

WHITE PAPER

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

## 2026 Enrollment Updates

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*Leveraging Wakely's Medicare Advantage Competitive Analysis Tool (WMACAT) and Strategic Market Analysis and Ranking Tool (SMART), this analysis builds on part 1, "How Medicare Benefits Are Evolving for 2026: Insights on Premium Trends, Supplemental Benefits, and Plan Benefits," and highlights how enrollment in Medicare Advantage plans is being affected.*

## INTRODUCTION

The Medicare Advantage (MA) market continues to undergo rapid transformation, shaped by intensifying competition, evolving regulatory requirements, shifting financial dynamics, and member expectations for increasingly rich and differentiated benefits. As these forces continue to reframe the market heading into 2026, timely insight into benefit design trends remains critical for stakeholders seeking to maintain competitiveness and deliver sustainable value.

Building on our prior analysis of the MA benefit landscape, this paper updates and extends Wakely's earlier work to reflect the January and February 2026 contract/plan/state/county (CPSC) enrollment data,<sup>1</sup> which was released earlier this month. As the first paper in Wakely's 2026 MA market paper series, this analysis offers an updated, high-level assessment of the 2026 MA benefit landscape, highlighting key trends and notable changes relative to prior years.

This updated analysis examines benefit enhancements, reductions, and shifts in overall plan value using Wakely's Medicare Advantage Competitive Analysis Tool (WMACAT) and Wakely's Strategic Market Analysis and Ranking Tool (SMART). By leveraging these tools, we assess plan competitiveness beyond traditional measures and provide refreshed insights into how plans are positioning themselves in an increasingly dynamic MA environment.

Key findings include:<sup>2</sup>

- **The average member premium** for general enrollment plans was \$12.09 per member per month (PMPM) in 2025, compared with \$14.27 PMPM in 2026 based on 2026 enrollment, yielding an 18% 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 percentage of members in a premium plan increased slightly from 23% in 2025 to 24% in 2026.
- **The average Part B premium reduction** increased from \$15.43 PMPM in 2025 to \$19.14 PMPM in 2026 for general enrollment plans based on 2026 enrollment, an increase of roughly 24%. Like the member premium, the number of plans offering a Part B premium reduction stayed relatively consistent at 32% in 2025 and 2026; however, the percentage of members in a plan offering a Part B premium reduction decreased slightly from 32% to 31% from 2025 to 2026.

<sup>1</sup> Centers for Medicare & Medicaid Services. Monthly Enrollment by CPSC. January and February 2026. 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>.

<sup>2</sup> Excludes Prescription Drug Plans and Employer Group Waiver Plans.

- **The average maximum out-of-pocket (MOOP)** amount increased to \$5,434 in 2026 from \$5,129 in 2025 for general enrollment plans based on 2026 enrollment – a 6% increase between the two years.
- **The average plan value-add<sup>3</sup>** for general enrollment plans decreased roughly 11.0% between 2025 and 2026. Similarly, dual eligible special needs plans (D-SNPs) also saw a decrease in average plan value-add, but to a much smaller degree than general enrollment plans—only about 0.5%.

### ENROLLMENT CHANGES FROM 2025 TO 2026

**Table 1** summarizes MA enrollment trends from 2025 to 2026, highlighting changes by plan type, enrollment category, coverage type, premium structure, and Part B premium reduction status. It presents both absolute enrollment changes and percentage growth or decline, providing a comprehensive view of where enrollment is expanding, stabilizing, or contracting across major segments of the MA market. Overall totals are included to contextualize segment-level shifts within the broader enrollment landscape. Note that Prescription Drug Plans (PDPs) and Employer Group Waiver Plans (EGWPs) are excluded.

**Table 1. Enrollment Trends, 2025–2026**

Plan/Enrollment/ Coverage Type	2025 Enrollment	2026 Enrollment	Difference	% Difference
<b>Plan Type</b>				
HMO	18,339,325	18,852,844	513,519	2.8%
PPO	10,251,916	9,838,318	(413,598)	-4.0%
<b>Enrollment Type</b>				
General Enrollment	21,039,614	20,923,865	(115,749)	-0.6%
C-SNP	1,392,290	1,601,515	209,225	15.0%
D-SNP	6,034,053	6,041,326	7,273	0.1%
I-SNP	125,284	124,456	(828)	-0.7%

<sup>3</sup> Wakely metric calculated using the methodology described in the “WMACAT Value-Add Metric: How It Assesses Plan Value” section of this paper.

