Medicare Advantage in 2026: Actual Enrollment and Benefit Results, in Context

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SUMMARY

- The Medicare Advantage (MA) market remains stable in 2026, with MA enrollment increasing by 1.1 million (3.1%), driven primarily by growth in Special Needs Plans (SNPs) and, to a lesser extent, non-SNP HMO plans. MA growth outpaced traditional Medicare, increasing MA penetration by 0.4 percentage points to 51.6%.
- After years of growth, the combined market share of the top seven parent organizations (POs) began declining in 2024, coinciding with the phase-in of an updated risk adjustment model. This change may have increased margin pressure on larger carriers with more extensive coding and diagnosis capture programs. Growth among smaller carriers, by contrast, has accelerated: in 2026, smaller insurers grew by nearly 10% compared to 1.0% for the top seven.
- In 2026, approximately 3 million MA beneficiaries were impacted by plan terminations. However, overall enrollment results suggest that most selected an alternative MA plan. Notably, overall PPO enrollment remained roughly flat despite UnitedHealth Group terminating PPO plans which previously covered about 600,000 beneficiaries.
- The majority of counties experienced growth in MA enrollment in 2026, particularly in SNPs. A small number of non-metro and rural counties experienced larger enrollment declines than in prior years, often associated with targeted, localized plan exits (i.e., Minnesota and Vermont).
- Rebate payments from CMS to insurers increased to all-time highs in 2026 for both non-SNPs and SNPs, indicating increased funding for supplemental benefits and other benefit enhancements. Higher rebates were driven by CMS benchmarks rising faster than plan bids. However, modest declines in some 2026 enrollment-weighted benefit values suggest insurers have incorporated updated cost expectations for supplemental benefits.

BACKGROUND

This brief examines actual 2026 MA enrollment data released by CMS in February in the context of longer-term enrollment and benefit trends. It builds on a previously published January 2026 ARC report, [1] by incorporating newly available enrollment data and plan commentary following the Annual Enrollment Period (AEP). In the prior report, we

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presented results of our earlier analysis of plan offerings using the CMS-provided landscape and benefit files and found the 2026 MA market remained strong when viewed in historical context, with multiple zero-premium MA plans available to 99% of Medicare-eligible individuals, continued growth in special needs plan (SNP) offerings, and overall benefit values near historic highs.

Ahead of the 2026 MA Annual Enrollment Period (AEP), CMS stated in a press release that it expected enrollment in the MA and Part D programs to remain stable, while noting that plans, in contrast, had projected a decrease in MA enrollment. [2] Industry and other stakeholders emphasized plan exits and benefit changes as key risks to enrollment.[3]

Newly available enrollment data shows that contrary to industry projections, MA enrollment has continued its historical growth, increasing by 1.1 million as of February 2026. Trends vary by product, SNP type, geography, and parent organization as outlined in a recent KFF report.[4]

Using these updated enrollment data, this brief presents an analysis of MA market trends from 2019 to 2026 by segment, parent organization, and geography and assesses enrollment-weighted changes in Part C and D benefits. As in our prior work, our goal is to provide context around recent changes across the MA market.

OVERALL ENROLLMENT

MA enrollment increased by 1.1 million, or 3.1%, from February 2025 to February 2026, reflecting modestly slower growth relative to prior years. The number of Medicare-eligible beneficiaries rose by 1.7 million to 68.6 million, or 2.5%, in 2025. With MA enrollment growing at a faster rate than traditional Medicare, the MA penetration rate rose by 0.4 percentage points to 51.6%.

Table 1 presents a breakdown of MA enrollment changes from 2019 to 2026. The MA enrollment growth in 2026 was driven by continued growth in SNPs, supported by an expansion in the number of SNPs across the MA market.[5] There was also moderate growth in non-SNPs driven by HMOs. PPO and employer group waiver plan (EGWP) segments both had a slight decrease in year-over-year enrollment, following years of consistent growth.

