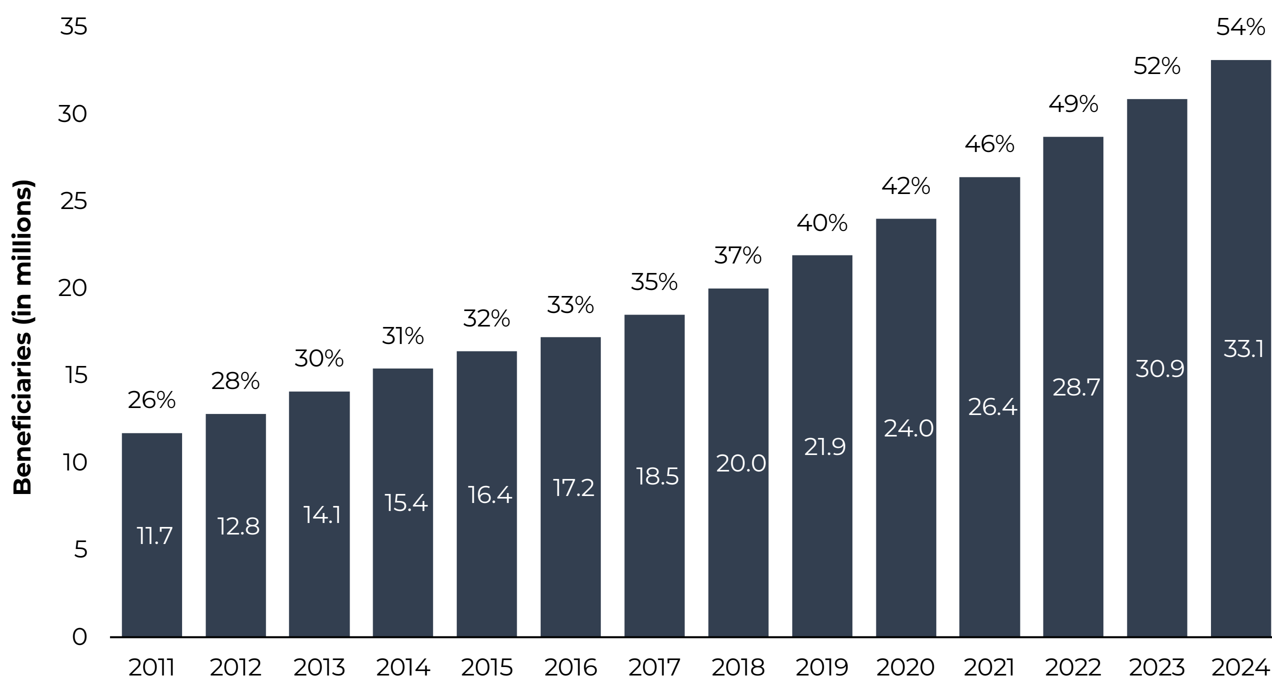
SECTION

9

Medicare Advantage

Chart 9-1 Enrollment in MA plans, 2011–2024



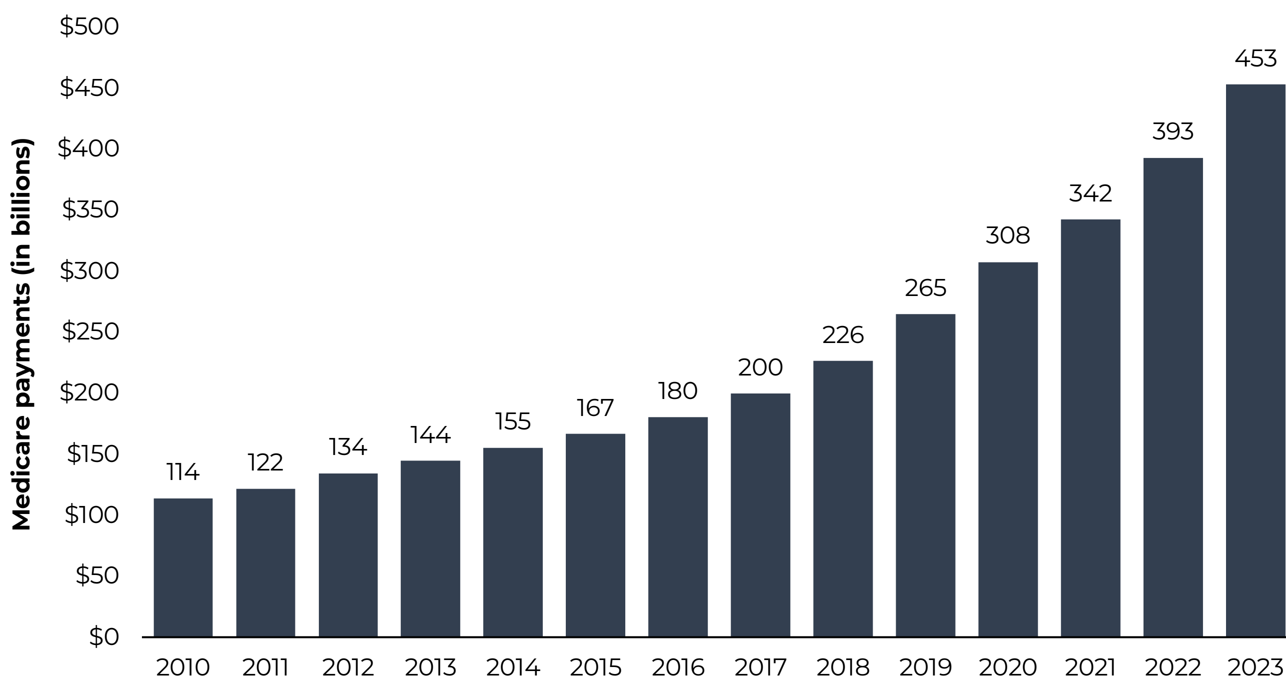
Note: MA (Medicare Advantage). Percentages indicate the share of total MA-eligible enrollment.