Plan/Enrollment/ Coverage Type	2025 Enrollment	2026 Enrollment	Difference	% Difference
<b>Coverage Type</b>				
MA-PD	27,826,335	27,872,929	46,594	0.2%
MA-Only	764,906	818,233	53,327	7.0%
<b>Premium Type (GEs Only)</b>				
\$0 Premium	16,210,140	15,907,615	(302,525)	-1.9%
Non-\$0 Premium	4,829,474	5,016,250	186,776	3.9%
<b>Part B Premium Reduction Type (GEs Only)</b>				
\$0 Part B Buydown	6,748,447	6,440,012	(308,435)	-4.6%
Non-\$0 Part B Buydown	14,291,167	14,483,853	192,686	1.3%
<b>Total Enrollment</b>	<b>28,591,241</b>	<b>28,691,162</b>	<b>99,921</b>	<b>0.3%</b>

The growth by plan, coverage, and enrollment types from 2025 to 2026 offers insights into how the market is trending, such as:

- **Overall enrollment growth remains modest.** Total enrollment increased by approximately 100,000 members year over year, representing growth of just 0.3%, indicating a relatively mature and competitive market.
- **HMO growth contrasts with PPO decline.** HMO enrollment grew by 2.8%, adding more than 500,000 members, while PPO enrollment declined by 4.0%. Historically, PPO plans have seen growth, with a 12% increase in enrollment from 2023 to 2024, and a 2.3% increase from 2024 to 2025.
- **Special needs plans continue to drive growth.** Enrollment in Chronic Condition Special Needs Plans (C-SNPs) increased by 15.0%, the fastest-growing segment highlighted in the table, while D-SNP enrollment was essentially flat and enrollment in Institutional Special Needs Plans (I-SNPs) declined slightly.
- **General enrollment edged downward.** General MA enrollment declined by 0.6%, reinforcing that overall growth is being driven by specific niches rather than broad-based expansion.
- **MA-only enrollment is growing faster than MA-PD.** MA-only plans grew by 7.0%, significantly outpacing MA-PD growth of 0.2%, which may reflect affordability pressures or increased availability of stand-alone Part D options.
- **Premium sensitivity is evident.** Enrollment in premium plans grew by 3.9%, while \$0 premium plans declined by 1.9%, suggesting some willingness among members to pay premiums, potentially in exchange for richer benefits or improved networks.
- **Part B premium reduction offerings are losing share.** Plans with a Part B premium reduction experienced a 4.6% enrollment decline, whereas plans without a Part B premium reduction grew by 1.3%.

The top 10 parent organizations based on 2026 enrollment<sup>4</sup> are explored in **Table 2** (next page). Humana experienced the biggest gains by far, adding over 1 million members (+20%) between December 2025 and February 2026. Devoted Health, Inc., and SCAN Group show the fastest growth, although at a smaller scale. UnitedHealth Group, while still the largest parent company, is experiencing the largest absolute decline in enrollment (-726K, -8.7%).

<sup>4</sup> Excludes PDP, EGWP, private fee-for-service, National Program of All-Inclusive Care for the Elderly (PACE), Medicare Medical Savings Accounts, and 1876 Cost Plans.

**Table 2. Enrollment Trends by Top Parent Organizations, 2025–2026**

Parent Organization	2025 Enrollment	2026 Enrollment	Difference	% Difference
UnitedHealth Group, Inc.	8,342,871	7,617,249	-725,622	-8.7%
Humana Inc.	5,150,093	6,188,896	1,038,803	20.2%
CVS Health Corporation	2,864,295	2,723,193	-141,102	-4.9%
Kaiser Foundation Health Plan, Inc.	1,402,365	1,429,688	27,323	1.9%
Elevance Health, Inc.	1,660,517	1,351,542	-308,975	-18.6%
Centene Corporation	961,091	932,009	-29,082	-3.0%
Health Care Service Corporation	858,694	761,162	-97,532	-11.4%
Devoted Health, Inc.	206,447	455,579	249,132	120.7%
SCAN Group	309,397	422,887	113,490	36.7%
Healthfirst, Inc.	362,180	367,332	5,152	1.4%
Other	6,473,291	6,441,625	-31,666	-0.5%
<b>Total</b>	<b>28,591,241</b>	<b>28,691,162</b>	<b>99,921</b>	<b>0.3%</b>

## **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 D-SNPs are excluded from the cost sharing evaluation.

### **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 Centers for Medicare & Medicaid Services (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,<sup>5</sup> 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.

