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WHITE PAPER

The Value Shift: How Medicare Advantage Benefits Are Evolving for 2026

Insights on Premium Trends, Supplemental Benefits, and Plan Value

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JANUARY 2026

INTRODUCTION

The Medicare Advantage (MA) market continues to experience rapid transformation, driven by competitive pressures, regulatory changes, financial windfalls, and member expectations of richer benefits. As we enter 2026, understanding these shifts is critical for stakeholders seeking to maintain market relevance and deliver value.

Setting the course for this analysis, on October 30, 2025, the Centers for Medicare & Medicaid Services (CMS) released the 2026 MA plan benefit data.[1] In this first paper in Wakely's 2026 MA market paper series, we provide an initial analysis of the 2026 MA benefit landscape, highlighting key trends and changes for 2026. The analysis offers high-level insights into benefit enhancements, reductions, and overall plan value shifts, leveraging Wakely's Medicare Advantage Competitive Analysis Tool (WMACAT) and Wakely's Strategic Market Analysis and Ranking Tool (SMART) to assess plan competitiveness beyond traditional measures.

To develop the proxy 2026 beneficiary figures, Wakely used the CMS September 2025 contract/plan/state/county (CPSC) enrollment data,[2] with adjustments to the service area based on the 2026 landscape file released by CMS in November 2025.[3] Specifically, plans with a service area expansion have 0 enrollment for the 2026 expansion counties, and plans with a service area reduction have 0 enrollment in the counties where the plan will no longer be offered in 2026.

Key findings[4] include:

- **The average member premium** for general enrollment plans was $12.09 per member per month (PMPM) in 2025, compared with $14.77 PMPM in 2026 based on proxy 2026 enrollment, yielding a 22% increase in average member premium. While the average member premium increased between 2025 and 2026, the number of plans with a premium stayed relatively consistent at around 32% of plans.
- **The average Part B premium reduction** increased from $15.43 PMPM in 2025 to $16.99 PMPM in 2026 for general enrollment plans based on proxy 2026 enrollment, an increase of roughly 10%. Like the member premium, the number of plans offering

[1] Centers for Medicare & Medicaid Services. PBP Benefits – 2026. Available at: https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-advantagepart-d-contract-and-enrollment-data/benefits-data/pbp-benefits-2026.
[2] Centers for Medicare & Medicaid Services. Monthly Enrollment by CPSC. September 2025. Available at: https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-advantagepart-d-contract-and-enrollment-data/monthly-enrollment-contract/plan/state/county/monthly-enrollment-cpsc-2025-09.
[3] Centers for Medicare & Medicaid Services. Medicare Advantage (Part C) and Prescription Drug Plans (Part D) List. Updated November 16, 2025. Available at: https://www.cms.gov/files/zip/cy2026-landscape-202511.zip.
[4] Excludes PDPs and EGWPs.

a Part B premium reduction stayed relatively consistent at 32% between 2025 and 2026.

- **The average maximum out-of-pocket (MOOP)** amount increased to $5,307 in 2026 from $5,128 in 2025 for general enrollment plans based on proxy 2026 enrollment, which is a 3.5% increase between the two years.
- **The average plan value-add**[5] for general enrollment plans decreased roughly 11.0% between 2025 and 2026. Similarly, D-SNPs also saw a decrease in average plan value-add, but to a much smaller degree than general enrollment plans—only about 2.6%.

Although 2026 enrollment change remains an important piece of the puzzle, the bigger trend is clear: plans are tightening benefits in 2026 as a response to continued revenue pressures.

WMACAT VALUE-ADD METRIC: HOW IT ASSESSES PLAN VALUE

The WMACAT value-add metric is a proprietary metric that Wakely developed to provide a comprehensive assessment of MA plan value. It can be used as a comparative metric to evaluate relative changes in plan design year over year and is not intended to represent pricing.

This metric incorporates **five** core components:

1. Part C Medicare-Covered Reduction in Cost Sharing

Wakely leverages its MA Part C pricing model to assess plan benefit design using a consistent claims-based benchmark. Each plan's design is compared with the amount a member would pay under Medicare fee-for-service (FFS). The differential between FFS cost sharing and each plan's benefit design represents the quantified value-add. This approach ensures comparability across plans by applying a uniform evaluation standard. Note that Dual-Eligible Special Needs Plans (D-SNPs) are excluded from the cost sharing evaluation.

