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The Value Shift: Inside the C-SNP Surge

How Rapid Growth, Market Concentration, and Benefit Design Are Reshaping the Medicare Advantage Landscape

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SUMMARY

This paper is part two of "The Value Shift" series in which Wakely examines how market forces, benefit design, and competitive dynamics are redefining value across MA. Leveraging Wakely's Medicare Advantage Competitive Analysis Tool (WMACAT) and Strategic Market Analysis and Ranking Tool (SMART), this analysis focuses specifically on how growth, concentration, and benefit strategies are transforming the C-SNP market.

Chronic Condition Special Needs Plans (C-SNPs) have entered a period of rapid and uneven expansion, fundamentally reshaping the Medicare Advantage (MA) landscape heading into 2026. Originally designed to support beneficiaries with complex chronic conditions, C-SNPs have evolved from a niche offering into one of the fastest-growing MA segments.

Between 2019 and 2026, the number of available C-SNPs nearly quintupled, with the most pronounced acceleration occurring after 2023. Growth has been driven largely by plans that focus on beneficiaries with diabetes, cardiovascular disease, and chronic heart failure, accounting for nearly all new C-SNP offerings in 2026. In contrast, plans centered on other Centers for Medicare & Medicaid Services (CMS)-approved chronic conditions have stagnated or exited the market. These trends point toward a consolidation of the market around broader, higher-volume clinical groupings rather than specialized, condition-specific offerings.

Geographic concentration mirrors these condition-level trends. Nearly half of all 2026 C-SNPs are offered in just five states, resulting in dense competition and robust consumer choice in select markets while leaving large portions of the country with limited or no access. Enrollment patterns reflect this imbalance.

Benefit design trends from 2025 to 2026 further illustrate the increasing complexity of competing in the C-SNP space. Using WMACAT's proprietary value-add metric, this paper finds that overall value-add declined year over year, yet C-SNPs experienced smaller reductions than general enrollment plans. Amid market pressures, C-SNPs continue to invest heavily in Part C Supplemental benefits such as transportation, over the counter (OTC) allowances, and Flex Cards, reinforcing their positioning as condition-focused, care-intensive products.

Taken together, these findings depict a C-SNP market that is expanding rapidly but unevenly, defined by condition and geographic concentration, rising operational demands, and heightened competitive pressure. As part of "The Value Shift" series, this paper underscores that C-SNP growth cannot be evaluated in isolation from broader MA value trends. Organizations considering entry or expansion will need clear strategic intent, condition-aligned benefit design, scalable verification processes, and operational readiness. Tools like WMACAT and SMART provide a critical foundation for assessing competitive positioning, benefit investment tradeoffs, and long-term sustainability as C-SNPs continue to play a more central role in Medicare Advantage portfolios.

BACKGROUND AND PURPOSE

C-SNPs are designed specifically for MA members with qualifying chronic conditions. CMS recognized that chronically ill beneficiaries often account for a disproportionate share of Medicare spending and require care models that differ from those offered in standard MA plans. In response, C-SNPs were authorized under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and first implemented in 2006.

CMS-Approved Chronic Conditions and Groupings[1]

In fall 2008, CMS finalized a list of 15 chronic conditions eligible for C-SNPs:

1. Chronic alcohol and other drug dependence
2. Autoimmune disorders (with limitations)
3. Cancer, excluding pre-cancer conditions or in-situ status
4. Cardiovascular disorders (with limitations)
5. Chronic heart failure (CHF)
6. Dementia
7. Diabetes mellitus
8. End-stage liver disease
9. End-stage renal disease (ESRD)
10. Severe hematologic disorders (with limitations)
11. HIV/AIDS
12. Chronic lung disorders (with limitations)
13. Chronic and disabling mental health conditions (with limitations)
14. Neurologic disorders (with limitations)
15. Stroke

CMS prohibits C-SNPs from being built around multiple unrelated comorbidities. Only five clinically linked condition groupings are explicitly approved (see bulleted list below). Beneficiaries need to only have one of the qualifying conditions to be eligible for enrollment in these grouped C-SNPs.

- Diabetes mellitus and chronic heart failure
- Chronic heart failure and cardiovascular disorders
- Diabetes mellitus and cardiovascular disorders
- Diabetes mellitus, chronic heart failure, and cardiovascular disorders
- Stroke and cardiovascular disorders.