<sup>5</sup> 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.

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

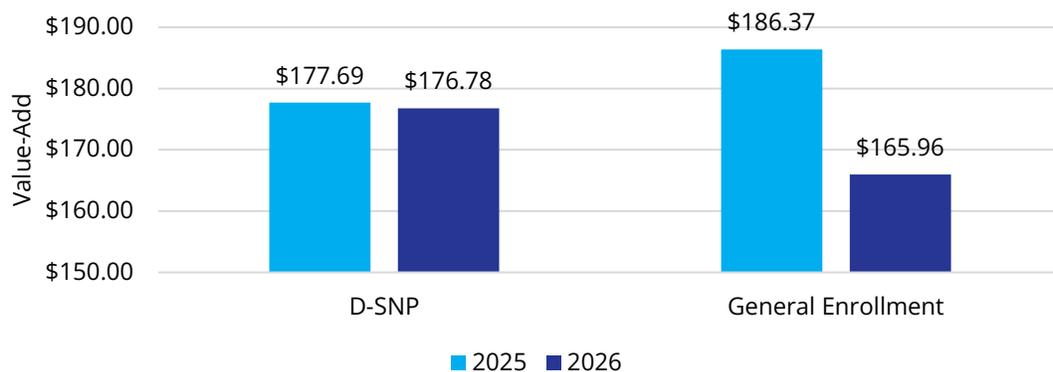
**Why It Matters**

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.

**SUMMARY OF BENEFIT VALUE CHANGE FROM 2025 TO 2026**

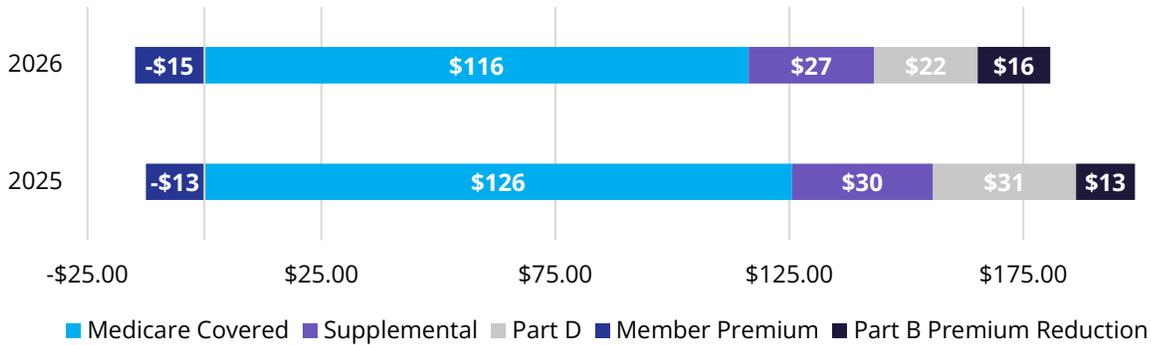
Using the WMACAT value-add metric, we summarized the average plan value-add for 2025 and 2026 for all MA-PD D-SNPs and General Enrollment plans in **Figure 1**. On average, both D-SNP and General Enrollment plan types experienced a reduction in plan value-add by 0.5% and 11.0%, respectively.

**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 76% of the general enrollment population and approximately 86% of the D-SNP population. **Figure 3** (below) and **Figure 4** (next page) summarize the plan value-add metric and 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**