[5] Wakely metric calculated using the methodology described in the "WMACAT Value-Add Metric: How It Assesses Plan Value" section of this paper.

2. Part C Supplemental Benefits

Each benefit is evaluated using different assumptions based on Wakely data and models. Although WMACAT does not model plan-specific utilization, it applies a consistent methodology to estimate relative value, enabling standardized comparisons across diverse benefit offerings.

3. Part D Prescription Drug Coverage

Prescription drug coverage is assessed using the 2026 CMS Out-of-Pocket Cost (OOPC) model, which calculates member cost sharing under a defined standard benefit design versus the plan's benefit design.

4. Member Premium

We incorporate premium amounts as reductions to the plan value-add.

5. Part B Premium Reduction

We incorporate Part B premium reduction as an enhancement to the plan value-add.

The total plan value-add is a combination of these five components. For D-SNPs,[6] we exclude Part C Medicare-covered reduction in cost sharing, member premium, and Part B premium reduction, due to integration with Medicaid coverage. Note that the total value-add calculation excludes MA-only plans.

> General enrollment value-add = Part C Medicare-covered reduction in cost sharing + Part C supplemental + Part D – member premium + Part B premium reduction
>
> D-SNP value-add = Part C supplemental + Part D

Why It Matters

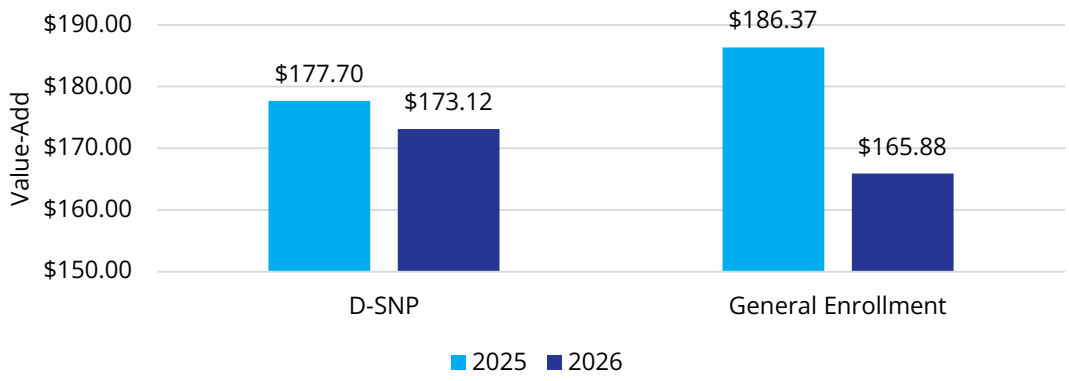
By harmonizing these components under a unified framework, the WMACAT value-add metric provides stakeholders with a robust, apples-to-apples comparison of plan value, accounting for both affordability and benefit richness. This methodology supports strategic decision-making, competitive benchmarking, and market positioning in an increasingly complex MA environment.

[6] There may be state-specific adjustments to plan design for D-SNPs (e.g., addition of supplemental benefits in the bid from one year to the next). These are not explicitly adjusted for in the D-SNP value-add and may be affecting the results.

SUMMARY OF BENEFIT VALUE CHANGE FROM 2025 TO 2026

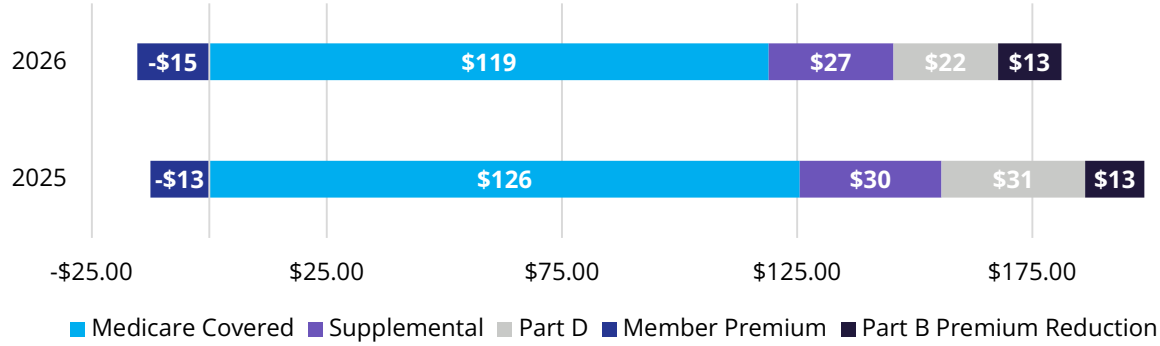
Using the WMACAT value-add metric, we summarized the average plan value-add for 2025 and 2026 for all MA-PD D-SNPs and General Enrollment plans in **Figure 1**. On average, both D-SNP and General Enrollment plan types experienced a reduction in plan value-add by 2.6% and 11.0%, respectively.