TABLE 1: MA ANNUAL ENROLLMENT BY SEGMENT, 2019-2026 (MILLIONS)

Year	MA Penetration Rate	Non-SNP			SNP	EGWP	Total	MA Y/Y % Growth
		PPO	HMO	Total				
2026	51.6%	8.6	12.8	21.5	8.2	5.8	35.5	3.1%
2025	51.2%	8.7	12.5	21.2	7.3	5.9	34.4	4.0%
2024	50.7%	8.4	12.2	20.6	6.6	5.8	33.1	7.2%
2023	48.4%	7.5	12.2	19.8	5.6	5.5	30.9	7.6%
2022	46.1%	6.8	12.1	18.9	4.6	5.2	28.7	8.7%
2021	43.2%	5.8	11.7	17.5	3.8	5.0	26.4	10.1%
2020	40.1%	4.9	11.0	15.9	3.3	4.7	24.0	9.5%
2019	37.7%	4.2	10.1	14.5	2.9	4.5	21.9	

Notes: Source is authors' analysis of CMS penetration and enrollment files. [6] [7] Values correspond to February in each year. MA enrollment totals exclude cost and PACE plans. Penetration reflects all managed care plans, though excludes counties missing from the penetration files (typically related to county-definition changes or small sizes).

In 2026, changes to plan offerings resulted in close to 3 million MA beneficiaries being impacted by plan terminations.[8] However, overall enrollment results suggest that most affected beneficiaries selected an alternative MA plan, with KFF estimating that 69% had the option to enroll in another plan from the same PO, and 99% had the option to enroll in another MA plan.[9] By our analysis, 1.2 million beneficiaries impacted by terminations were enrolled in PPOs, driven by UnitedHealth Group's decision to prioritize plans which more tightly manage cost and terminate many of its PPO plans.[10] Often, when POs terminate a plan, beneficiaries are automatically enrolled in similar plans with the same PO ("crosswalking"). However, by rule enrollees cannot be crosswalked from PPO to HMO plans. Still, overall PPO enrollment decreased by only 40,000, indicating that most beneficiaries affected by PPO terminations were still able to enroll in an alternative PPO plan.

ENROLLMENT BY PARENT ORGANIZATION

The seven largest POs have accounted for over 70% of MA enrollment since at least 2019. These include UnitedHealth, Humana, CVS Health, Kaiser, Elevance, Centene, and Health Care Service Corporation (HCSC).[11]

Table 2 shows MA enrollment split by these "Top 7" POs and "All Other" organizations. From 2019 to 2023, the top seven carriers grew faster than other organizations and increased their market share. From 2023 to 2026, their share has been flat or declining. This was most dramatic in 2026, where growth in Top 7 enrollment was 1.0%, compared to 9.7% in all other plans.

This shift in growth from large plans to smaller plans has coincided with CMS' three-year phase-in of the revised (V28) CMS-HCC risk adjustment model.[12] CMS projected that the revised model would put downward pressure on average MA risk scores.[13] While impacts vary at the PO-level, larger carriers with extensive chart review and other diagnosis capture programs may have experienced greater decreases in risk scores, potentially influencing strategic decisions around plan and benefit offerings during this period.