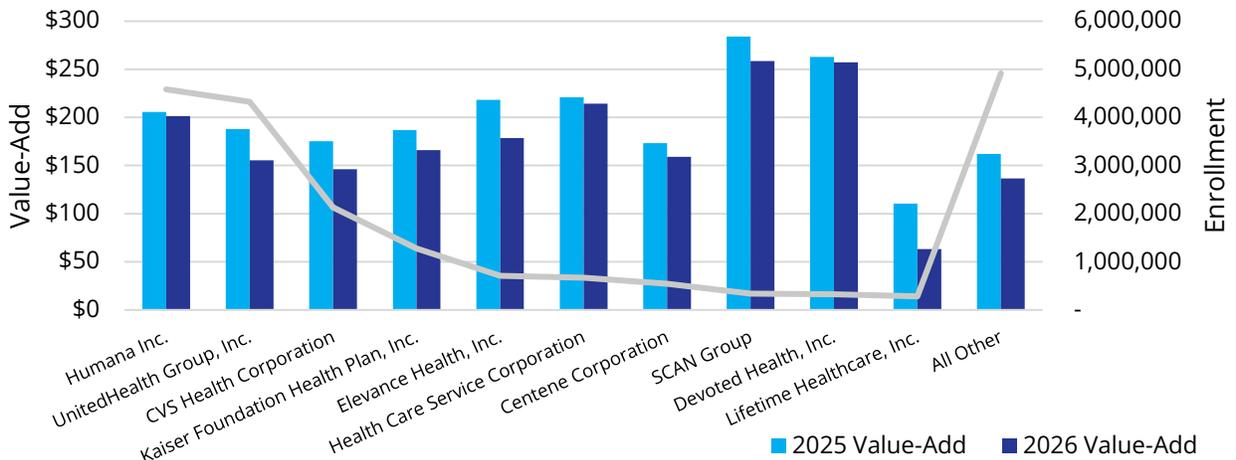
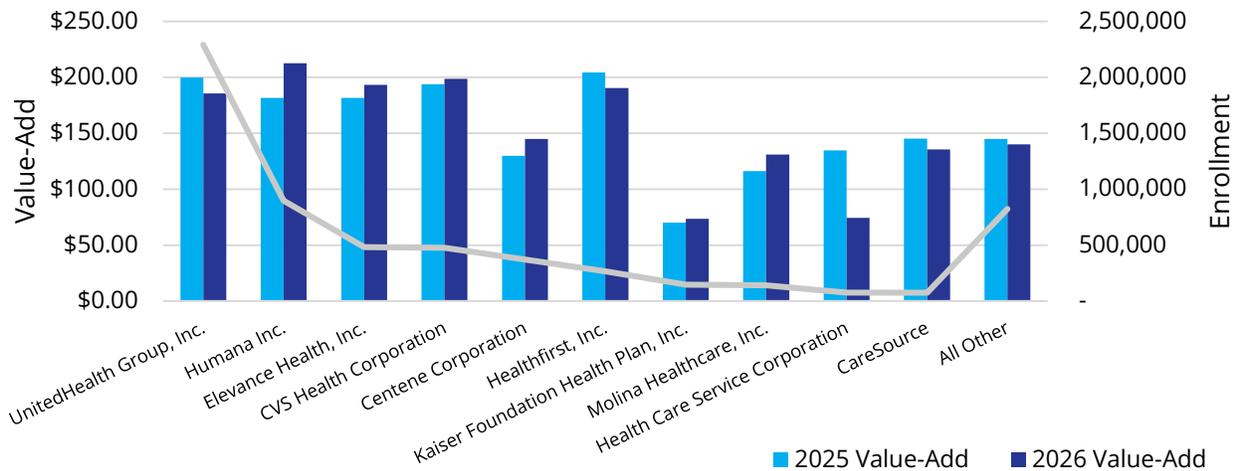


Figure 4. Value-Add Changes, Top 10 Parent Organizations, D-SNP



As **Figure 3** demonstrates, general enrollment plans, on average, show a decrease in plan value-add between 2025 and 2026. Humana surpassed United Healthcare as having the largest enrollment for this population and maintained a relatively stable value-add between 2025 to 2026, compared to United Healthcare’s decrease of 17%.