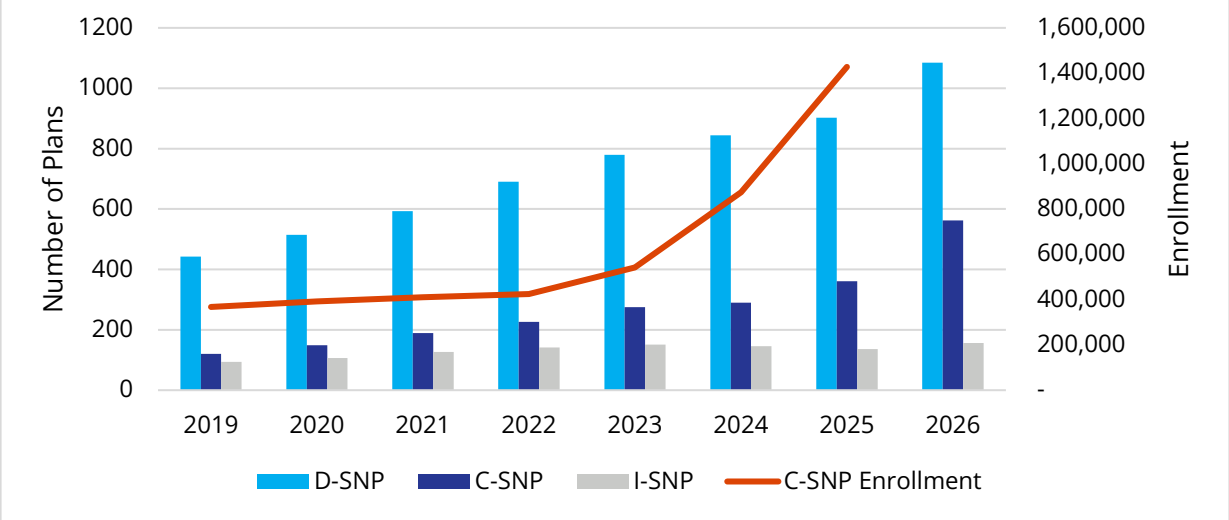
[1] Centers for Medicare & Medicaid Services. Chronic Condition Special Needs Plans (C-SNPs). Updated September 9, 2024. Available at: https://www.cms.gov/medicare/enrollment-renewal/special-needs-plans/chronic-conditions.

MA plans do have the option of developing their own multiple condition C-SNPs; however, unlike the CMS-approved condition groupings, beneficiaries must have **all** the qualifying conditions in the MA plan's specific grouping.

THE GROWTH OF C-SNPS

C-SNPs have shifted from a niche offering to one of the fastest-growing segments in the MA market. The number of C-SNPs available to beneficiaries has nearly doubled between 2024 and 2026 (see **Figure 1**). Enrollment in C-SNPs reached a turning point in 2023, with an average annual enrollment trend of roughly 60% between 2023 and 2025.

Figure 1. C-SNP Growth, 2019–2026



Following a similar pattern, the number of parent organizations offering a C-SNP was relatively stable from 2019–2022 (around 23) and increased from 28 in 2023 to 37 in 2026.

Types of C-SNPs

Although MA organizations may offer C-SNPs covering a variety of chronic conditions, C-SNP growth is limited to only a few types of C-SNPs (see **Table 1**).

Table 1. Growth in Number of Available C-SNPs by Chronic Condition, 2025–2026

C-SNP Condition/ Grouping	2025 Enrollment	Number of Plans in 2025	Number of Plans in 2026	Number of Terminated Plans	Number of New Plans
Cardiovascular Disorders, Chronic Heart Failure, Diabetes	1,287,964	284	470	30	207
Cardiovascular Disorders, Diabetes	61,943	10	5	5	0
Chronic Lung Disorders	31,363	32	31	4	3
Diabetes Mellitus*	8,354	11	1	4	0
Chronic Kidney Disease	6,449	41	35	10	4
Chronic Heart Failure, Diabetes*	3,409	2	0	0	0
Chronic Heart Failure	2,604	1	1	0	0
Cardiovascular Disorders, Chronic Heart Failure*	1,433	1	0	0	0
Chronic Mental Health	1,260	2	4	0	2
HIV_AIDS	590	1	1	0	0
Obesity, Overweight, Metabolic Syndrome	0	0	1	0	1
Dementia	0	1	0	1	0
Cardiovascular Disorders	0	1	0	1	0

*Several plans added conditions as shown in the cardiovascular disorders, chronic heart failure, diabetes row, 2026 column.

