ANALYSIS OF THE 2026 MEDICARE ADVANTAGE PLAN LANDSCAPE

The 2026 Medicare Advantage Landscape Signals Shifting Benefits And Rising Costs For Some Beneficiaries

BETTER MEDICARE
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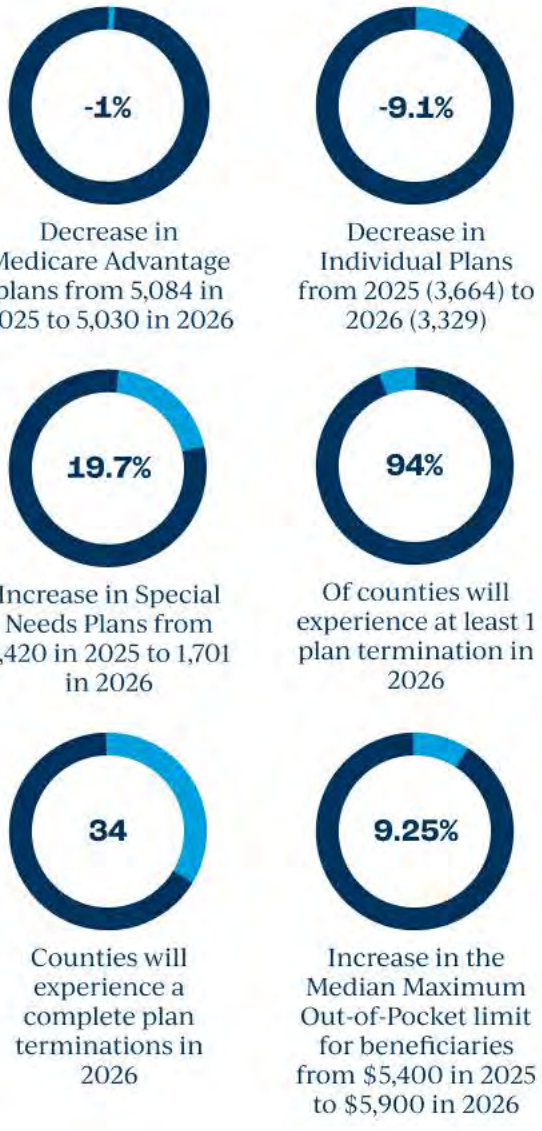
Executive Summary

Recent legislative and regulatory changes to the Medicare Advantage program have increased requirements on plans and put pressure on the funding required for benefits. As a result, many plans are reducing plan and benefit offerings, increasing potential out-of-pocket costs to beneficiaries, or exiting the market all together. In 2026, the number of Medicare Advantage plans nationally will decrease from 5,084 in 2025 to 5,030 in 2026, including a decrease from 3,664 (2025) to 3,329 (2026) individual Medicare Advantage plans, and an increase from 1,420 (2025) to 1,701 (2026) in Special Needs Plans (SNPs). Among the top 25 parent organizations by number of plan offerings, 52% are decreasing their individual plan offerings while 64% are increasing their SNP offerings. At the same time, the number of zero-dollar premium plans will rise slightly from 2,977 in 2025 to 2,995 in 2026, driven primarily by growth in zero-dollar premium SNPs.

While most beneficiaries will still have multiple coverage options, plan exits are creating notable gaps in certain regions: 34 counties across six states (California, Montana, Oregon, South Dakota, Vermont and Wyoming) had all of their 2025 Medicare Advantage plans fully terminate for 2026. More broadly, 94% of counties experienced at least one plan termination heading into 2026. Meanwhile, the median maximum out-of-pocket (MOOP) limit for beneficiaries will increase from $5,400 to $5,900 in 2026. Although most plans will continue to offer dental, vision, and hearing benefits, many individual plans are decreasing their supplemental benefits that close coverage gaps, such as transportation, over the counter (OTC) benefits, meals and nutrition assistance. Not all changes will be negative; for example, more plans will continue offering in-home support services, with an increase to 13% of plans offering the benefit in 2026 (up from 9% in 2025).

State-level variation remains substantial, but the national trend indicates a clear retrenchment among Medicare Advantage plans in a challenging environment with increased healthcare utilization and policy changes putting pressure on plan operations and payment.

Figure 1: Key Changes in 2026 Medicare Advantage Landscape



Background on Medicare Advantage

Medicare Advantage is the managed care option in Medicare and is a public-private partnership, meaning benefits are offered by private health plans and approved by the federal government. Medicare Advantage provides the same inpatient and outpatient services as Medicare Fee-for-Service, but also additional benefits and services such as an integrated Part D plan, reduced cost sharing, and supplemental benefits. Nearly all beneficiaries enrolled in Medicare Advantage plans also receive additional supplemental benefits not covered under Fee-For-Service (FFS) Medicare, such as dental, vision, and hearing coverage. In 2025, 34.1 million beneficiaries chose Medicare Advantage, representing 54% of Medicare enrollment.

The Medicare Advantage Population is More Diverse than Ever

The Medicare Advantage population is increasingly diverse and more complex. Today's Medicare Advantage beneficiaries have higher rates of clinical and social risk factors than those in Fee-for-Service Medicare. More beneficiaries in Medicare Advantage are low-income, identify as a racial and ethnic minority, and have more chronic conditions.

31% of Medicare Advantage enrollees identify as Black, Latino, or Asian, compared to about 18.8% of beneficiaries in Fee-For-Service Medicare[1]

52% of Medicare Advantage beneficiaries live below 200% of the federal poverty level[2]

1. Better Medicare Alliance, State of Medicare Advantage, 2025 Report.
2. Better Medicare Alliance, State of Medicare Advantage, 2025 Report.

Context for 2026 Medicare Advantage Plan Offerings

Recent regulatory and legislative developments continue to shape the environment for 2026 Medicare Advantage plan offerings. Although CMS projects modest payment growth for 2026, plans are simultaneously navigating several structural changes that increase operational and financial complexity.

These include the full phase-in of the updated CMS–HCC risk adjustment model (V28), continued implementation of the Inflation Reduction Act's Part D benefit redesign, ongoing adjustments to Medicare Advantage benchmarks, and declining Star Ratings, which reduce quality bonus payments, therefore tightening benefit budgets. Plans are also reporting higher utilization, which is adding additional financial strain across the program.[1]

Plans are also adapting to heightened oversight, expanded reporting and data submission requirements, and evolving expectations related to marketing, beneficiary communications, and network adequacy. Collectively, these factors are reshaping the operating landscape for Medicare Advantage organizations, requiring many to re-evaluate benefits, pricing, and administrative strategies as they prepare their 2026 offerings.