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 enrollment indicates six of the top 10 parent organizations (Humana, Elevance, CVS, Centene, Kaiser, and Molina) are offering a richer benefit package in 2026, whereas those outside of the top 10 show roughly a 3% 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**

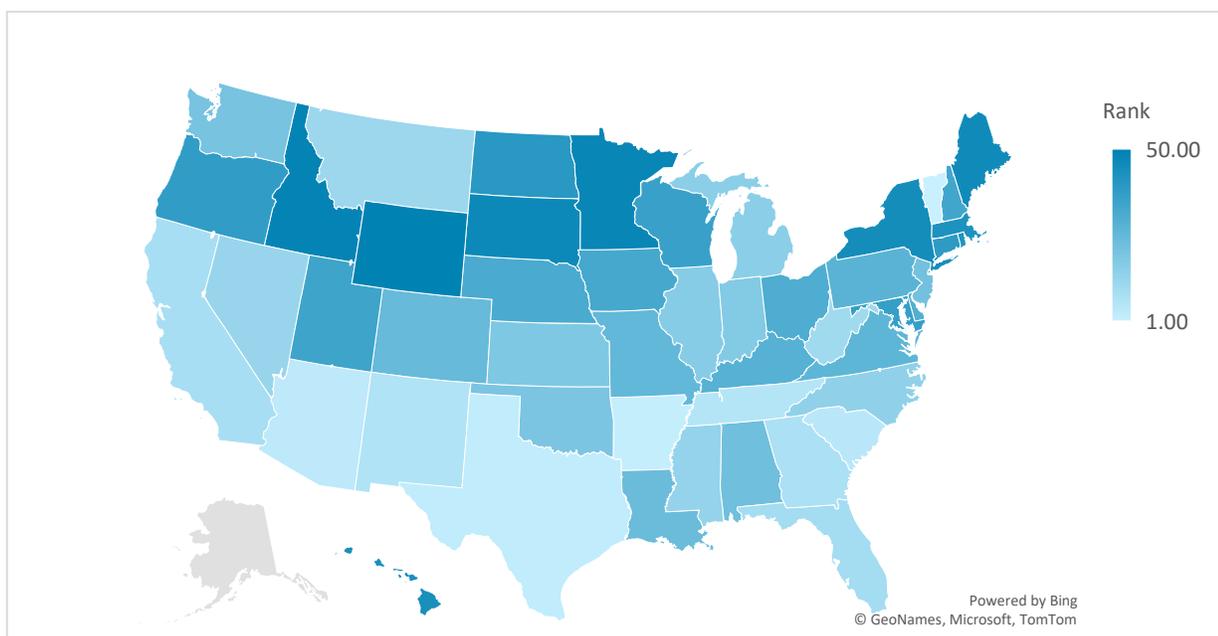
**Figure 5** (next page) presents the enrollment-weighted value-add by state for the general enrollment population. To develop this view, we first calculated each state’s value-add change from 2025 to 2026. We then ranked states from those experiencing the least reduction (or greatest enhancement) to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

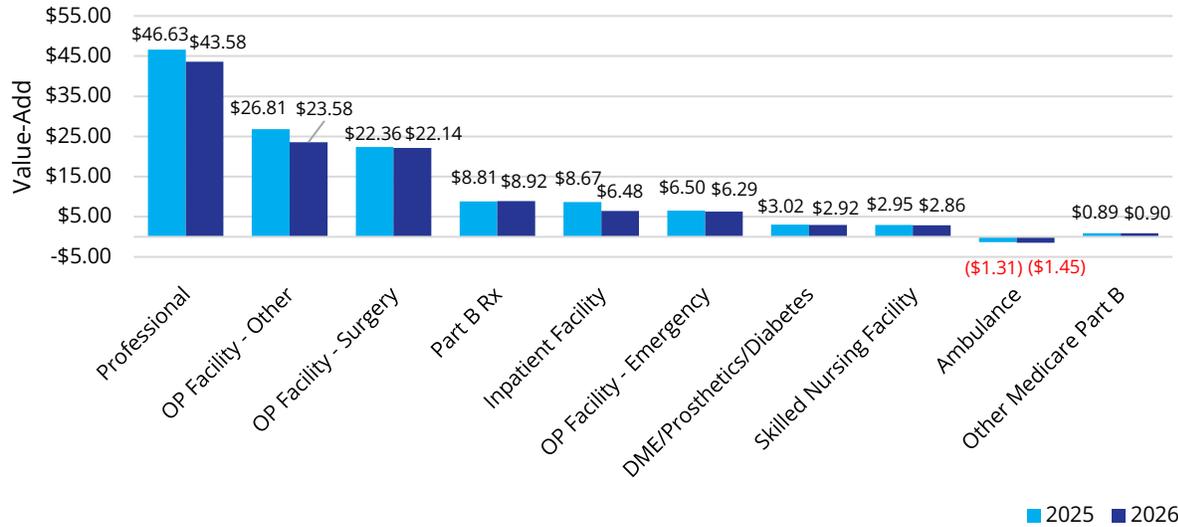


Wyoming, Idaho, and Minnesota reduced benefits in general enrollment plans to the greatest extent from 2025 to 2026. Conversely, Arkansas, Texas, and Arizona reduced benefits the least from 2025 to 2026. Vermont is the only state to indicate an increase in benefit enhancement, on average, between 2025 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.<sup>6</sup>