Figure 1. Change in Plan Value-Add from 2025 to 2026



For general enrollment plans, average value-add between 2025 and 2026 is decreasing across all core components except for the Part B premium reduction as shown in **Figure 2**. The decrease in Part C Medicare-covered reduction in sharing and Part D are the main drivers.

Figure 2. Plan Value-Add by Component for General Enrollment Plans for 2025 to 2026



PLAN VALUE-ADD CHANGE BY PARENT ORGANIZATION

Wakely also analyzed the plan value-add change for the top 10 largest enrollment parent organizations, separated between general enrollment and D-SNP. These organizations enroll roughly 78% of the general enrollment population and around 89% of the D-SNP population. **Figures 3** and **4** summarize the plan value-add metric and proxy 2026 enrollment for general enrollment plans and D-SNPs, respectively, for 2025 and 2026.

Figure 3. Value-Add Changes, Top 10 Parent Organizations, General Enrollment

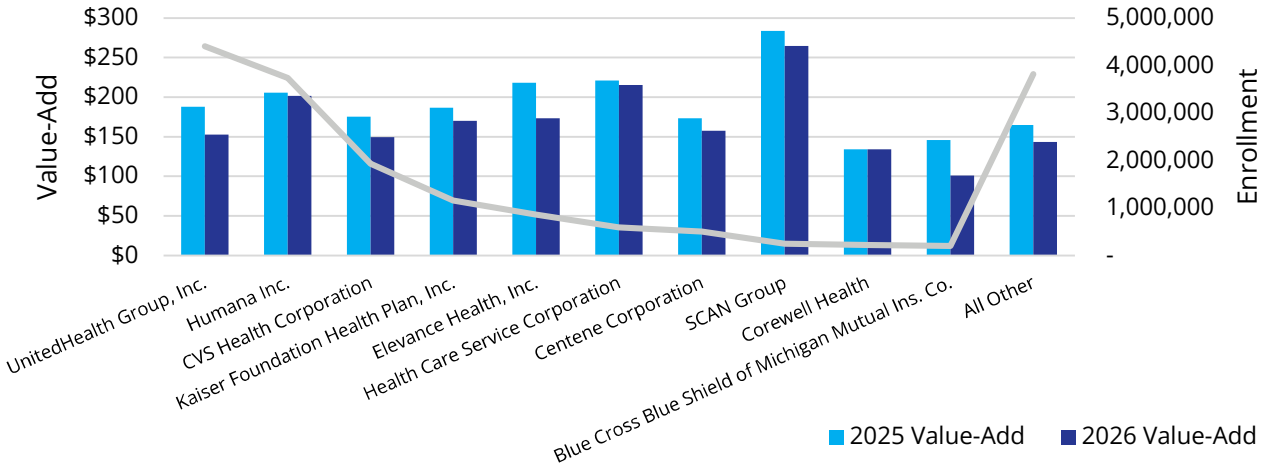
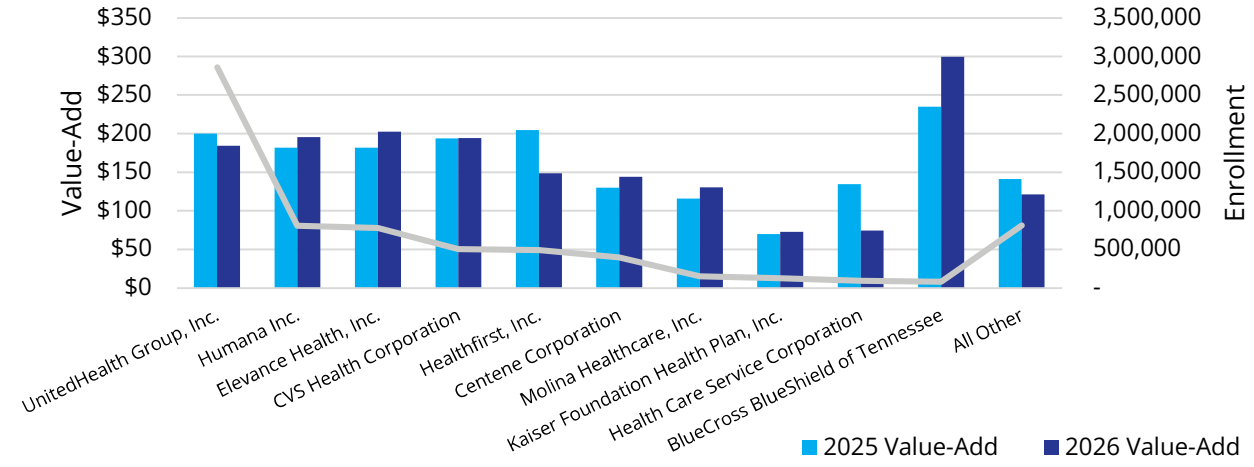


