73% in 2025 and 85% in 2024. The average annual maximum benefit for OTC and additional supplemental benefits is decreasing 5%, from $387 to $366, which follows a similar reduction in these benefits in 2025. Still, average amounts remain higher than in 2022 ($327) and these benefits are becoming easier to use with most plans now providing pre-loaded electronic debit cards, often referred to as flex cards. Eighty-seven percent of MA plans also include an Enhanced Part D benefit (a more generous prescription benefit than the statutorily defined standard plan), consistent with previous years.

The average Part B premium buy-down continues to rise, reaching $31 per month in 2026. This figure reflects that approximately one-third of plans offer buy-downs averaging around $100, meaning the Part B premium for plan beneficiaries is reduced by $100 per month. The growth in Part B buy-downs complements the expansion of zero-premium MA plan options, as discussed in the Medicare Advantage Options section above. While beneficiaries in zero-premium plans pay no MA premium, they are still responsible for the Medicare Part B premium, net of any buy-down.

For D-SNPs, average benefits are generally flat or improving. We focus on supplemental benefits, as cost sharing is less salient for D-SNPs, where Medicaid covers most beneficiary cost sharing. Over 90% of plans offer vision, dental, fitness, and OTC benefits. The average annual value of OTC and additional supplemental benefits continues to increase, reaching $1,958 in 2026. The OTC and additional supplemental benefits are provided through flex cards in 96% of plans (not shown in table).

Flex cards can be used to cover OTC non-prescription drugs and medical supplies and, often, “non-primarily health-related benefits,” which can include groceries, utilities, and transportation.[12] Beneficiary eligibility for these non-primarily health-related benefits is determined by insurer-defined criteria within rules established by CMS. Changes to these CMS rules in 2026 led many plans to revise eligibility criteria: shifting from eligibility based on financial need under the Value-Based Insurance Design (VBID) model to eligibility based on specified chronic conditions under the Special Supplemental Benefits for the Chronically Ill (SSBCI) program.[13] [14] [15] This shift in defining the eligible population did not affect the average value of D-SNP supplemental benefits from 2025 to 2026 (reflected in the OTC and Additional Benefit Annual Value column of Table 4b), and approximately 70% of beneficiaries have qualifying chronic conditions.[16] However, changes in eligibility criteria may be confusing for beneficiaries, making it difficult to understand how they qualify for benefits and which supplemental benefits they are eligible to receive.

TABLE 4A: AVERAGE BENEFITS FOR NON-SNPS, 2022-2026

Year	MOOP *avg.*	Primary Care Copay *avg.*	Specialty Copay *avg.*	Deduct-ible *% Plans*	Deduct-ible *avg.*	Vision *% Plans*	Dental *% Plans*	Fitness *% Plans*	OTC *% Plans*	OTC and Add'l Benefit Annual Value *avg.*	Part B Prem. Monthly Buy-down *avg.*	Enhanc-ed Part D *% plans*
2026	$5,819	$0	$33	10%	$546	99%	98%	93%	67%	$366	$31	87%
2025	$5,524	$1	$30	10%	$547	99%	98%	95%	73%	$387	$25	88%
2024	$5,153	$2	$30	5%	$713	99%	97%	98%	85%	$414	$20	88%
2023	$4,974	$2	$29	6%	$749	99%	97%	99%	87%	$392	$16	88%
2022	$4,918	$3	$30	7%	$804	98%	94%	98%	82%	$327	$10	88%
2026 vs 2025	5%	-63%	7%	0%	0%	1%	0%	-3%	-6%	-5%	24%	0%
2026 vs 2022	18%	-86%	9%	3%	-32%	1%	3%	-5%	-15%	12%	208%	-1%

TABLE 4B: AVERAGE BENEFITS FOR D-SNPS, 2022-2026

Year	Vision *% Plans*	Dental *% Plans*	Fitness *% Plans*	OTC *% Plans*	OTC and Add'l Benefit Annual Value *avg.*	Enhanced Part D *% plans*
2026	96%	93%	92%	96%	$1,958	77%
2025	97%	95%	90%	97%	$1,913	14%
2024	96%	91%	94%	96%	$1,901	13%
2023	96%	90%	94%	96%	$1,739	29%
2022	95%	91%	91%	95%	$1,271	55%
2026 vs 2025	-1%	-2%	2%	-1%	2%	63%
2026 vs 2022	1%	2%	1%	1%	54%	22%