The growth in plan types from 2025 to 2026 offers insights into how C-SNPs are trending:

- Almost all the growth was driven by cardiovascular, chronic heart failure, and diabetes C-SNPs, with 207 new plans introduced in 2026.
- Several small single- or dual-condition categories disappear by 2026 (e.g., dementia, cardiovascular disorders only), which indicates plans are migrating from narrow, single-condition C-SNPs toward broader groupings that capture more eligible members under one clinical model and benefit set.
- A new obesity/overweight/metabolic syndrome C-SNP will be offered for the first time in 2026. It will be interesting to keep an eye on 2026 enrollment and whether this trend will continue into 2027.

D-SNP Look-alikes

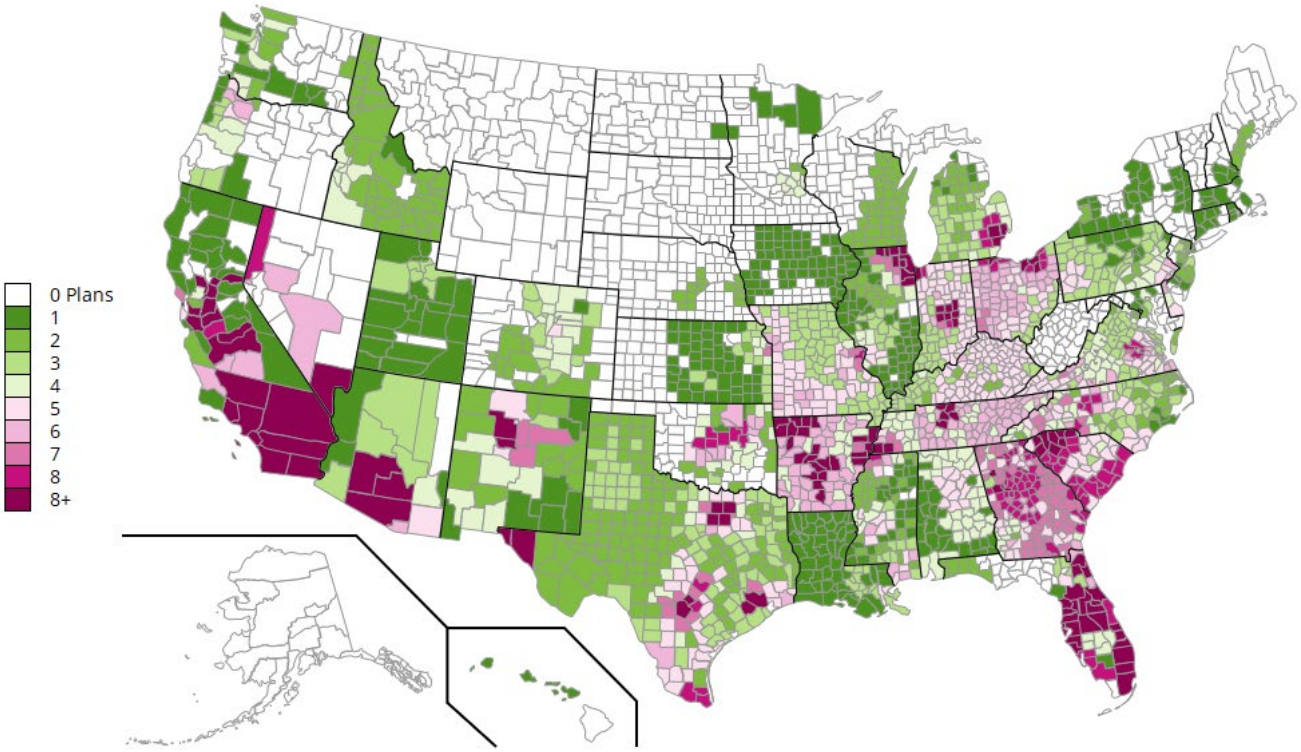
The growth in C-SNPs in recent years could be driven in part by the increased restrictions around dual integration. Specifically, there is a push toward aligning Medicare and Medicaid beneficiaries under the same organization. CMS has also created restrictions around general enrollment plans with a high percentage of dual-eligible members (i.e., D-SNP look-alikes"). These restrictions currently do not apply to C-SNPs. As a result, some organizations have used the C-SNP product to retain their dually eligible members. The CY2027 Medicare Advantage and Part D Proposed Rule,[2] however, signals increased CMS scrutiny of plans that function similarly to D-SNP look-alikes, which could lead to future restrictions or expanded oversight extending to C-SNPs. If finalized, these changes would likely limit the ability of MA plans to use C-SNPs as an alternative pathway to retain dually eligible beneficiaries without deeper Medicare–Medicaid integration.