Figure 4. Value-Add Changes, Top 10 Parent Organizations, D-SNP



As **Figure 3** demonstrates, general enrollment plans, on average, show a decrease in plan value-add between 2025 and 2026. United Healthcare, the parent organization with the largest 2026 proxy enrollment among general enrollment plans, shows roughly a 18% decrease in value-add for 2025 to 2026.

For D-SNPs, **Figure 4** indicates that the value-add for 2025 and 2026 is in flux, depending on the parent organization's size. In fact, the 2026 proxy indicates six of top 10 parent organizations (Humana, Elevance, Centene, Molina, Kaiser, and BlueCross BlueShield of Tennessee) are offering a richer benefit package in 2026, whereas those outside of the top 10 show roughly a 14% reduction in plan value-add. There is a clear distinction between the general enrollment and D-SNP population product design strategies, as some large organizations may have invested more in D-SNP products.

VALUE-ADD METRIC HEATMAP

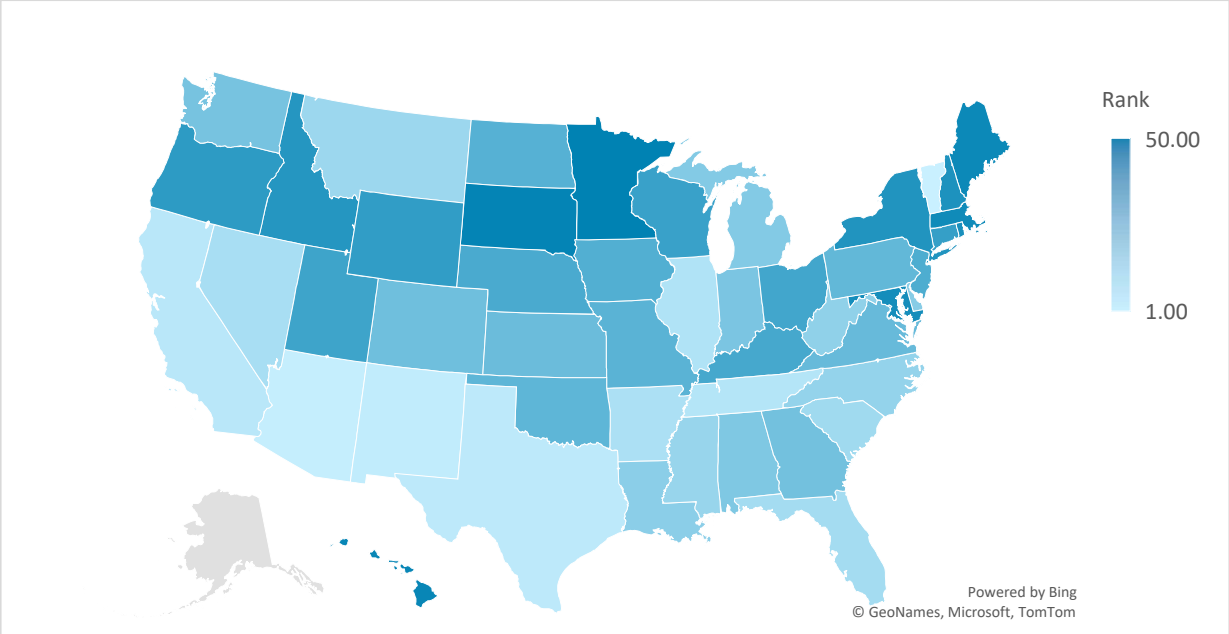
Figure 5 (next page) presents the enrollment-weighted value-add by state for the general enrollment population. To develop this view, we first calculated each state's value-add change from 2025 to 2026. We then ranked states from those experiencing the least reduction (or greatest enhancement) to those experiencing the largest reduction in value-add.