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



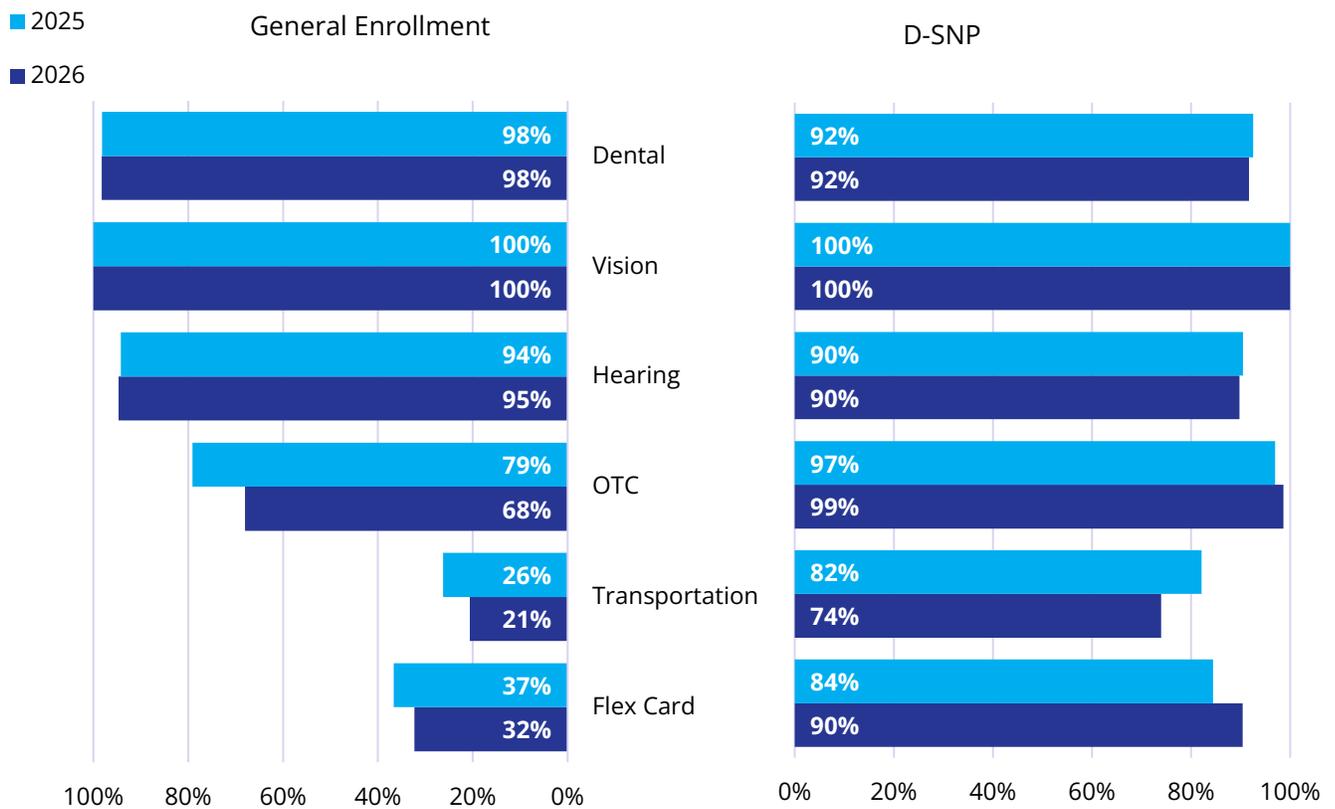
Across all service categories, the Part C Medicare-covered value-add decreased from \$125.28 in 2025 to \$116.14 in 2026, indicating a 7% reduction in benefit richness. This decrease is primarily driven by Professional and Outpatient (OP) Facility – Other services. Note that the value-add metrics reflect the impact of the MOOP and plan deductible, as well as the benefit cost sharing parameters.