State Prevalence

Of the nearly 600 C-SNPs available in 2026, almost 50% are concentrated in five states: Florida, California, Texas, Arizona, and Illinois. **Figure 2** (next page) shows the number of available plans in each county nationwide; dark pink counties have the most plans, green counties have the fewest plans, and unshaded areas have no C-SNPs.

[2] Wakely Consulting Group. Summary of CMS's Contract Year 2027 Proposed Rule for Medicare Programs. December 2025. Available at: https://www.wakely.com/blog/summary-of-cmss-cy2027-proposed-rule/.

Figure 2. Map of Available C-SNPs in 2026



PRODUCT DESIGN CHANGES FROM 2025 TO 2026

Wakely used its WMACAT and SMART tools to analyze changes in member premiums, maximum out-of-pocket costs, and benefit design changes from 2025 to 2026. The WMACAT value-add metric is a proprietary measure 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.[3] The following sections differentiate C-SNPs that target the low-income premium subsidy (LIPSA)[4] and those that don't, as the product design and targeted population are likely to differ. For general C-SNPs (that don't target the LIPSA), the total value-add metric = Part C Medicare-covered reduction in cost sharing + Part C Supplemental + Part D – member premium + Part B premium reduction. For LIPSA-targeting C-SNPs, the total value-add metric = Part C Supplemental + Part D.

[3] For more information on WMACAT's plan value-add, go to: https://www.wakely.com/blog/the-value-shift-how-medicare-advantage-benefits-are-evolving-for-2026/.
[4] We identified LIPSA targeting C-SNPS if the plan premium is at or lower than the published LIPSA values.

General C-SNPs

Key findings from the analysis include:

- **The average member premium** in 2025 was $0.40 per member per month (PMPM) in 2025 versus $0.70 PMPM in 2026 based on proxy 2026 enrollment[5]. The percent of plans with a non-$0 premium decreased from 5.7% to 5.0% between 2025 and 2026. These two statistics indicate that premiums are uncommon among C-SNPs that don't target the LIPSA.
- **The average Part B premium reduction** increased from $27.95 PMPM in 2025 to $29.68 PMPM in 2026 based on proxy 2026 enrollment, an increase of roughly 6%, largely driven by Florida which saw an increase from $124.71 PMPM in 2025 to $139.27 PMPM in 2026.
    - Even though the average Part B premium reduction increased, the percent of plans offering any Part B premium reduction decreased from 33% in 2025 to 29% in 2026.
- **The average maximum out-of-pocket (MOOP)** amount increased to $4,640 in 2026 from $4,444 in 2025 based on proxy 2026 enrollment, which is roughly a 4% increase between the two years.
- **The average plan value-add** decreased roughly 8% between 2025 and 2026. This decrease is consistent across Medicare-covered reductions in cost sharing, Part C Supplemental, and Part D with an increase in the Part B premium reduction slightly offsetting the decline across years.

Using the WMACAT value-add metric, we summarized the average plan value-add for 2025 and 2026 for C-SNPs and General Enrollment plans in **Figure 3** (next page). While both C-SNPs and General Enrollment plans saw a decrease in value-add on average, C-SNPs only declined by approximately 8% versus 11% for General Enrollment plans. As **Figure 4** (next page) demonstrates, C-SNPS on average invest more in benefits than general enrollment plans, particularly for Part C Supplemental benefits.

[5] To develop the proxy 2026 beneficiary figures, Wakely used the CMS September 2025 contract/plan/state/county (CPSC) enrollment data, with adjustments to the service area based on the 2026 landscape file released by CMS in November 2025. 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.