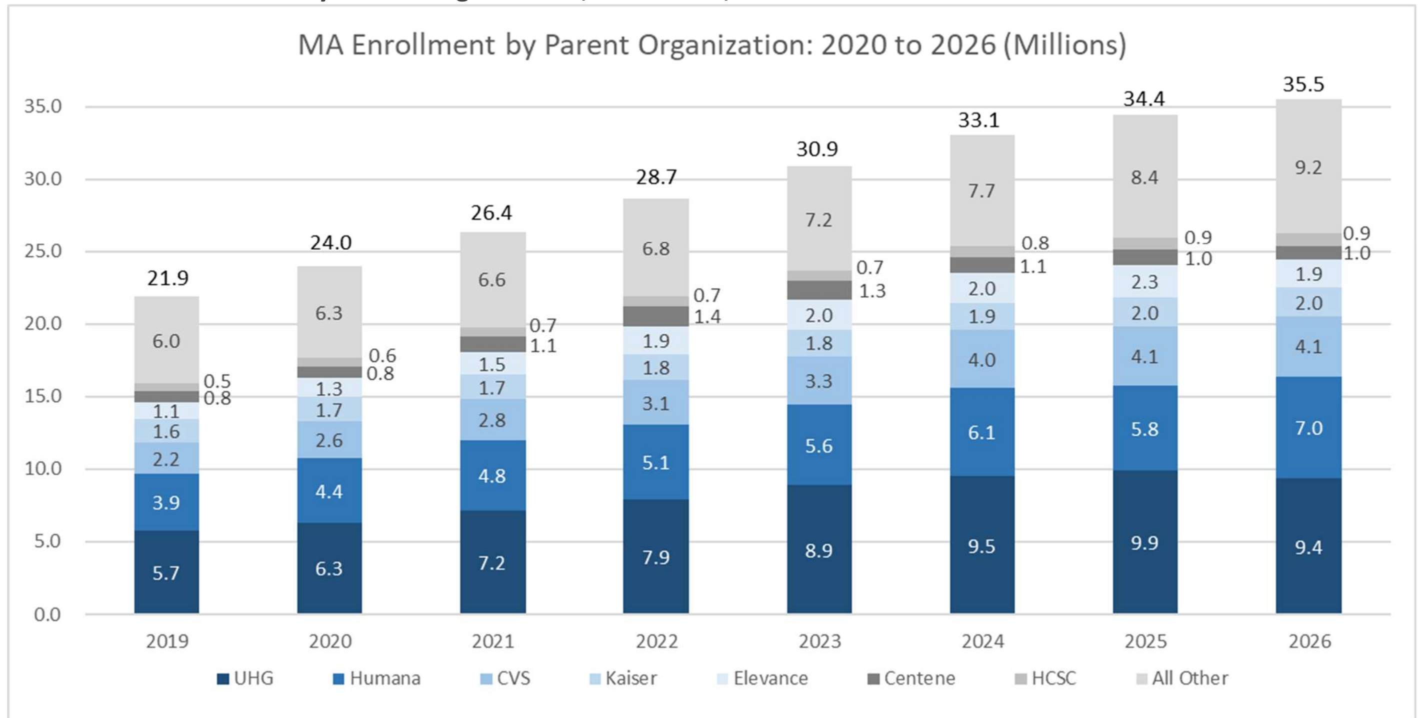
TABLE 2: MA ENROLLMENT – TOP SEVEN COMPARED TO ALL OTHER PARENT ORGANIZATIONS, 2019-2026, MILLIONS

Year	MA Annual Enrollment (Millions)			Y/Y Growth		
	Top 7	All Other	Total	Top 7	All Other	Total
2026	26.3	9.2	35.5	1.0%	9.7%	3.1%
2025	26.0	8.4	34.4	2.5%	9.0%	4.0%
2024	25.4	7.7	33.1	7.1%	7.3%	7.2%
2023	23.7	7.2	30.9	8.2%	5.7%	7.6%
2022	21.9	6.8	28.7	10.7%	2.8%	8.7%
2021	19.8	6.6	26.4	12.0%	5.0%	10.1%
2020	17.7	6.3	24.0	11.1%	5.5%	9.5%
2019	15.9	6.0	21.9			

Note: Source is authors' analysis of CMS penetration and enrollment files. The Top 7 includes UnitedHealth, Humana, CVS Health, Kaiser, Elevance, Centene, and HCSC. HCSC includes Cigna plans prior to acquisition. Centene includes Wellcare plans prior to acquisition. Values correspond to February in each year. MA enrollment totals exclude cost and PACE plans.

Chart 1 reflects the distribution of MA enrollment by PO from 2019 to 2026. Each of the top seven had steady increases in enrollment from 2019 to 2025. Between 2025 and 2026, UnitedHealth and Elevance experienced enrollment declines while CVS Health, Kaiser, Centene, and HCSC saw relatively flat enrollment, and Humana captured the majority of overall growth. Concurrently, the collective “All Other” smaller carriers maintained steady enrollment growth from 2019 to 2026, increasing their market share from 2024 to 2026.