The resulting ranking drives the color coding shown in **Figure 5**:

- Lighter blues represent states with smaller declines in value-add between 2025 and 2026.
- Darker blues represents states with larger average percentage reductions in value-add over the same period.

This visualization allows for a clear comparison of how value-add shifts vary across states as indicated by the percent change in value-add from 2025 to 2026.

Figure 5. Ranking of Value-Add Percent Change by State, General Enrollment

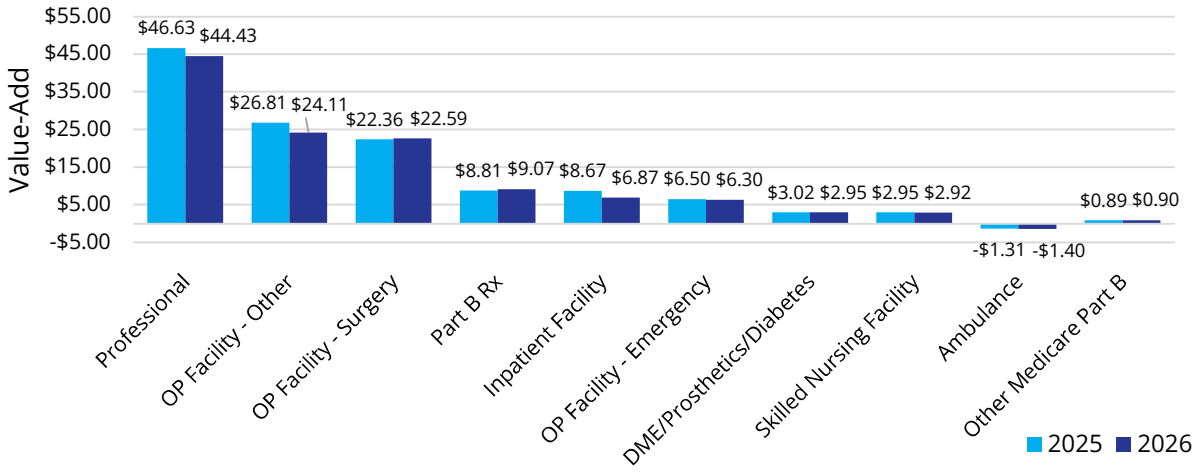


Minnesota, South Dakota, and Hawaii reduced benefits in general enrollment plans to the greatest extent from 2025 to 2026. Conversely, Arizona, New Mexico, and Texas reduced benefits the least from 2025 to 2026. Vermont is the only state to indicate an increase in benefit enhancement, on average, between 2025 and 2026. The appendix contains more details on the state specific value-add changes from 2025 to 2026.

REDUCTION IN MEDICARE-COVERED COST SHARING

Figure 6 shows the average Part C Medicare-covered plan value-add for 2025 and 2026 by major type of service category for general enrollment plans.[7]

Figure 6. Reduction in Cost Sharing Value-Add by Type of Service, General Enrollment