Better Medicare Alliance analyzed the 2026 landscape and benefits data to better understand how Medicare Advantage plans are responding to these pressures and the impact on beneficiaries. Each year, CMS releases the Medicare Advantage and Part D Landscape and Plan Benefit Package files, which detail plan offerings and premiums in advance of the Medicare annual enrollment period. CMS released the Medicare Advantage and Part D Landscape files for calendar year 2026 on September 26, followed shortly thereafter by the Plan Benefit Package files. This issue brief highlights the recent changes in plan availability and offerings for beneficiaries in advance of the 2026 enrollment period. The analysis excludes Medical Savings Account (MSA), Private Fee-for-Service (PFFS), Employer Group Waiver (EGWPs), Program of All-inclusive Care for the Elderly (PACE), Cost, and Demonstration plans.

Beneficiaries Can Enroll in Different Types of Medicare Advantage Plans Based on Eligibility

Individual Plans

Most beneficiaries in Medicare Advantage are enrolled in "individual" Medicare Advantage Prescription Drug (MA-PD) plans which integrate coverage for Medicare Part A, B, and D benefits, as well as provide supplemental benefits. A small portion of beneficiaries are enrolled in Medicare Advantage plans that provide only Part A and B coverage. These plans include Preferred Provider Organizations (PPO) and Health Maintenance Organizations (HMO).

Special Needs Plans

A subset of beneficiaries can choose to enroll in Special Needs Plans (SNPs), which are Medicare Advantage plans for beneficiaries who are dually eligible for both Medicare and Medicaid (D-SNP), beneficiaries with certain chronic conditions (C-SNP), or beneficiaries who require institutional level care (I-SNP). Nearly all Medicare Advantage beneficiaries enrolled in a SNP are enrolled in a D-SNP, which provide tailored benefits for beneficiaries who are dually eligible. In 2025, 7.2 million beneficiaries are enrolled in SNPs.[1]

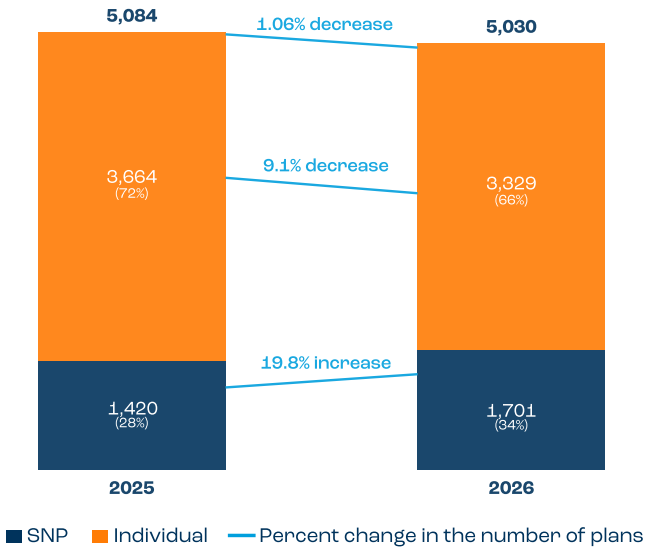
1. Analysis of the Centers for Medicare & Medicaid Services Monthly Contract Summary Reports, January 2017-2025. Available here.

Key Findings from Analysis of the 2026 Medicare Advantage Plan Offerings

Availability of Plans

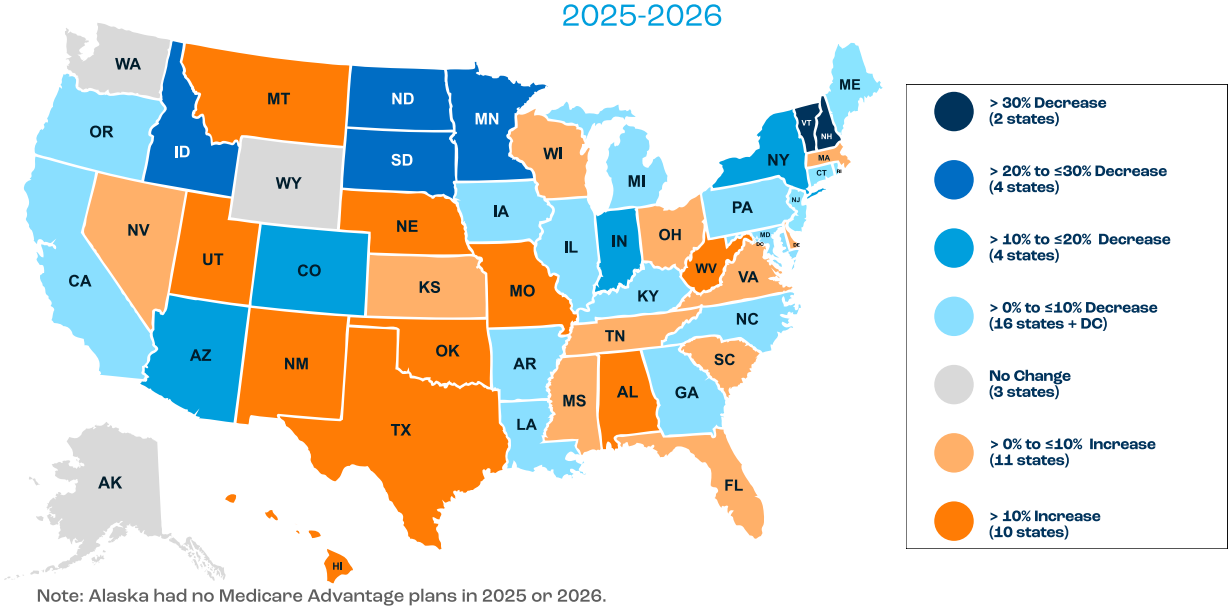
Consistent with the trend in 2025, the 2026 landscape shows a continued decline in the total number of Medicare Advantage plans, driven primarily by a reduction in individual plan offerings despite growth in SNPs. The total number of Medicare Advantage plans is decreasing by 1.06% (-45 plans) nationwide. From 2025 to 2026, the number of individual plans decreased by 9.1%; while the number of SNPs increased by 19.8% (Figure 2). Of the top 25 parent organizations by number of plan offerings, 52% are decreasing their individual plan offerings while 64% are increasing their SNP offerings.

Figure 2: Number of Plans by SNP and Individual Plan, 2025-2026



However, the change in the number of plans available from 2025 to 2026 varies greatly at the state level: 6 states (Idaho, Minnesota, New Hampshire, North Dakota, South Dakota, and Vermont) are experiencing a greater than 20% decrease in the number of Medicare Advantage plans, while 10 states (Alabama, Hawaii, Missouri, Montana, Nebraska, New Mexico, Texas, Oklahoma, Utah, and West Virginia) are experiencing a greater than 10% increase in the number of plans (Figure 3). Vermont's change is worth noting, as the state experienced a greater than 30 percent increase in Medicare Advantage plan availability from 2024 to 2025, but is now seeing a significant decrease heading into 2026.