Notes: Source is authors' analysis of CMS Landscape Files, Plan Benefit Package Files, and Plan/County Penetration. Copay amounts are the maximum copays for each category. A small number (2%) of non-SNPs have physician coinsurance and are excluded from this exhibit. The deductible average amount is the average for plans which have a combined deductible across services; additional plans may have service-specific deductibles which are not included here. OTC and Additional Benefits include the maximum amount for OTC, VBID, and SSBCI benefits. Amounts are weighted by eligibility. Abbreviations: MOOP: Maximum Out-of-Pocket; OTC: Over-the-Counter.

MEDICARE ADVANTAGE FUNDING AND MARGINS

Federal payments to MA plans are administered by CMS and are impacted by county-level benchmark payments, contract-level Star Ratings, beneficiary-level risk scores, and plan bids. As shown in Table 5, we estimate that, considering these components, funding for MA plans is increasing by 8.5% in 2026, a rate significantly higher than the 2.4% increase in 2025 and 4.4% increase in 2024.

We calculated these increases using CMS benchmark amounts, actual or preliminary Star Ratings, and MA enrollment weights. The risk-adjustment components of the increases are based on CMS's published estimates in the annual rate announcement and accompanying fact sheets. [17] [18] [19] [20] [21] [22] [23] Overall, our estimated increases are generally in line with CMS projections.[24] Benchmark amounts are based on actual per-capita spending in traditional Medicare and anticipated inflation, with county-level adjustments which increase or decrease benchmarks in areas with historically much lower or higher spending relative to national averages.[25] This approach of basing benchmarks on inflation-adjusted recent actual spending allows MA funding to increase when medical cost trends are higher. For 2026, CMS updated the baseline data used to develop the increases between the Advance Notice in January 2025 and the Final Announcement in April 2025 to reflect more recent trends, driving the large 2026 funding increase.[26]

Another broad indicator of MA funding and plan benefit generosity is the size of CMS rebate payments that plans use to fund reduced cost sharing and supplemental benefits. Plans earn rebates when their pricing of traditional Medicare benefits (the plan "bid") is below the corresponding benchmark. While 2026 rebates are not yet available, in 2025 rebates reached $211 per beneficiary per month, up 22% since 2022 and 88% since 2019, though the pace of those increases has slowed since 2023.[27]

TABLE 5: ANNUAL MEDICARE ADVANTAGE PLAN PAYMENT INCREASES, 2019-2026

Year	Average Benchmark *(Per Beneficiary Per Month; 1.0 risk score)*	Benchmarks and Star Ratings *(% Change)*	Risk Model, Normalization, and Coding Pattern Changes *(% Change)*	Risk Score Coding Trend *(% Change)*	Total Funding *(% Change)*	Rebate *(Per Beneficiary Per Month)*
2026	$1,261	+9.4%	-3.0%	+2.1%	+8.5%	na
2025	$1,153	+1.0%	-2.5%	+3.9%	+2.4%	$211
2024	$1,141	+2.2%	-2.2%	+4.4%	+4.4%	$210
2023	$1,117	+3.7%	-0.8%	+3.5%	+6.4%	$209
2022	$1,078	+5.3%	-1.4%	0.0%	+3.9%	$173
2021	$1,023	+4.4%	-2.3%	+3.6%	+5.7%	$147
2020	$980	+6.0%	-2.9%	+3.3%	+6.3%	$128
2019	$925					$112
2026 vs 2022		+16.3%	-8.5%	+13.9%	+21.7%	+22.0%
2026 vs 2019		+32.0%	-15.0%	20.8%	37.7%	+87.9%

Notes: Benchmark source is authors' analysis of CMS Landscape Files, CMS benchmark amounts, actual or preliminary Star Ratings, and MA enrollment weights.[28] [29] MA risk coding intensity, model revisions, normalization, and coding trend source is CMS's rate announcement fact sheet for the respective year. CMS did not provide an estimated coding trend in 2022, and we have conservatively assumed 0.0%. Rebates source is Figure 11-2 of March 2025 MedPAC Report to the Congress. Counties outside of the 50 states and Washington D.C. are excluded.