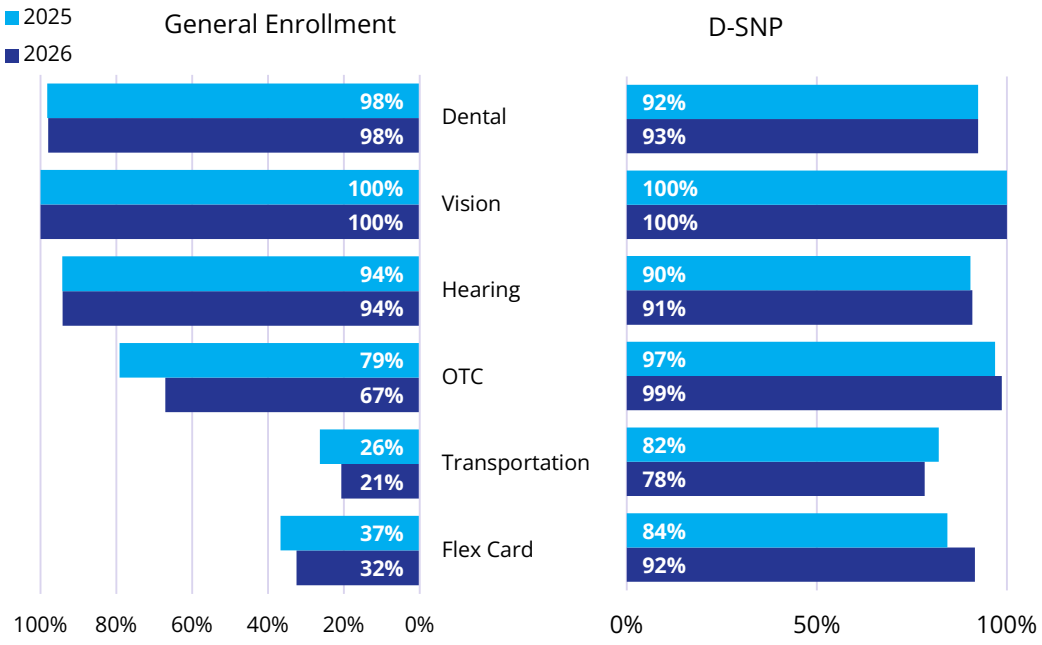
Across all service categories, the Part C Medicare-covered value-add decreased from $125.28 in 2025 to $118.69 in 2026, indicating a 5.3% reduction in benefit richness. This decrease is primarily driven by Professional and Outpatient (OP) Facility – Other services. Note that the value-add metrics reflect the impact of the MOOP and plan deductible, as well as the benefit cost sharing parameters.

[7] Includes MA-only plans, so numbers differ slightly from **Figure 2**.

SUPPLEMENTAL BENEFITS

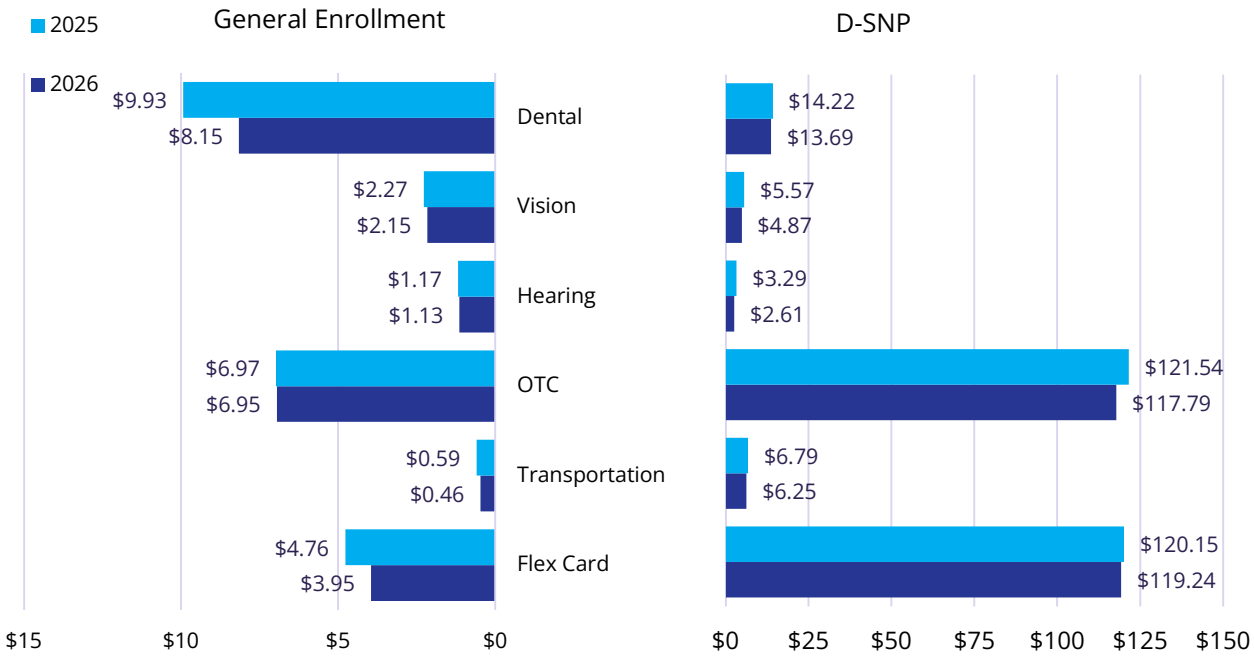
Plans have grown more creative in how they offer supplemental benefits over the years. **Figure 7** shows the percentage of enrollment in plans with several common supplemental benefits in 2025 and 2026, separated by general enrollment plans and D-SNPs. **Figure 8** (next page) depicts the change in supplemental value-add between 2025 and 2026.