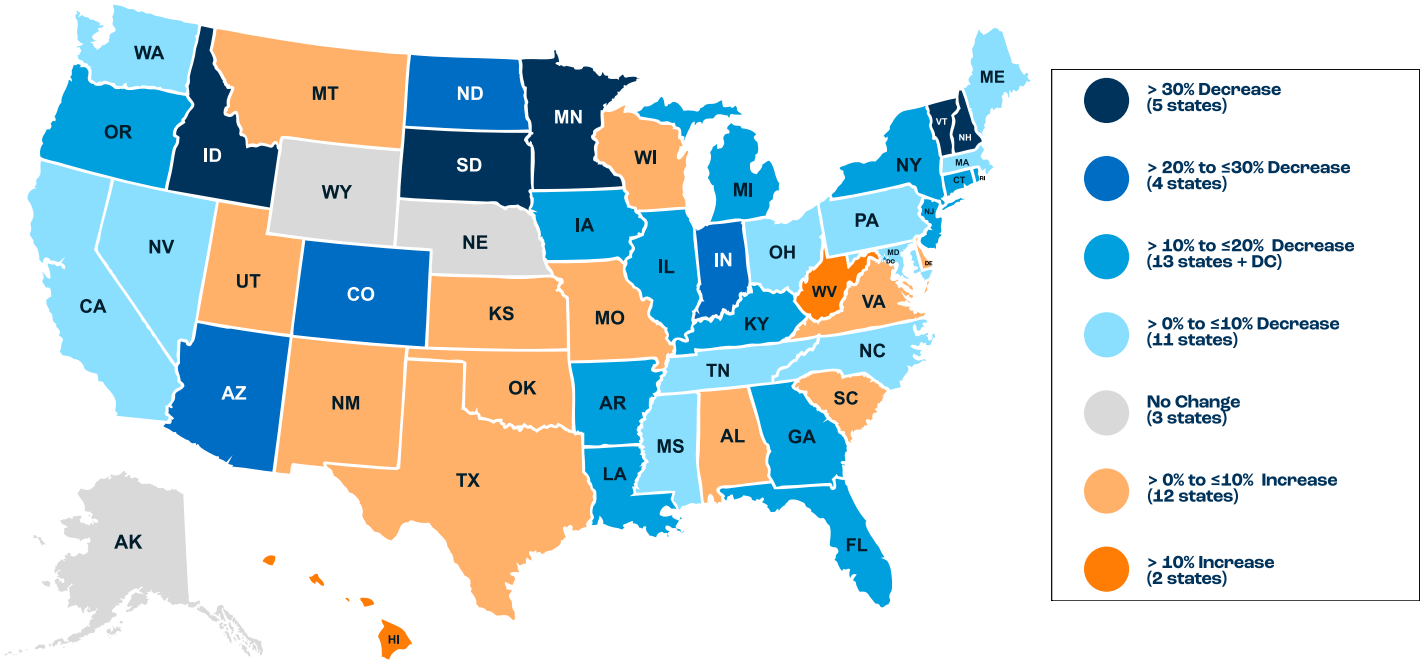
Figure 3: Percent Change in the Number of All Medicare Advantage Plans, 2025-2026



Note: Alaska had no Medicare Advantage plans in 2025 or 2026.

The number of individual Medicare Advantage plans is increasing in 14 states and decreasing in 33 states and Washington D.C. (Figure 4).

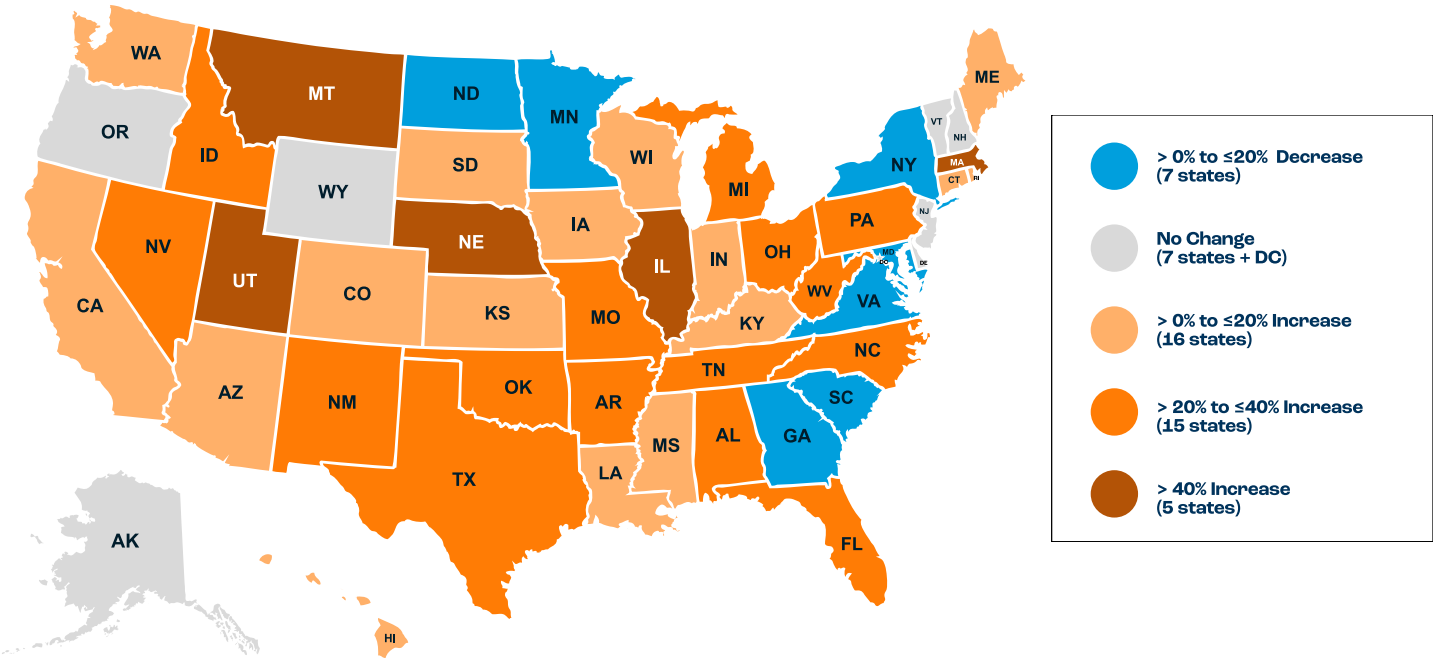
Figure 4: Percent Change in the Number of Individual Plans, 2025-2026



Note: Alaska had no Medicare Advantage plans in 2025 or 2026.

The availability of SNPs varies by state as well, with an increase in the number of SNPs (36 states) and a decrease in 7 states. (Figure 5).