Chart 1: MA Enrollment by Parent Organization, 2019-2026, Millions



Note: Source is authors' analysis of CMS penetration and enrollment files. The Top 7 includes UnitedHealth, Humana, CVS Health, Kaiser, Elevance, Centene, and HCSC. HCSC includes Cigna plans prior to acquisition. Centene includes Wellcare plans prior to acquisition. Values correspond to February in each year. MA enrollment totals exclude cost and PACE plans.

In the first half of 2025, large insurers reported earnings challenges as medical cost trends exceeded expectations. UnitedHealth and Elevance reduced their earnings projections by 15-40%, and Centene projected an even larger decline (reflecting challenges in both Medicaid and Medicare).[14] [15] [16] These elevated trends and earnings challenges emerged as plans were finalizing 2026 MA offerings due in early June. Importantly, because earnings reflect the margin between revenues and costs, a 40% reduction in earnings corresponds to only approximately a 3% deterioration in revenues relative to costs, meaning headline earning declines can seem to overstate the magnitude of underlying fundamentals.[17]

By mid-2025, trends and earnings began to stabilize. The largest publicly-reporting POs ultimately reported full-year 2025 earnings in line with or exceeding their mid-year projections.[18] [19] [20] [21] [22] On earnings calls, insurers indicated that 2026 pricing corresponded to elevated 2025 trends. For example, UnitedHealth explained that trend “was in line with our expectation of approximately 7.5% and supports our 2026 trend expectation of 10%,” and CVS Health noted that medical costs remained elevated and is “not expecting that to change in 2026.”

Taken together, these dynamics suggest that earnings and cost trends have stabilized heading into 2026, with potential upside if medical cost trends moderate from recent highs.

ENROLLMENT BY GEOGRAPHY

Most counties experienced growth in MA enrollment in 2026 across metropolitan (metro), non-metro, and remote areas. As shown in Table 3, 71% of metro, 62% of non-metro and 67% of remote counties experienced growth in non-SNP enrollment, and approximately 80% of counties experienced growth in SNP enrollment. Over a multi-year period, non-SNP growth has been faster in non-metro and remote areas, with annualized growth from 2019 to 2026 of 5% in metro areas, 7% in non-metro areas, and 8% in remote counties. SNP growth has been even more rapid, especially in non-metro (22% annualized) and remote (25% annualized) areas. These patterns are consistent with the rapid expansion in plan offerings, especially zero-premium plans, in non-metro and remote counties.[23]

From 2025 to 2026, however, a meaningful number of non-metro and remote counties experienced large reductions in MA plan offerings and corresponding enrollment. As shown in Table 3, 5% of non-metro and 7% of remote counties experienced reductions in enrollment of greater than 25%. Of these, most impacted beneficiaries were in Vermont and Minnesota, where 150,000 beneficiaries reside in counties that no longer have an MA option.

Overall, these results indicate that while individual POs made targeted changes to their geographic footprints, MA options remained widely available across the vast majority of geographies.

TABLE 3: MA ENROLLMENT BY GEOGRAPHY

	Non-SNP			SNP		
	Metro	Non-Metro	Remote	Metro	Non-Metro	Remote
2026 Enrollment (Millions)	22.5	2.5	1.3	6.5	0.8	0.4
Portion of Counties with 2026 Growth	71%	62%	57%	85%	84%	78%
Portion of Counties with 2026 Decrease of more than 25%	2%	5%	7%	3%	2%	4%
2026 vs 2025 Enrollment Change	1%	0%	-1%	14%	11%	8%
2026 vs 2022 Enrollment Change (Annualized)	3%	4%	4%	16%	18%	18%
2026 vs 2019 Enrollment Change (Annualized)	5%	7%	8%	16%	22%	25%

Note: Source is authors' analysis of CMS enrollment files. Remote is defined as counties with a Rural-Urban Continuum Code 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.