Figure 3. Change in Plan Value-Add from 2025 to 2026

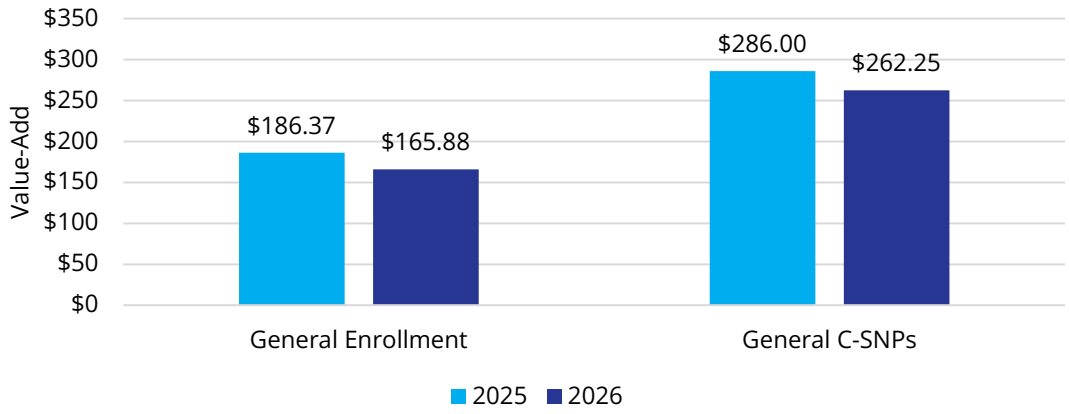
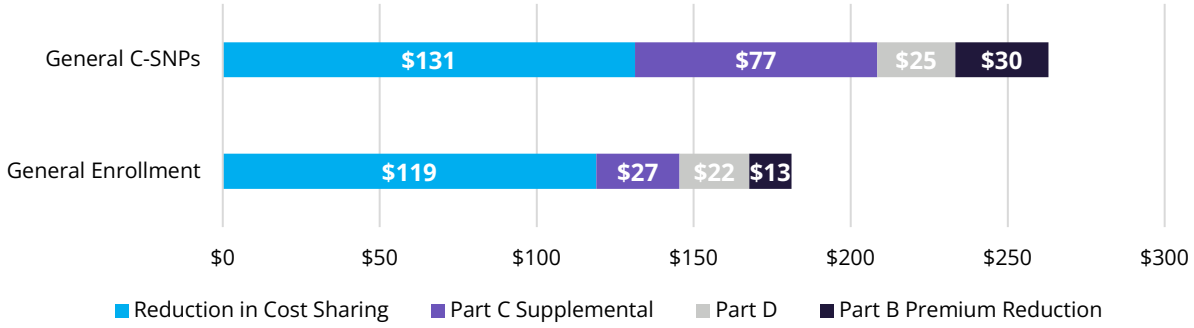
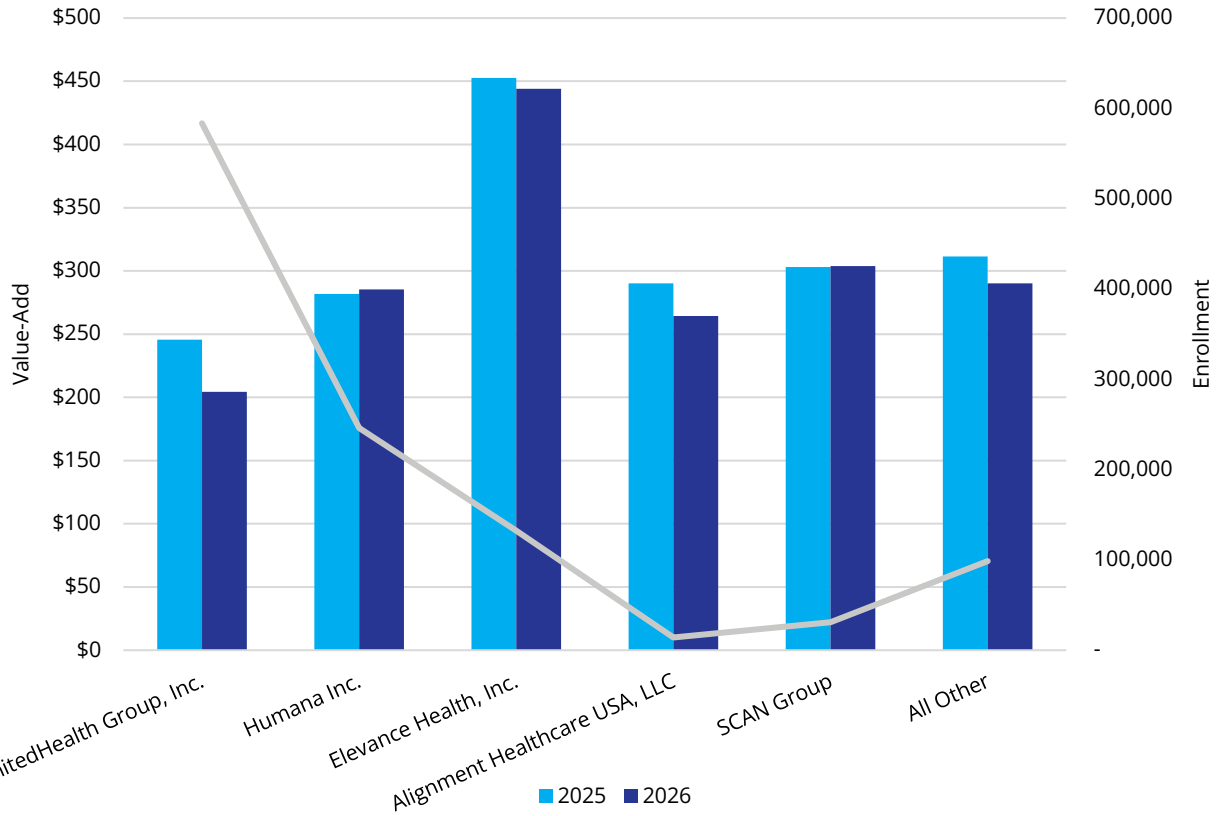