Several large POs reported 2025 margin pressure in their MA businesses, which they attributed to funding reductions or inadequate increases. To assess the adequacy of funding at a high level, funding increases can be compared to trends reported by insurers. For example, in its third quarter earnings call, UnitedHealth stated that it expects "significantly elevated" medical cost trends of 7.5% in 2025 and 10% in 2026.[30] [31] Humana expects 2025 and 2026 trends "on the higher end of mid [single digits]."[32] Elevance Health, somewhat in contrast, explained that MA "trend has been elevated, but manageable, and we now expect our operating margin to increase slightly in 2025, though still well below our long-term range."[33] These insurer-reported trend amounts are higher than funding increases in 2025, but appear broadly in-line with the 2026 increase.

Insurer costs have also been impacted by changes under the Inflation Reduction Act (IRA) related to Medicare Part D, beginning in 2023 and ramping up through 2026. The more meaningful changes impacting plan liabilities include an annual $2,000 out-of-pocket cap per person and plans paying a larger share of drug costs for beneficiaries in the catastrophic phase. These changes require MA plans to allocate an increasing share of rebates to Part D to avoid premium increases.[34]

Combining this funding analysis with our observations on plan options and benefits, we find that funding and rebates increased quickly for several years prior to 2024 and plans aggressively offered correspondingly richer benefits. In 2024 and 2025, plan rebates flattened as funding growth slowed. Plans correspondingly moderated the pace of benefit expansion, but not by enough to fully offset the extent to which cost trends emerged higher than expected, leading to margin pressure. In 2026, plans appear to be using the relatively large funding increase to offset margin pressure, elevated medical cost trends, and IRA-related Part D costs, while maintaining competitive benefits with modest targeted pullbacks across non-SNP benefits and geographies.

PARENT ORGANIZATION ANALYSIS

Several large POs have highlighted reductions in plan options or benefits as a strategy to improving the financial performance of their MA businesses. Table 6 presents key measures for the seven largest POs, which together account for roughly three quarters of MA enrollment. Most of these large POs are reducing their non-SNP footprint, with UnitedHealth, Humana, CVS Health, and Elevance Health each reducing the number of counties in which they participate by at least 5%.

Outside these large POs, geographic coverage is more stable. In 2026, 12 POs are entering the MA market and only 5 POs are exiting (not shown in table). Excluding the 7 largest POs, 111 POs are maintaining the same geographic coverage, while 27 are expanding and 31 are contracting. Devoted Health is increasing its geographic coverage by 65% (nearly 400 new counties).

By product type, the largest POs are reducing PPO offerings more sharply than health maintenance organizations (HMOs). Five of the seven are reducing the number of non-SNP PPOs by at least 15%. UnitedHealth, for example, is reducing the number of PPO plans by 25%, while maintaining roughly the same number of HMO plans. During annual open enrollment periods, beneficiaries can shop for plans and can switch to another PO or another plan with the same PO.

Despite the pull-back in non-SNP offerings, most large POs continue expanding SNPs. Geographies with D-SNPs are increasing for 5 of the 7 largest POs. Geographies with C-SNPs are increasing for 4 of the 7, including order-of-magnitude growth for CVS Health and Health Care Service Corporation (HCSC). SNPs for institutionalized beneficiaries (I-SNPs) remain the least common SNP type, and the number of options is generally decreasing.

MOOP amount changes vary by PO. Humana average MOOP amounts are decreasing, while CVS Health, Elevance Health, Kaiser, Centene, and HCSC are increasing MOOP amounts by greater than health care inflation. UnitedHealth MOOP amounts are modestly increasing.