Figure 5: Percent Change in the Number of SNPs, 2025-2026



Note: Alaska had no Medicare Advantage plans in 2025 or 2026. Vermont had 1 SNP in 2025 and no SNPs in 2026.

Plan Terminations

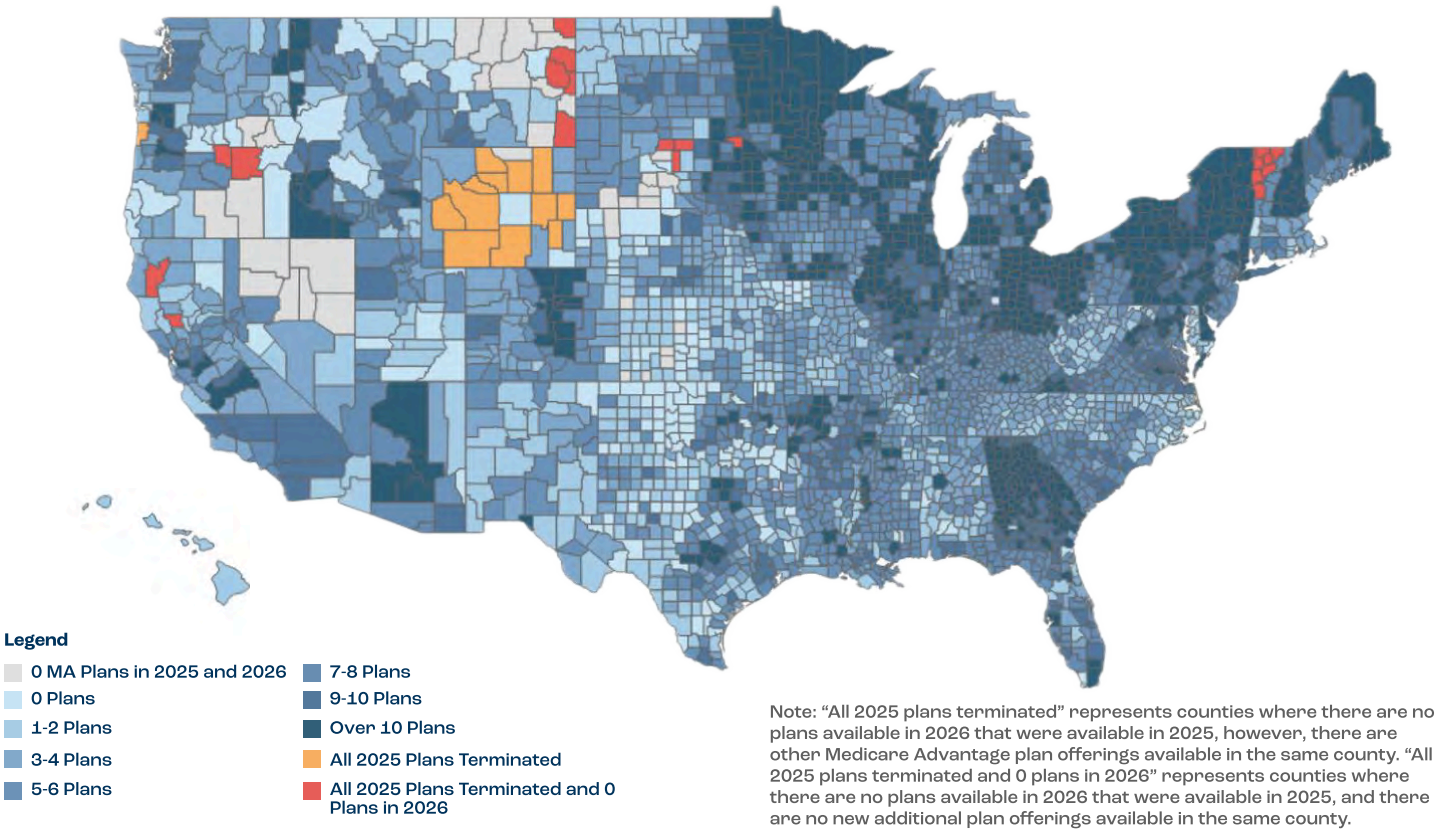
As in 2025, plan terminations continue to contribute to changes in Medicare Advantage plan availability heading into 2026. While most beneficiaries will still have multiple coverage options, full exits, crosswalk activity, and targeted service area reductions illustrate ongoing portfolio streamlining across several parent organizations.

A **plan crosswalk** occurs when a Medicare Advantage organization discontinues a plan but automatically enrolls its members into a different plan offered by the same parent organization for the next contract year. CMS permits crosswalking when the plan accepting the members is determined to be a similar plan to the one being discontinued.

Fully terminated plans remain concentrated geographically. More than half of all Medicare Advantage plans were fully terminated in Vermont and South Dakota, representing the highest share of complete exits nationwide. Although these states have smaller Medicare Advantage populations overall, several large markets are also significantly affected by full terminations. New York, Minnesota, Pennsylvania, and California each have more than 100,000 beneficiaries enrolled in plans in 2025 that will not return in 2026.