Figure 7. Percent of Enrollment in Common Supplemental Benefits



Between 2025 and 2026, the percentage of members with access to common supplemental benefits has, on average, stayed consistent or slightly decreased among the general enrollment population. The percentage of members who are enrolled in plans that offer over the counter (OTC) drug coverage, transportation, and Flex Card benefits has decreased by 12%, 6%, and 4%, respectively. Conversely, the D-SNP population saw in increase in member access to a supplemental benefit categories except transportation (a 4% decrease). Notably, almost all D-SNP beneficiaries have OTC as a supplemental benefit.

Figure 8. Supplemental Value-Add by Plan Type

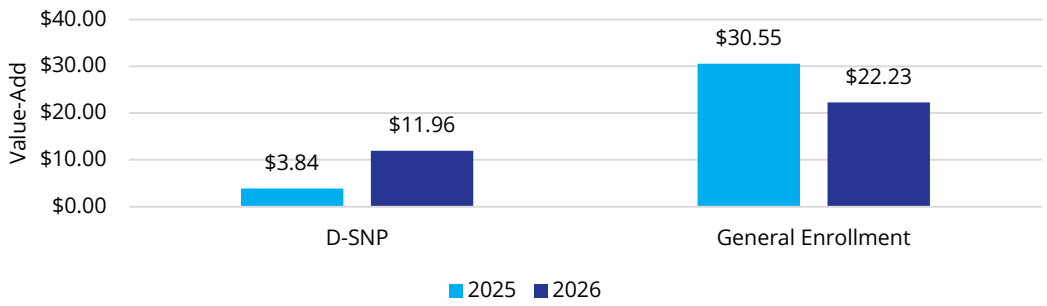


Notably, general enrollment plans maintained their OTC benefits and reduced Dental and Flex Card benefits. D-SNPs on average maintained supplemental benefit levels from 2025 to 2026. For purposes of **Figure 8**, Flex Cards that allow funds to be used on OTC benefits are shown in both the OTC and Flex Card data points.

PART D

Part D continues to evolve rapidly as plans navigate the dual impact of the Inflation Reduction Act (IRA) reforms and the sunset of the Value-Based Insurance Design (VBID) model. The IRA's restructuring of the Part D benefit has reshaped plan economics, and **Figure 9** (next page) highlights how these policy shifts are reflected in overall Part D value-add across plan types.

Figure 9. Part D Value-Add by Plan Type.



The increase in Part D value-add for D-SNPs is potentially tied to the subset of plans that participated in the VBID model. Through VBID, plans were able to lower cost sharing for low-income members, driving additional value that is now rolling off with the program's end. Alternatively, this increase could be driven by enhancements to the benefit structure in response to the increase in the direct subsidy payment from CMS to plans. A follow-up paper will take a deeper look at specific plan design adjustments in response to the VBID sunset.

In contrast, general enrollment plans reduced Part D benefits by roughly 27% on average, reflecting the broader pressure of IRA-driven benefit redesign and more rigid revenue environments.

CONCLUSION

The 2026 MA landscape is undergoing meaningful recalibration. Tightening revenue, evolving federal policies, and varying strategic priorities across general enrollment and D-SNP plans are driving broad reductions in benefit richness. Although final enrollment outcomes will shape the fuller story of 2026, the prevailing theme is clear: **Plans have materially tightened benefit designs in response to sustained financial pressure**.