SUPPLEMENTAL BENEFIT PREVALENCE AND AVERAGE VALUES

In the recently released March 2026 Report to the Congress, MedPAC reported that average plan rebates increased to all-time highs for both non-SNPs ($199 per month in 2026, up 6%) and SNPs ($275 per month, up 1%).[24] Plans must use rebates to fund benefit enhancements relative to traditional Medicare – including cost sharing reductions, supplemental benefits, and Part B or D premium buy-downs. Therefore, rebates are a key indicator of the overall value of supplemental benefits.

Rebates reflect the difference between risk-adjusted CMS benchmarks and plan bids (i.e., the costs to plans to provide traditional Medicare benefits). Increases in rebates generally indicate that risk-adjusted benchmarks increased faster than bids. Several factors can drive this dynamic, including the CMS-set payment growth rate, risk

model updates, star rating changes, anticipated medical inflation, and competitive pressures. We previously estimated that 2026 funding for MA would increase by 8.5%, high by historical standards.[1]

However, all-time high rebates do not necessarily translate to all-time high enhanced benefits if the cost of providing those benefits is also increasing. Using actual enrollment data to develop weighted-average benefit values across MA, we found modest declines in enrollment-weighted benefits in several categories.[25] Our findings are consistent with recent Milliman and Wakely reports on enrollment-weighted benefits.[26, 27]

Table 4 summarizes changes across key benefit categories. We focus on adding additional context to the benefit changes and exploring potential drivers of the divergence between increasing rebate dollars and declining benefit values. For premium and cost-sharing measures, the analysis focuses on non-SNPs, as these features are less relevant for SNP beneficiaries whose costs are often covered by Medicaid.

TABLE 4: SUMMARY OF BENEFIT CHANGES FROM 2025 TO 2026

Benefit	Discussion
MAPD Premiums (Non-SNPs)	In 2026, 76% of beneficiaries are enrolled in zero-premium plans, in line with 2025, and up from 69% in 2022. Across all beneficiaries, average premiums are $14.29, up from $12.64 in 2025.
Part B Premium Buy-down (Non-SNPs)	Thirty-one percent of beneficiaries are in plans that include a Part B premium buy-down in 2026, consistent with 2025 and up from 7% in 2022. Average buy-down amounts increased to $62 per month in 2026 from $44 in 2025. This, combined with stable, low MAPD premiums, demonstrates that POs have increasingly prioritized lowering up-front premium costs over benefit values.
Part C MOOP (Non-SNPs)	Enrollment-weighted maximum out of pocket (MOOP) amounts increased 7% in 2026, to $5,438 per year, from $5,086 in 2025. Despite this increase, MOOP levels are only 10% higher than in 2022, well below cumulative medical cost trends over that period.
Physician Copays (Non-SNPs)	Primary care copays are $0 for the vast majority of beneficiaries in 2026, consistent with prior years (enrollment-weighted average of $0.51 in 2026 compared to $0.67 in 2025). Specialty copays increased to $32.73 in 2026 from $28.79 in 2025, and $30.49 in 2022.
Medical Deductibles (Non-SNPs)	Deductibles remain uncommon in Medicare Part C but are increasing in prevalence, with 12% of beneficiaries in plans with deductibles in 2026, up from 9% in 2025 and 6% in 2022. Average deductible amounts are $506 per year in 2026, up from $463 in 2025, but down from $752 in 2022. This reflects the introduction of more plans with lower-dollar deductibles.
Dental and Vision	Over 98% of beneficiaries are in plans with dental and vision supplemental benefits, consistent with the past several years.