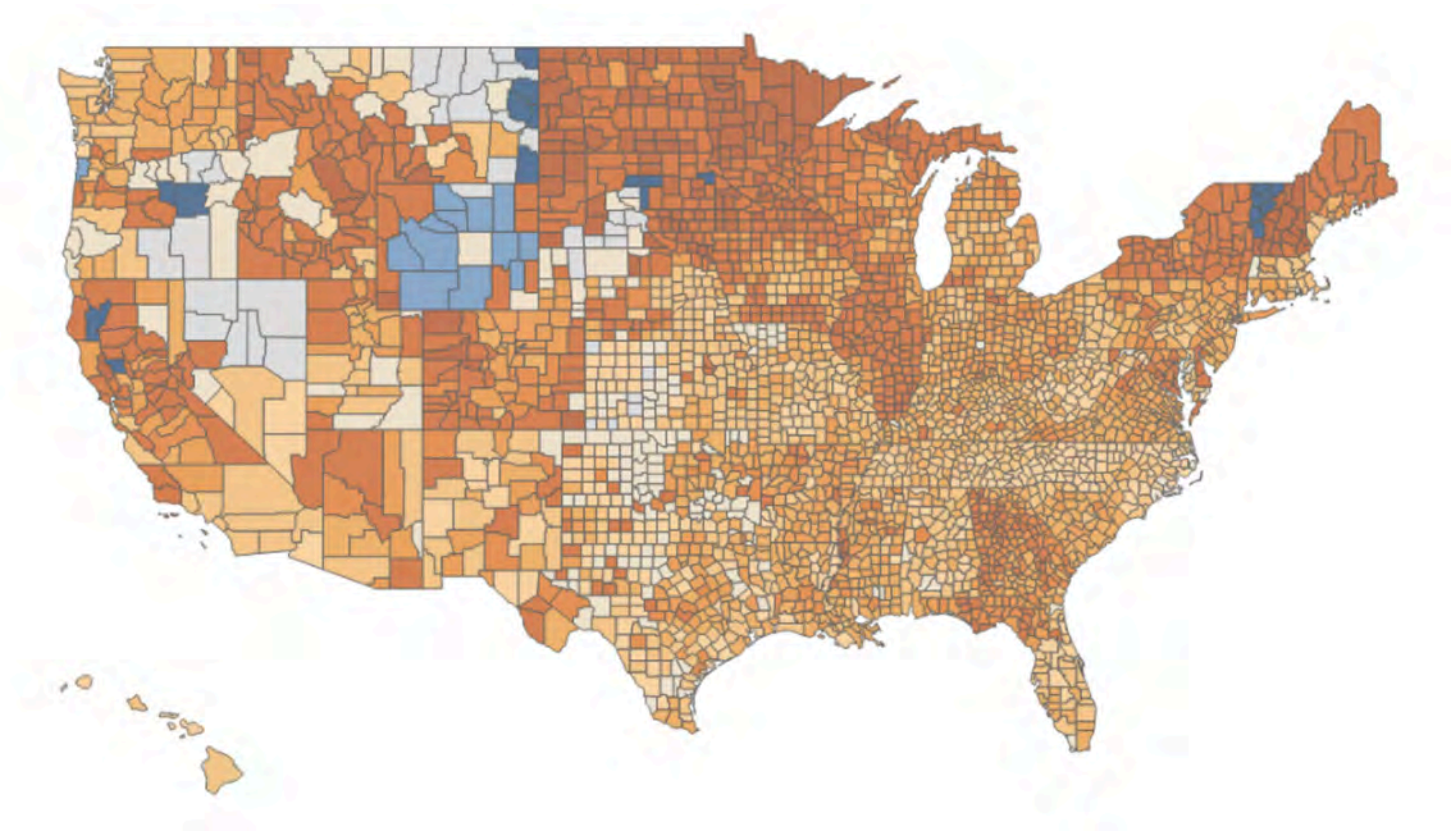
At the local level, 94% of counties experienced a plan termination. Complete exits were highly concentrated: 34 counties across six states (California, Montana, Oregon, South Dakota, Vermont and Wyoming) had all of their 2025 Medicare Advantage plans fully terminate for 2026 (Figures 6 and 7; see Appendix for a full list of counties). A small number of large counties—such as Erie and Monroe (NY), Hennepin (MN), Ada (ID), Maricopa (AZ), and Prince George's (MD)—each had more than 25,000 beneficiaries enrolled in plans that will be fully terminated for 2026.

Figure 6: County Map by Plan Count, 2025-2026



Note: "All 2025 plans terminated" represents counties where there are no plans available in 2026 that were available in 2025, however, there are other Medicare Advantage plan offerings available in the same county. "All 2025 plans terminated and 0 plans in 2026" represents counties where there are no plans available in 2026 that were available in 2025, and there are no new additional plan offerings available in the same county.

Figure 7: Plan Terminations by County, Percent of Plans



Note: "All 2025 plans terminated" represents counties where there are no plans available in 2026 that were available in 2025, however, there are other Medicare Advantage plan offerings available in the same county. "All 2025 plans terminated and 0 plans in 2026" represents counties where there are no plans available in 2026 that were available in 2025, and there are no new additional plan offerings available in the same county.

Crosswalks to plans under the same parent organization account for many of the transitions in 2026, particularly in states with large Medicare Advantage markets. These transitions preserve enrollee continuity while enabling organizations to consolidate product offerings. A smaller share of beneficiaries were crosswalked to plans under a different parent organization, reflecting continued consolidation and acquisition activity in select regions.

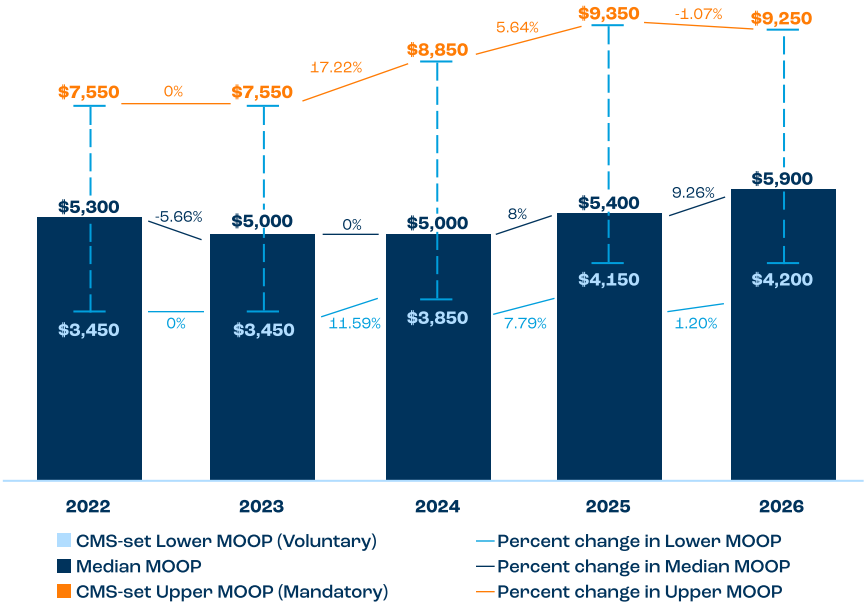
Service area reductions (i.e. instances where a plan withdraws from select counties while continuing to operate elsewhere) occurred in a number of counties. The counties with the largest number of beneficiaries impacted are located in Washington, California, Virginia, and New York. These reductions do not represent full exits but can meaningfully limit plan availability in affected communities.

Maximum Out-of-Pocket Limits

All Medicare Advantage plans must have a maximum out-of-pocket limit (MOOP) at or below a maximum set annually by CMS—$9,350 in 2025 and $9,250 in 2026. In addition, plans with a MOOP at or below a lower, voluntary threshold—$4,150 in 2025 and $4,200 in 2026—gain additional cost-sharing flexibility for certain services.

In 2026, the median MOOP will increase by $500 to $5,900, a 9.3% increase from $5,400 in 2025 (Figure 8). 97% of plans will offer reduced MOOP (below the annual limit set by CMS).