Key 2026 Market Dynamics

- **Overall contraction in benefit richness** driven by revenue pressure and policy changes.
- **Divergent strategies across segments:**
    - General enrollment plans: Notable declines across nearly all WMACAT value-add components
    - D-SNP plans: Comparatively stable value-add, with several large parent organizations *enhancing* benefits for 2026
- **Part D enhancements in D-SNPs** could be linked to both the sunset of the VBID model and increased direct subsidy.

Looking ahead, organizations will need to navigate sustained revenue constraints, the ongoing rollout of IRA reforms, the planned 2027 regulatory change, and the operational and financial effects of VBID's sunset. Achieving the right balance between affordability, benefit relevance, and financial sustainability will be central to competitive positioning in the 2027 and 2028 bid cycles.

Wakely will continue to monitor these emerging trends and provide deeper analysis, including a forthcoming paper focused specifically on plan responses to the VBID sunset and other structural pressures that are influencing Part D and supplemental benefit strategies.

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ABOUT WAKELY

Founded in 1999, Wakely Consulting Group, an HMA Company, is well known for its top-tier healthcare actuarial consulting services. With nine locations nationwide, Wakely boasts deep expertise in Medicare Advantage, Medicaid managed care, risk adjustment and rate setting, market analyses, forecasting, and strategy development. The firm's actuaries bring extensive experience across all sectors of the healthcare industry, collaborating with payers, providers, and government agencies.

APPENDIX

Change in Plan Value-Add by State for 2025 to 2026, General Enrollment Plans

State	% Change	$ Change	Rank[8]
Vermont	21.3%	$27.03	1.00
Arizona	-7.1%	-$14.41	2.00
New Mexico	-7.5%	-$13.10	3.00
Texas	-7.6%	-$15.03	4.00
California	-7.6%	-$17.13	5.00
Tennessee	-8.1%	-$15.10	6.00
Illinois	-8.5%	-$16.24	7.00
Arkansas	-8.6%	-$15.66	8.00
Nevada	-8.7%	-$20.39	9.00
Florida	-9.0%	-$23.39	10.00
South Carolina	-9.7%	-$17.77	11.00
Montana	-9.8%	-$12.99	12.00
Mississippi	-10.4%	-$16.79	13.00
North Carolina	-10.5%	-$19.27	14.00
West Virginia	-10.6%	-$18.85	15.00
Louisiana	-11.0%	-$21.56	16.00

[8] Rank is based on % change, not $ change.

State	% Change	$ Change	Rank[8]
Delaware	-11.3%	-$19.57	17.00
Michigan	-11.8%	-$18.88	18.00
Alabama	-12.7%	-$22.06	19.00
Indiana	-12.8%	-$23.88	20.00
Washington	-12.8%	-$19.21	21.00
Georgia	-12.9%	-$22.66	22.00
Colorado	-13.0%	-$24.13	23.00
Kansas	-13.5%	-$25.24	24.00
Virginia	-13.6%	-$25.26	25.00
Pennsylvania	-14.0%	-$23.01	26.00
Oklahoma	-14.8%	-$27.16	27.00
Missouri	-15.1%	-$30.03	28.00
North Dakota	-15.2%	-$19.01	29.00
Iowa	-16.1%	-$27.97	30.00
New Jersey	-16.1%	-$24.97	31.00
Nebraska	-16.4%	-$26.99	32.00
Kentucky	-17.3%	-$33.82	33.00
Ohio	-18.1%	-$34.63	34.00
Utah	-20.2%	-$35.65	35.00

State	% Change	$ Change	Rank[8]
Wisconsin	-22.1%	-$36.55	36.00
Connecticut	-23.2%	-$34.49	37.00
Wyoming	-24.2%	-$37.25	38.00
Oregon	-24.7%	-$36.04	39.00
District of Columbia	-24.8%	-$37.56	40.00
Idaho	-24.9%	-$43.71	41.00
New York	-25.4%	-$31.83	42.00
New Hampshire	-26.1%	-$37.85	43.00
Rhode Island	-26.7%	-$46.17	44.00
Maryland	-31.1%	-$38.84	45.00
Massachusetts	-31.2%	-$46.53	46.00
Maine	-32.7%	-$56.04	47.00
Hawaii	-32.9%	-$41.86	48.00
South Dakota	-37.7%	-$51.03	49.00
Minnesota	-42.6%	-$48.37	50.00