Benefit	Discussion
Over-the-Counter and Supplemental Benefits	Over-the-counter (OTC) and additional supplemental benefits offered through programs like Special Supplemental Benefits for the Chronically Ill (SSBCI) have increasingly been offered through electronic debit cards ("flex cards"). Flex cards are much easier for beneficiaries to use than submitting reimbursement retrospectively, and therefore cost plans more to offer, as more beneficiaries fully take advantage of these benefits. **Non-SNPs**: In 2026, 69% of beneficiaries have access to an average annual benefit of $283, down from 81% and $340 in 2025. **SNPs:** OTC and additional supplemental benefits remain more common and significantly richer in SNPs. Beneficiaries and plans prioritize these cash-like benefits, because reducing premiums and cost-sharing is less meaningful to D-SNP beneficiaries, where those costs are often paid by Medicaid. In 2026, 99% of SNP beneficiaries have access to an average benefit of $1,798 per year, down from $1,934 in 2025. The 2026 average benefit levels are still more than $400 higher, on average, than in 2022.
Part D (Prescription Drug)	Pharmacy benefits have seen the most meaningful changes over the past two years, corresponding to benefit changes resulting from the Inflation Reduction Act. Similar to Part C, plans have generally prioritized maintaining low premiums (zero for most beneficiaries). Higher utilizing beneficiaries have benefited meaningfully from the 2026 statutorily determined out-of-pocket cap of $2,100 on all Part D plans, while lower utilizing beneficiaries are subject to higher deductibles and cost sharing, as discussed in more detail in the Part D Benefits section below.

Part D (Prescription Drug) Benefits Deeper Dive

The Inflation Reduction Act (IRA) of 2022 mandated meaningful changes to Part D benefit designs. With the introduction of a $2,000 annual out-of-pocket cap in 2025, the IRA materially reduced out-of-pocket spending for beneficiaries with high drug utilization. To offset this and other benefit changes, POs have had to consider adjustments to premiums, cost sharing, and formulary design. The result is that the IRA has made prescription drugs less expensive for higher utilizers and introduced tradeoffs that are less favorable for those with lower drug use.

Chart 2 illustrates how the prevalence and amount of key Part D benefit parameters have evolved in recent years. From 2022 to 2024, enrollment-weighted average Part D premiums (net of rebates), deductible values and prevalence, and coinsurance and copay values and prevalence remained generally consistent.

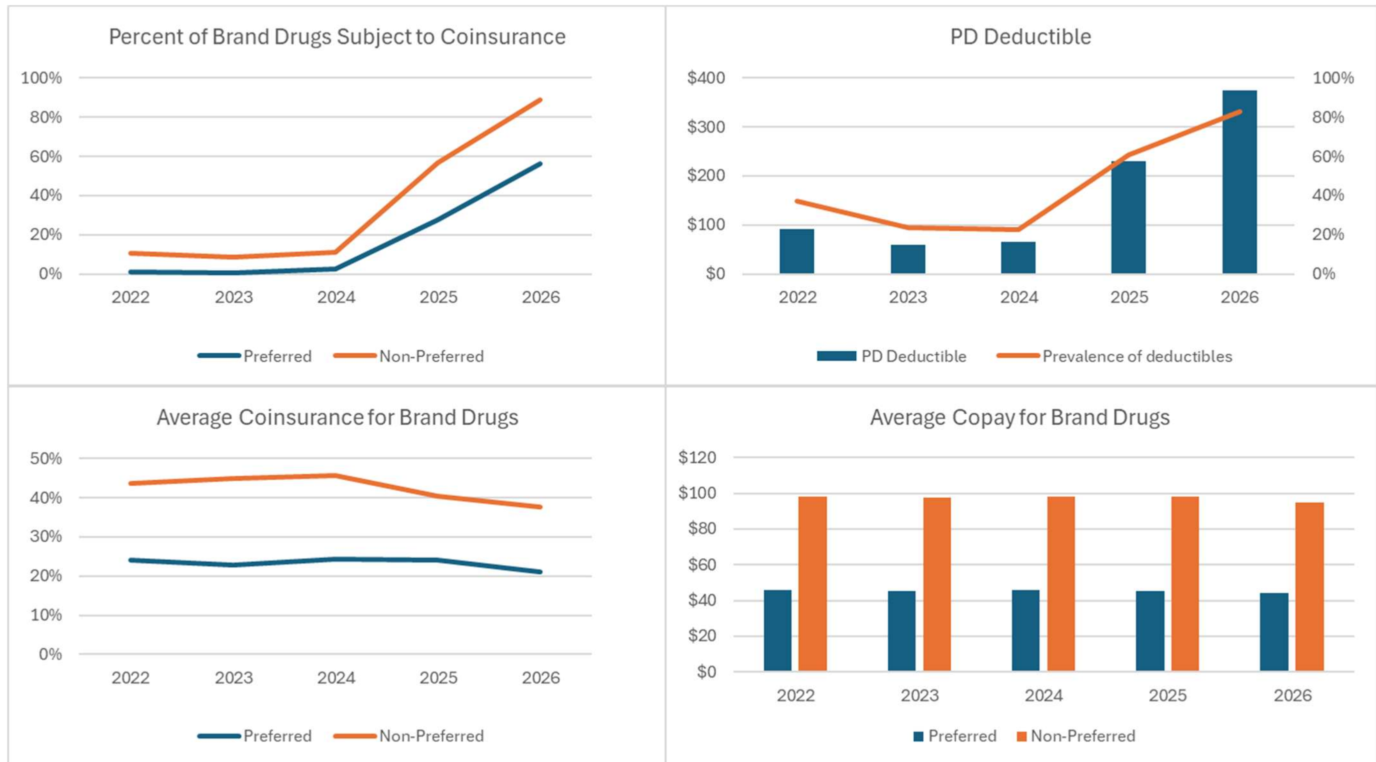
From 2025 to 2026, most of the IRA provisions related to Part D took effect, with the most significant changes occurring in 2025. POs prioritized maintaining relatively flat Part D premiums while allowing higher cost sharing under the out-of-pocket cap, in the form of increased deductibles and a meaningful increase in the prevalence of coinsurance on brand drugs.