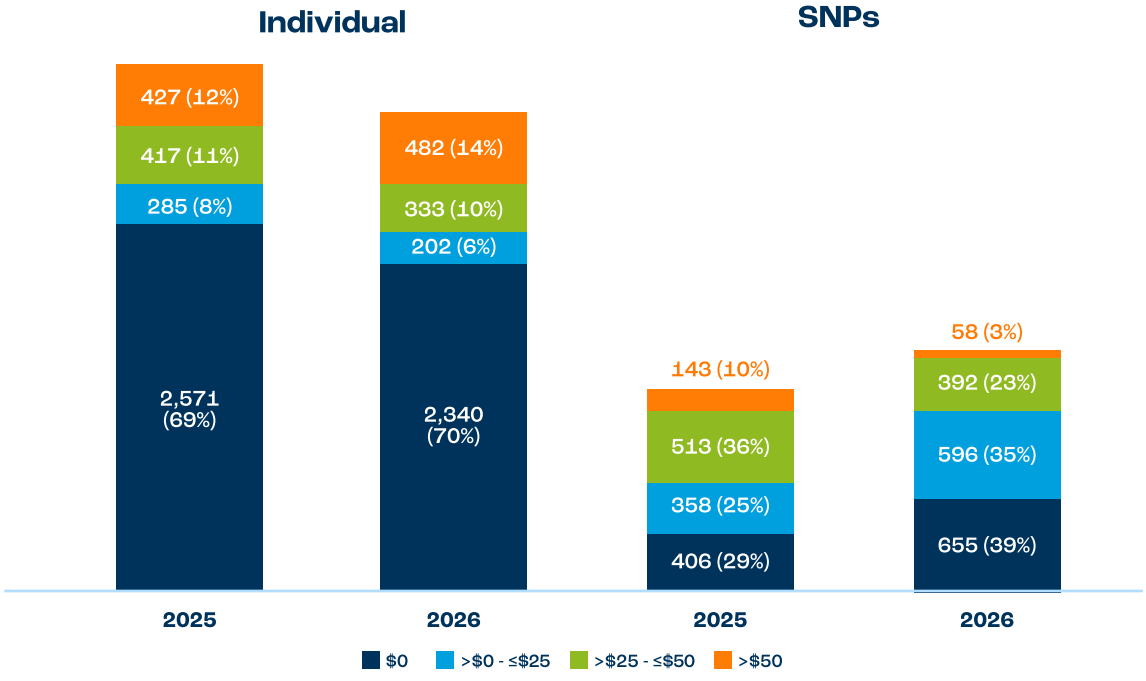
Figure 8: Maximum OOP Limits, Non-SNPs 2022-2026



Premium Trends

Medicare Advantage plans generally avoid increasing premiums and typically look to other levers first before adjusting monthly beneficiary costs.[2] However, the number of zero-dollar premium plans increased from 2,977 in 2025 to 2,995 in 2026. This change is driven by an increase in zero-dollar premium SNPs (from 406 in 2025 to 655 in 2026). By contrast, the number of zero-dollar individual plans declined from 2,571 in 2025 to 2,340 in 2026. Among plans with a premium, the average premium will be $46.64 in 2026 compared to $49.41 in 2025.

Figure 9: Number of Plans by Premium Amount, 2025-2026

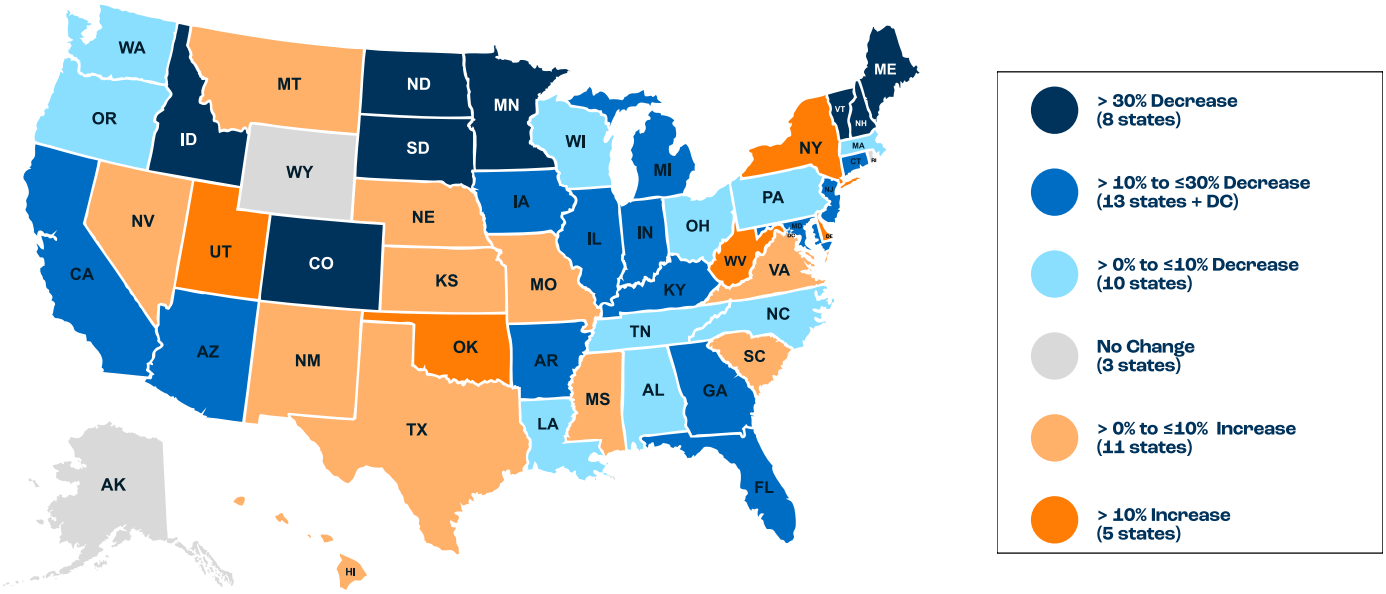


Note: Premium is defined as the monthly consolidated Part C + Part D premium.

Plans reduced the number of offerings with premiums between $25 and $50 in favor of more offerings with premiums under $25.