Figure 4. Plan Value-Add by Component for 2026



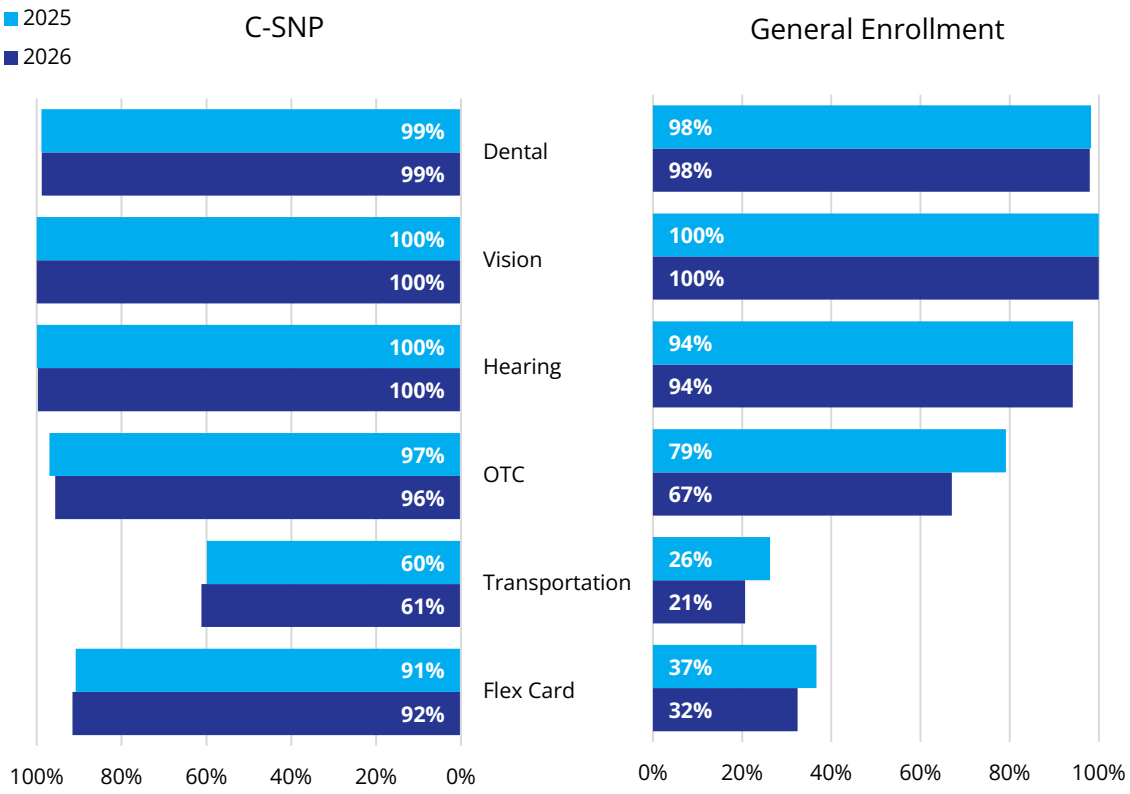
The change in value-add varies significantly by parent organization as shown in **Figure 5** (next page). Notably, United HealthCare saw a significant large decline year over year, whereas other organizations either remained relatively stable or increased value-add year over year.

Figure 5. Value-Add Changes for General C-SNPs, Top Five Parent Organizations



C-SNPs are distinct from other plan types given their focus on Part C Supplemental benefits. Although coverage for dental, vision, and hearing care is common across both C-SNPs and General Enrollment plans, C-SNPs distinguish themselves by more frequently offering benefits such as OTC allowances, transportation, and Flex Cards (see **Figure 6** on next page). It is also interesting to note that while the general enrollment trend from 2025 to 2026 was to pull back on benefits, C-SNP member access to these supplemental benefits remained relatively stable.