Enrollment-weighted non-SNP Part D premiums went up slightly in 2026 to $8.37 from $6.80 in 2025 (net of rebates, not shown in chart). However, premiums have declined from $10.90 in 2022, and the portion of beneficiaries who pay no premium for MAPD plans is at an all-time high of 76% for 2026. Despite rising drug costs, POs allocated an average of $11 less in rebates for non-SNPs to buy down Part D premiums in 2026 than in 2023, in part due to the IRA premium stabilization provision capping growth in the base beneficiary premium.[24]

The portion of plans that have a Part D deductible and the value of the deductible have both significantly increased in 2025 and 2026. Among non-SNP plans, 83% of beneficiaries are now subject to an average deductible of $375, up

from 24% and $59 in 2023. POs have also meaningfully updated their cost sharing structures for both preferred and non-preferred brand drugs. While fewer than 2% of beneficiaries were subject to coinsurances for preferred brand drugs in the 2022 to 2024 period, nearly 60% are subject to preferred brand coinsurance in 2026. For non-preferred brands, the portion of beneficiaries subject to coinsurance has increased to nearly 90%. Despite this increase in prevalence, average coinsurance and copay amounts have remained steady. The net effect of the out-of-pocket cap provision in the IRA, combined with higher deductibles and shifts away from copays and towards coinsurance, is that lower utilizing non-low-income beneficiaries are subject to higher cost sharing prior to reaching the out-of-pocket cap.

CHART 2: PREVALENCE AND AVERAGE BENEFIT VALUES (PART D, NON-SNPS)



Note: Source is authors' analysis of CMS enrollment and benefit files.

PARENT ORGANIZATION BENEFIT STRATEGIES

While directional changes in benefits across the seven largest POs are broadly similar, there are some distinctions which demonstrate strategic differences in how plans prioritize benefit design.

The largest organization, UHG, uses Part C deductibles rarely, with fewer than 2% of non-SNP enrollment in deductible plans in 2026, 10% below the national enrollment-weighted average. However, UHG also has fewer enrollees with a Part B premium buydown (13% compared to 31% nationally) and OTC/SSBCI supplemental benefits are approximately $100 lower than the national average. For Part D, UHG uses deductibles more frequently, with average deductibles $90 higher than national averages for non-SNPs. Preferred and non-preferred brands are both subject to coinsurance, but preferred brands average 17% compared to the national average of 21%.