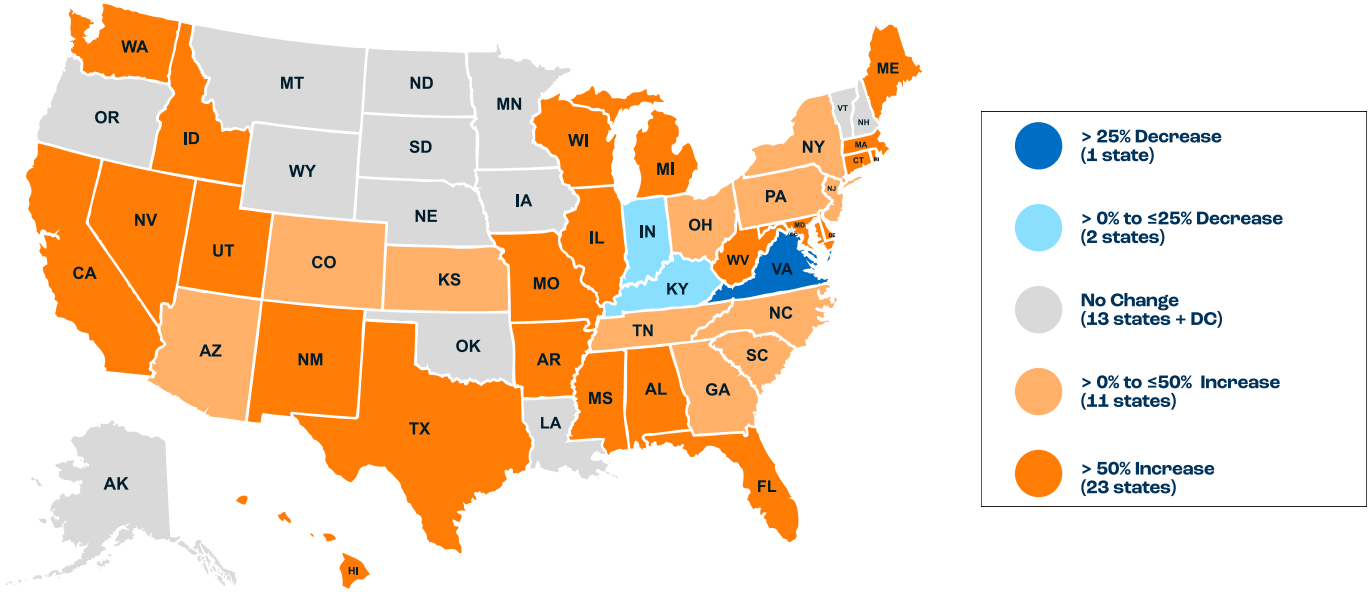
There is substantial variation by state in the availability of zero dollar-premium individual plans, with increases in 16 states and decreases in 31 states and Washington D.C. (Figure 10).

Figure 10: Percent Change in the Number of $0-Premium Individual Plans, 2025-2026



The availability of zero-dollar premiums in SNP plans increases in most states (34), with a decrease in the number of zero-dollar premium SNPs in only 3 states (Figure 11).

Figure 11: Percent Change in Number of $0-Premium SNPs, 2025-2026



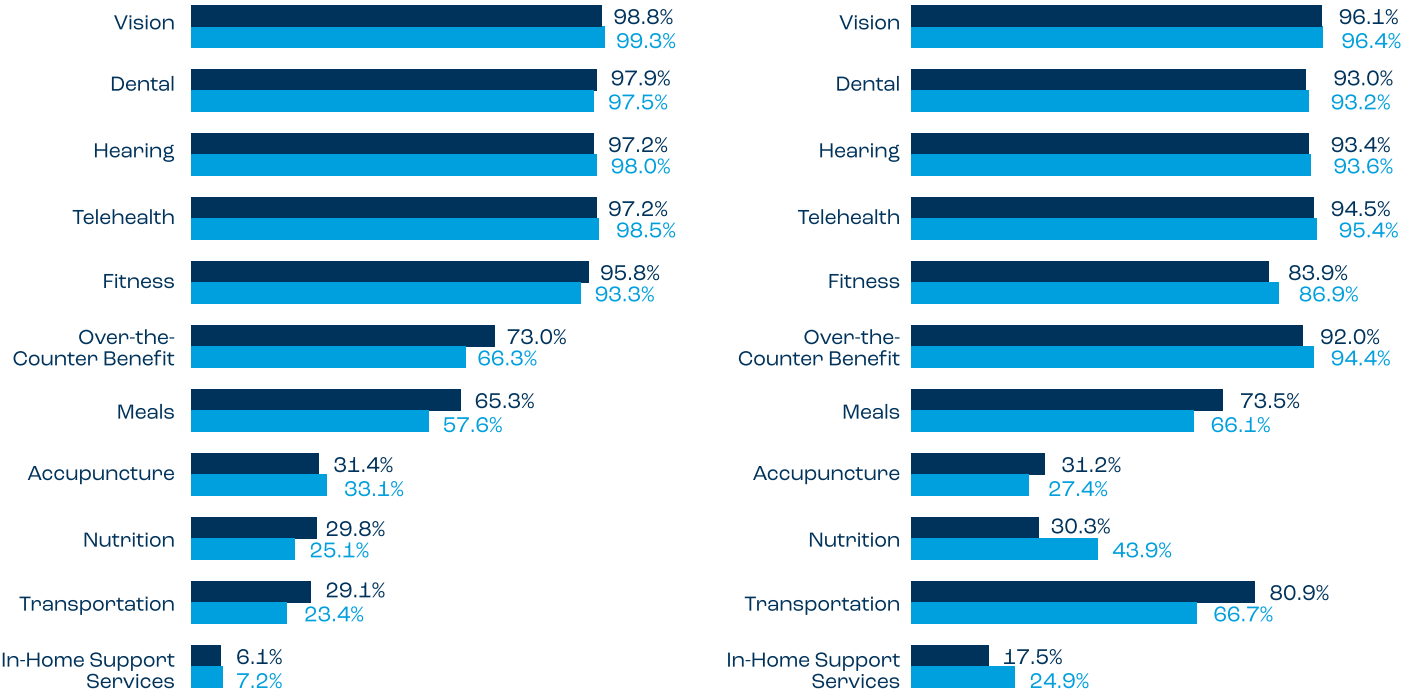
Supplemental Benefits

Through supplemental benefits, Medicare Advantage provides enhanced coverage of Medicare-covered benefits, such as reduced cost-sharing and lower premiums, while often providing benefits and services not covered by Medicare, such as vision, dental, and hearing coverage. Plans may also provide transportation to and from medical appointments, coverage for over the counter (OTC) medications and supplies, and support to maintain a nutritious diet. Medicare Advantage supplemental benefits generally fall into two categories:

- Primarily health-related supplemental benefits; and
- Special Supplemental Benefits for the Chronically Ill (SSBCI) are additional benefits that some Medicare Advantage plans can offer to help people with serious or ongoing health conditions. Benefits within the SSBCI category typically address social needs such as providing food, non-medical transportation, and housing, and are limited to beneficiaries with certain qualifying chronic conditions (e.g., diabetes). The percentage of individual plans offering at least one SSBCI will decrease in 2026, while the percentage of SNPs offering at least one of these benefits will be consistent with 2025.

Supplemental benefits are frequently an important component of beneficiaries' decision-making. By offering access to supplemental benefits, plans can offer support to beneficiaries experiencing social risk factors, such as food insecurity, housing insecurity, and transportation barriers. Access to supplemental benefits for Medicare Advantage beneficiaries can address holistic health by providing services that improve overall health outcomes, such as transportation, nutrition, and in-home support.