Figure 6. Percent of Enrollment in Common Supplemental Benefits



LIPSA-Targeting C-SNPs

Figure 7 (next page) shows the change in average plan value-add from 2025 to 2026 for LIPSA-targeting C-SNPs and D-SNPs. Unlike general enrollment plans and other C-SNPs, D-SNPs and LIPSA-targeting C-SNPs remained relatively stable year over year with only a slight decline in average value-add.

Figure 7. Change in Plan Value-Add from 2025 to 2026, D-SNPs vs. LIPSA-Targeting C-SNPs

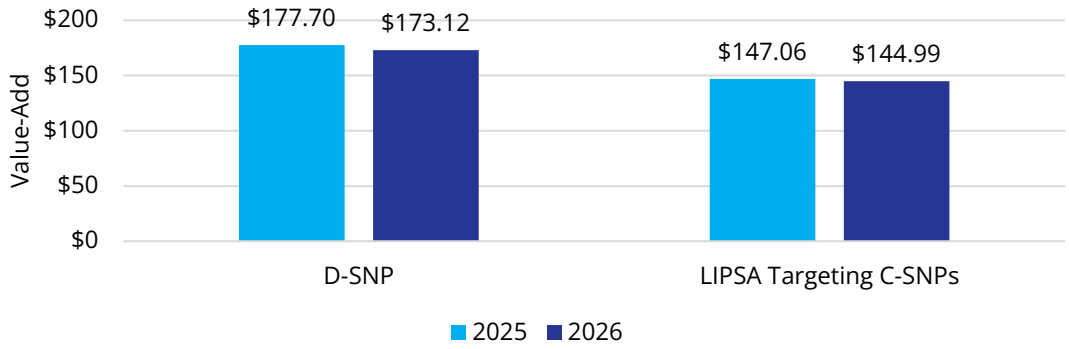
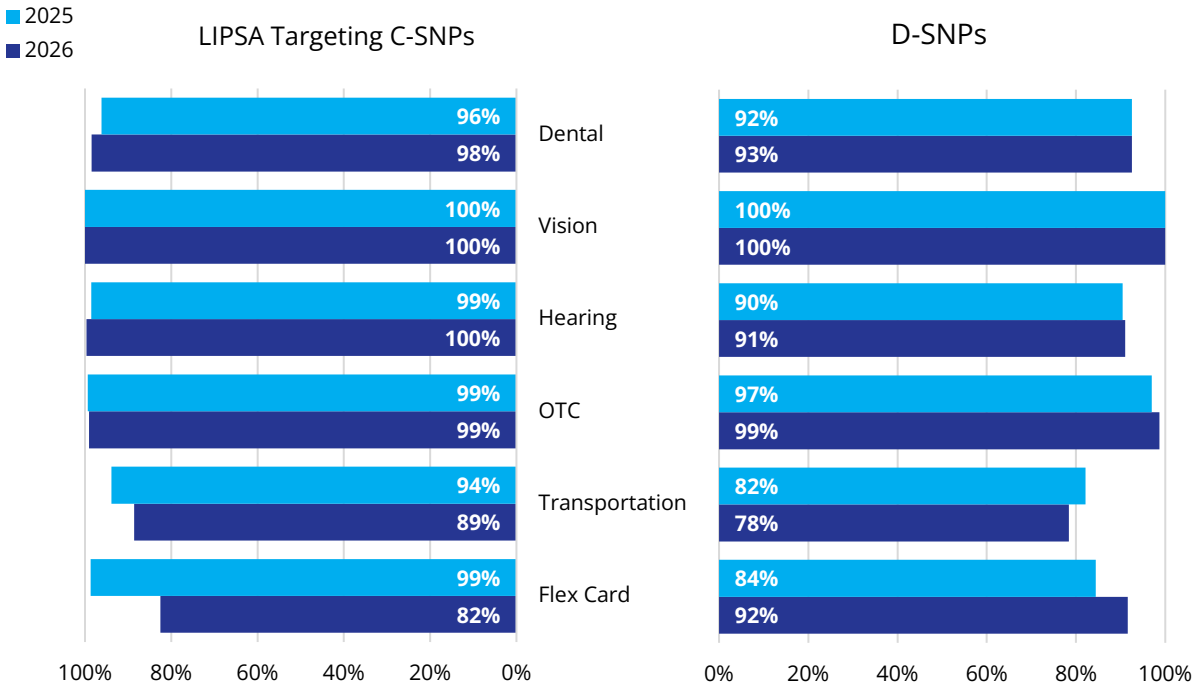


Figure 8 shows the percent of enrollment in several common supplemental benefits for LIPSA-targeting C-SNPs and D-SNPs. Both plan types frequently offer these benefits with C-SNP beneficiaries having more access to transportation and hearing. Plans offering Flex Cards declined significantly for LIPSA-centered C-SNPs, whereas access to Flex Cards for D-SNPs increased in 2025–2026.