TABLE 6: PARENT ORGANIZATION SUMMARY, 2026

	UnitedHealth	Humana	CVS Health	Elevance Health	Kaiser	Centene	Health Care Service Corp.
non-SNP							
Counties	2,597 (-8%)	2,655 (-4%)	2,083 (-6%)	952 (-13%)	118 (+0%)	1,731 (-2%)	948 (-2%)
Plans	524 (-12%)	653 (+10%)	483 (-15%)	159 (-21%)	90 (+15%)	187 (-16%)	232 (-28%)
HMO Plans	316 (-1%)	253 (+2%)	198 (-13%)	136 (-13%)	87 (+16%)	137 (-12%)	156 (-12%)
PPO Plans	206 (-25%)	389 (+18%)	285 (-16%)	23 (-48%)	3 (+0%)	45 (-27%)	76 (-46%)
MOOP	$5,923 (+2%)	$6,430 (-2%)	$6,353 (+11%)	$5,433 (+9%)	$4,676 (+9%)	$6,281 (+16%)	$5,732 (+3%)
HMO MOOP	$5,166 (+5%)	$4,879 (-8%)	$5,247 (+12%)	$4,787 (+13%)	$4,639 (+9%)	$6,083 (+18%)	$5,226 (+10%)
PPO MOOP	$7,030 (+4%)	$6,877 (-1%)	$6,984 (+11%)	$7,257 (+11%)	$6,117 (+20%)	$7,034 (+19%)	$6,540 (+2%)
D-SNP							
Counties	2,561 (+0%)	2,019 (+2%)	1,738 (+5%)	1,375 (+7%)	73 (+18%)	1,737 (+8%)	644 (-1%)
Plans	196 (+6%)	147 (+34%)	111 (-3%)	105 (+12%)	29 (+164%)	111 (+19%)	43 (-9%)
C-SNP							
Counties	2,086 (-0%)	1,089 (+4%)	234 (+1200%)	522 (-0%)	0 (+0%)	17 (+6%)	46 (+207%)
Plans	97 (-3%)	74 (+16%)	44 (+633%)	56 (-8%)	0 (+0%)	5 (+25%)	8 (+100%)
I-SNP							
Counties	472 (-8%)	1,135 (-5%)	151 (-1%)	5 (-81%)	0 (+0%)	0 (+0%)	0 (+0%)
Plans	29 (-26%)	13 (+0%)	4 (-20%)	5 (-29%)	0 (+0%)	0 (+0%)	0 (+0%)

Notes: Source is authors' analysis of CMS Landscape Files and Plan/County Penetration. Percentage in parentheses reflects 2026 vs 2025 change. Averages are weighted by county-level eligible Medicare beneficiaries. Counties outside of the 50 states and Washington D.C. are excluded, as are counties without FIPS-level eligibility data (typically related to county definition changes). Abbreviations: SNP: Special Needs Plan; D-SNP: Dual-Eligible SNP; C-SNP: Chronic SNP; I-SNP: Institutional SNP; MOOP: Maximum Out-of-Pocket; HMO: Health Maintenance Organization; PPO: Preferred Provider Organization

CONCLUSIONS

The vast majority of beneficiaries continue to have access to a wide range of MA plans offering substantially richer benefits than traditional Medicare. Although our analysis of the 2026 MA landscape found reductions in plan options and benefits, particularly among some of the largest insurers, these changes are modest when viewed against the recent years' rapid growth, with plan availability and benefit generosity remaining high by historical standards.

In a few geographies representing less than 0.5% of beneficiaries, such as Vermont and rural parts of Colorado and Minnesota, reductions are more pronounced. However, these reductions are not associated with federal funding decreases, and more localized research is needed to understand the underlying drivers and implications.

In announcing the 2026 offerings, CMS noted that plans project MA enrollment of 34 million in 2026.[1] While this would be slightly lower than the 34.9 million beneficiaries enrolled in 2025, CMS noted that plans have historically understated enrollment projections, and therefore expect enrollment to remain stable. Consistent with this view, the Medicare Trustees Report released in June 2025 projected MA growth of 4.5% in 2026.[2]

In earnings calls and other communications, many of the largest POs have cited margin pressure, rising medical costs, and IRA-related Part D impacts as key challenges. Even so, with higher 2026 federal funding, POs are maintaining historically strong plan offerings and benefits, with only modest targeted pullbacks, particularly among non-SNPs. Overall, the 2026 landscape suggests continued MA market strength and stability.

DISCLOSURES

This work was supported by Arnold Ventures. ARC maintains full editorial and analytical control.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all communications with respect to actuarial services. Tim Bulat, Brandi Dries, and Ryan Brake are members in good standing of the American Academy of Actuaries and meet the qualification standards for performing the analyses in this brief.

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