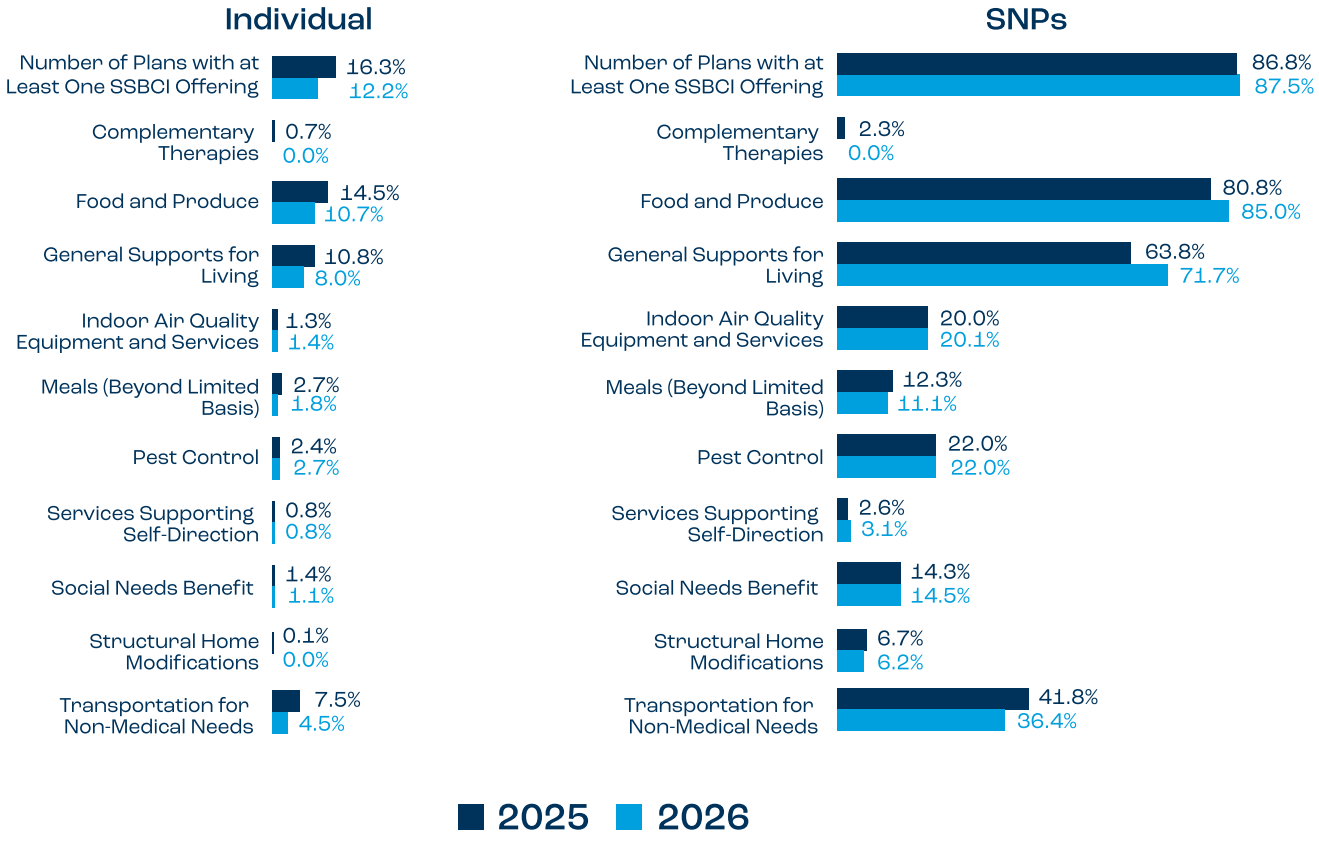
Figure 12: Percent of Plans Offering Primarily Health Related Supplemental Benefits. 2025-2026



In 2026, most Medicare Advantage plans will continue to offer vision, dental, and hearing benefits. However, the percentage of individual plans offering fitness, meals, nutrition, OTC items, and transportation benefits will decrease from 2025 to 2026, while the percentage offering acupuncture, in-home support services, and telehealth will increase. Among SNPs, the percentage of plans offering acupuncture, meals, and transportation will decrease, while the percentage offering fitness, hearing, in-home support services, nutrition, and OTC benefits will increase.

In 2026, the number of individual plans with at least 1 SSBCI offering decreased to 12.2% from 16.3% in 2025. By contrast, the number of SNP plans with at least 1 SSBCI offering increased slightly to 87.5% in comparison to 86.8% (Figure 13).

Figure 13: Percent of Plans Offering SSBCI, 2025-2026



Looking Ahead

The 2026 open enrollment period was October 15, 2025, through December 7, 2025. During this window, beneficiaries selected plans for coverage beginning January 1, 2026. The current Medicare Advantage policy environment is creating pressures that are forcing plans to make difficult decisions about benefit design and affordability, leading some to reduce service areas or exit markets altogether. As regulatory and financial constraints intensify, plans are facing higher costs that translate into fewer supplemental benefits and less generous cost-sharing protections for enrollees. These pressures not only limit innovation and flexibility, but also risk undermining the stability and value that beneficiaries have come to expect from coverage.

Methodology

Avalere Health conducted this analysis on behalf of Better Medicare Alliance. The Avalere Health team analyzed plan benefits data in the 2022-2026 Landscape files and the Q4 2022-Q1 2026 Plan Benefit Package (PBP) files released by CMS. Avalere excluded Medical Savings Account, Private Fee-for-Service, Employer Group Waiver, Program of All-inclusive Care for the Elderly (PACE), and Demonstration plans from the analysis.

Of note, due to different naming conventions that plans use to describe their supplemental benefits – primarily those not associated with specific rubric/category in the PBP file structure – Avalere Health's counts may be an underestimate of the availability of specific supplemental offerings. The analysis reflects Medicare Advantage plans (defined on the contract-plan-segment level) in the 50 states and Washington, D.C.

Notes

1. Milliman, Emerging Medicare Advantage and Part D trends from 2024 financial statements. Linked here
2. Investopedia, Medicare Advantage Premiums are Getting Cheaper Next Year – But Your Overall Costs Could Still Rise. Linked here

Appendix

Counties that had Medicare Advantage plans in 2025 and do not in 2026

State	Counties with Full Terminations
California	Colusa, Trinity
Montana	Carter, Dawson, Richland, Sheridan, Wibaux
Oregon	Grant, Tillamook, Wheeler
South Dakota	Faulk, Grant, Hyde, Potter
Vermont	Addison, Chittenden, Franklin, Grand Isle, Lamoille, Orleans, Rutland, Washington
Washington	Big Horn, Campbell, Carbon, Converse, Fremont, Hot Springs, Johnson, Niobrara, Platte, Sublette, Sweetwater, Washakie