Humana, which had the most enrollment growth among the largest POs in 2026, uses medical deductibles more frequently than average, with 33% of non-SNP enrollment in plans with deductibles. However, the value of such

deductibles is $100 less than the national average. Humana offers Part B benefit buy-downs more frequently than average; more than 75% of beneficiaries have this benefit. For Part D non-SNP, Humana also frequently uses deductibles, with 83% of beneficiaries subject to them with amounts that are $20 higher than national averages.

Kaiser, the fourth largest organization by enrollment, prioritizes cost sharing reductions for traditional benefits, with MOOPs $1,860 lower, on average, than national averages. No beneficiaries are subject to either a medical or Part D deductible. However, Part B premium buy-downs are much less prevalent and OTC and additional supplemental benefits are $180 lower than national averages.

A separate appendix contains additional details on PO-specific benefit averages across the 2022 to 2026 period.[28]

CONCLUSIONS

MA enrollment in 2026 shows the market remains strong and stable. Despite stakeholders' focus on plan terminations and benefit changes, enrollment through 2026 AEP continued to grow, increasing by 1.1 million with market penetration reaching 51.6% of Medicare beneficiaries. The popularity of MA reflects benefits that remain near all-time highs and are significantly more generous than traditional Medicare. Growth was driven by continued SNP expansion and modest gains in non-SNP HMOs, while PPO and EGWPs declined slightly after years of growth.

There are exceptions to these overall trends. A small number of counties experienced large enrollment declines, associated with targeted, localized plan exits such as those in Minnesota and Vermont. Furthermore, nearly 3 million beneficiaries were impacted by plan terminations. While most of these beneficiaries selected alternative MA plans, many likely faced changes in provider networks and benefit structures.

At the same time, market dynamics have begun to shift. The seven largest POs, which account for over 70% of MA enrollment, have seen their combined market share decrease as growth among smaller carriers has accelerated. Although the relatively large 2026 payment update led to record high rebate levels, large insurers continue to cite rising medical costs, changes in federal funding, and the phased implementation of CMS' V28 risk adjustment model as challenges influencing benefit design and plan offerings.

Looking forward, recent earnings commentary conveys confidence in 2026 financial projections, reflecting some stabilization in medical cost trends. However, CMS recently finalized a 2027 MA rate increase of approximately 5% (including expected coding trend), lower than the 8.5% funding increase for 2026. The implications of this increase will depend on how medical cost trends emerged through the first few months of 2026, as insurers finalize 2027 bids this month.

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. Brandi Dries, Ryan Brake, and Tim Bulat 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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END NOTES

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[17] Because earnings reflect the margin between revenues and costs, percentage changes in earnings can overstate underlying cost pressures. For example, if revenues remain at 100 and costs increase from 92 to 95, earnings decline from 8 to 5 (−38%), even though revenues still exceed costs and this reflects only a ~3% increase in costs relative to revenues. An 8% margin is broadly consistent with reported Medicare Advantage margins for large insurers such as UnitedHealth in 2024.
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[23] See our previous brief (refer to end note 1) for additional insight into the recent rapid expansion in plan offerings, especially zero-premium plans, in non-metro and remote counties.
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[25] In our prior report (refer to end note 1), we identified modest reductions in some benefits. Updating that analysis using actual enrollment yields similar findings.
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[27] Marino D, Nelessen A. The Value Shift: How Medicare Advantage Benefits are Evolving for 2026: 2026 Enrollment Updates. https://www.wakely.com/wp-content/uploads/2026/02/The-Value-Shift-How-Medicare-Advantage-Benefits-Are-Evolving-for-2026.pdf
[28] Refer to the separate Appendix [Medicare Advantage in 2026 - Actual Enrollment and Benefit Results, in Context (2026.06.08)] document, accompanying this brief, for additional details on specific Parent Organization benefit averages across the 2022 to 2026 period.