<sup>6</sup> Includes MA-only plans, so numbers differ slightly from Figure 2.

**SUPPLEMENTAL BENEFITS**

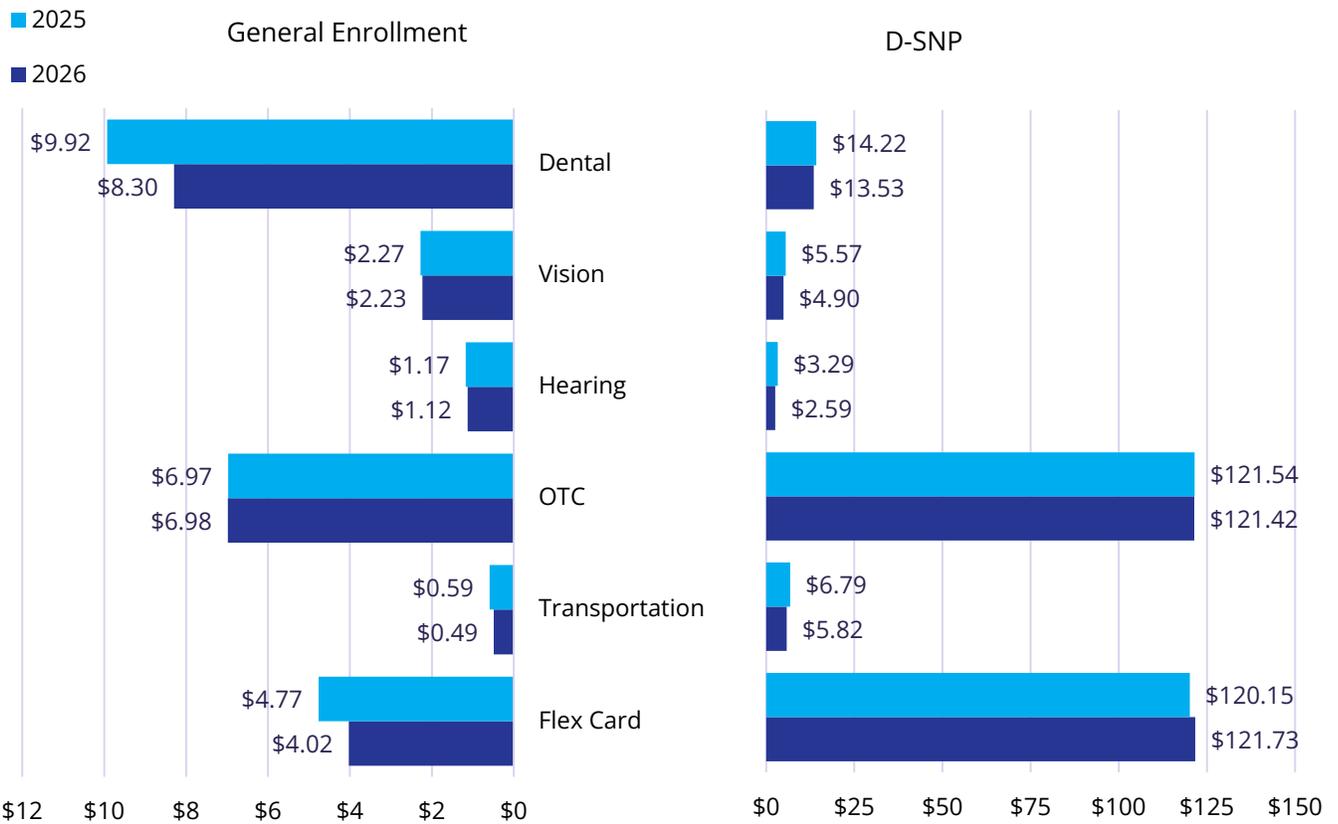
Plans have grown more creative in how they offer supplemental benefits over the years. **Figure 7** shows the percentage of enrollment in plans with several common supplemental benefits in 2025 and 2026, separated by general enrollment plans and D-SNPs. **Figure 8** (next page) depicts the change in 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 11%, 6%, and 4%, respectively. Conversely, the D-SNP population saw an increase in member access to a supplemental benefit categories except transportation (an 8% decrease). Notably, almost all D-SNP beneficiaries have OTC as a supplemental benefit.