Figure 8. Percent of Enrollment in Common Supplemental Benefits



CONSIDERATIONS FOR SUCCESS

As C-SNPs continue to expand rapidly and become a more prominent feature of the MA landscape, organizations evaluating entry or growth must navigate a set of strategic, operational, and market-driven considerations. The following themes are critical to ensure a sustainable, competitive, and compliant C-SNP offering.

1. Define a Clear Market Strategy and Enrollment Objective

C-SNPs should not be viewed in isolation, but rather as part of an integrated Medicare Advantage strategy. Key strategic considerations include whether C-SNPs are intended to drive net new growth; retain existing members, including dual-eligible populations affected by D-SNP look-alike rules; or differentiate the organization in specific competitive markets. Understanding the target enrollment pathway is essential to setting realistic performance expectations, resource needs, and risk tolerance.

2. Ensure Competitive and Condition-Aligned Benefit Design

C-SNP performance is closely tied to how well benefits meet the needs of the condition cohort the plan is targeting. Given the variability in 2026 benefit positioning observed across parent organizations and states, plans should determine where they intend to compete on richness versus affordability and how that component aligns with their strategic goals.

3. Evaluate Feasibility and Scalability of Verification and Eligibility Processes

C-SNPs require precise and timely condition verification, which can vary greatly in complexity depending on the clinical grouping. Plans should assess whether they have (or can build) efficient processes to confirm eligibility, manage enrollment pathways, and maintain compliance with CMS requirements. Broader groupings may offer operational advantages, while narrow or less common conditions often require more specialized workflows.

4. Understand Operational Complexity and Resource Requirements

While growing quickly, C-SNPs remain operationally intensive products relative to general enrollment MA plans. Organizations must ensure adequate infrastructure across areas such as member communications, network configuration, utilization management, data exchange, and compliance oversight. As the C-SNP market expands, CMS scrutiny is likely to increase, making operational readiness a key determinant of long-term sustainability.

5. Assess Competitive Landscape and Geographic Viability

C-SNP availability remains highly concentrated in certain states and counties. Before entering a market, plans should analyze local MA penetration, competitor C-SNP presence, care delivery infrastructure, and the prevalence of qualifying chronic conditions. In some markets, differentiation may be challenging without a clearly defined niche or unique clinical angle.

CONCLUSION

The 2026 C-SNP landscape reflects a market that is scaling rapidly but maturing unevenly. Growth has been significant, yet highly concentrated by both condition and geography. Expansion has increasingly favored broader, clinically related condition groupings that support scalability and operational efficiency, while narrower, single-condition C-SNPs continue to face structural and economic challenges.

At the same time, benefit and pricing trends indicate that C-SNPs are no longer insulated from the broader pressures reshaping Medicare Advantage. Declines in value-add, higher maximum out-of-pocket limits, and increased premium differentiation suggest that plans are making deliberate tradeoffs as competition intensifies and regulatory scrutiny grows. Although C-SNPs continue to invest more heavily in supplemental benefits than General Enrollment plans, sustaining this differentiation will require increasingly disciplined targeting and execution.

As part of Wakely's 2026 MA Market "The Value Shift" series, this paper reinforces that C-SNP expansion should not be evaluated solely through a growth lens. Long-term success will depend on how well these products fit within an organization's broader MA strategy, market footprint, and operational readiness. Tools like WMACAT and SMART provide critical insight into competitive positioning, benefit investment decisions, and geographic viability, enabling organizations to move beyond participation toward intentional, sustainable C-SNP strategies.

The question facing the market is no longer whether C-SNPs are relevant to MA strategies, but whether organizations are prepared to support them intentionally and sustainably. As competitive pressure and operational demands increase, success will hinge on clear strategic alignment, disciplined investment, and a realistic assessment of market opportunity. C-SNPs that are thoughtfully positioned, rather than opportunistically deployed, will be best equipped to deliver value to members while remaining durable in an increasingly complex MA environment.

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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.