Figure 8. Supplemental Value-Add by Plan Type

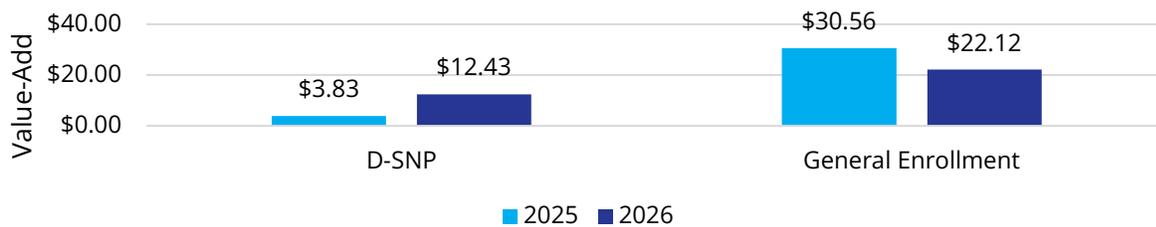


Notably, general enrollment plans maintained their OTC benefits and reduced Dental and Flex Card benefits. D-SNPs on average maintained supplemental benefit levels from 2025 to 2026. For the purposes of **Figure 8**, Flex Cards that allow funds to be used on OTC benefits are shown in both the OTC and 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** 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 28% 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. Early enrollment results suggest that these design changes are influencing member behavior, reinforcing that affordability and value tradeoffs are now central to plan strategy.

### 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.

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## APPENDIX

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

State	% Change	\$ Change	Rank <sup>7</sup>
VT	21.3%	\$27.03	1.00
AR	-4.0%	-\$7.36	2.00
TX	-6.0%	-\$11.91	3.00
AZ	-6.0%	-\$12.26	4.00
SC	-6.3%	-\$11.57	5.00
TN	-6.4%	-\$11.88	6.00
NM	-6.6%	-\$11.49	7.00
GA	-6.8%	-\$11.87	8.00
CA	-6.9%	-\$15.63	9.00
FL	-7.3%	-\$18.88	10.00
WV	-7.4%	-\$13.10	11.00
MT	-7.7%	-\$10.24	12.00
NV	-8.1%	-\$18.84	13.00
MS	-8.1%	-\$13.07	14.00
NC	-8.1%	-\$14.99	15.00
MI	-8.1%	-\$13.07	16.00
IL	-8.2%	-\$15.62	17.00

<sup>7</sup> Rank is based on % change, not \$ change.

State	% Change	\$ Change	Rank <sup>7</sup>
IN	-8.3%	-\$15.44	18.00
KS	-9.2%	-\$17.11	19.00
OK	-9.5%	-\$17.44	20.00
WA	-9.6%	-\$14.45	21.00
NJ	-9.7%	-\$14.97	22.00
AL	-10.0%	-\$17.46	23.00
LA	-10.1%	-\$19.83	24.00
CO	-10.4%	-\$19.22	25.00
MO	-11.1%	-\$21.97	26.00
VA	-11.4%	-\$21.13	27.00
PA	-12.1%	-\$19.98	28.00
KY	-12.2%	-\$23.91	29.00
DE	-13.4%	-\$23.33	30.00
OH	-14.4%	-\$27.45	31.00
NE	-14.4%	-\$23.78	32.00
IA	-14.5%	-\$25.22	33.00
NH	-16.0%	-\$23.18	34.00
UT	-16.7%	-\$29.42	35.00
WI	-18.8%	-\$30.97	36.00
MD	-19.0%	-\$23.75	37.00

State	% Change	\$ Change	Rank <sup>7</sup>
OR	-20.5%	-\$29.87	38.00
CT	-23.7%	-\$35.20	39.00
ND	-24.9%	-\$31.00	40.00
DC	-25.5%	-\$38.60	41.00
RI	-26.1%	-\$45.09	42.00
MA	-26.4%	-\$39.47	43.00
HI	-28.6%	-\$36.49	44.00
NY	-29.7%	-\$37.26	45.00
ME	-30.7%	-\$52.53	46.00
SD	-38.4%	-\$52.04	47.00
MN	-39.9%	-\$45.37	48.00
ID	-41.9%	-\$73.51	49.00
WY	-58.8%	-\$90.39	50.00