Source: CMS Medicare managed care contract reports and monthly summary reports, February 2011–2024.

> In February 2024, enrollment in MA plans, which are paid on an at-risk capitated basis, reached 33.1 million, or 54 percent of all eligible Medicare beneficiaries (only beneficiaries enrolled in both Part A and Part B are eligible to enroll in an MA plan). An additional 1 percent of all Medicare beneficiaries with both Part A and Part B coverage are enrolled in other private plans such as cost plans, plans under the Program of All-Inclusive Care for the Elderly (PACE), and Medicare–Medicaid Plans participating in CMS's financial alignment demonstration (data not shown).

> MA enrollment has grown steadily since 2011, increasing nearly threefold. Enrollment growth has been particularly rapid in recent years, climbing by at least 7 percent in each of the last six years.

Chart 9-2 **Medicare payments to MA plans, 2010–2023**



Note: MA (Medicare Advantage). In contrast to prior MedPAC estimates, the figures above do not include Medicare Medical Savings Account plans, cost-reimbursed plans, Medicare-Medicaid demonstration plans, and the Program of All-Inclusive Care for the Elderly. Dollar amounts are nominal figures, not adjusted for inflation.

Source: MedPAC estimates based on the reports of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance trust funds, 2020–2024.

> The Medicare program paid MA plans an estimated $453 billion in 2023 to cover Part A and Part B services for MA enrollees.

> The rapid growth in MA enrollment (see Chart 9-1) coincided with rapid growth in total Medicare payments to MA plans. From 2018 to 2024, total estimated payments to MA plans doubled on a nominal basis.

Chart 9-3 MA plans available to almost all Medicare beneficiaries, 2017–2024

	Share of Medicare beneficiaries living in counties with plans available					
	CCPs					
	HMO or local PPO (local CCP)	Regional PPO	Any CCP	PFFS	Any MA plan	Average plan offerings per beneficiary
2017	95	74	98	45	99	18
2018	96	74	98	41	99	20
2019	97	74	98	38	99	23
2020	98	73	99	36	99	27
2021	98	72	99	34	99	32
2022	99	74	99	35	99	36
2023	99	74	99	29	>99.5	41
2024	>99.5	74	>99.5	30	>99.5	43

Note: MA (Medicare Advantage), CCP (coordinated care plan), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service). These data do not include plans that have restricted enrollment (special needs plans, employer plans) or are not paid based on MA rates (cost plans and certain demonstration plans). For 2017 through 2021, "share of Medicare beneficiaries" includes beneficiaries who do not have both Part A and Part B coverage (i.e., includes all Medicare beneficiaries). As of 2022, "share of Medicare beneficiaries" includes only beneficiaries with both Part A and Part B coverage (i.e., MA-eligible beneficiaries).

Source: MedPAC analysis of plan bid data from CMS, 2017–2024.

> There are four types of MA plans, three of which are CCPs. Local CCPs include HMOs and local PPOs, which have comprehensive provider networks and limit or discourage use of out-of-network providers. Local CCPs may choose which individual counties to serve. Regional PPOs cover one or more entire states and have networks that may be looser than those of local PPOs. CCPs accounted for 98 percent of Medicare private plan enrollees as of February 2024 (data not shown). Since 2011, PFFS plans are required to have networks in areas with two or more CCPs. In other areas, PFFS plans are not required to have networks, and enrollees are free to use any Medicare provider.

> Since 2006, almost all Medicare beneficiaries have had MA plans available (data not shown). In 2024, local CCPs are available to nearly 100 percent of eligible Medicare beneficiaries, and regional PPOs are available to 74 percent of beneficiaries.

> The number of plans from which beneficiaries may choose in 2024 is higher than at any time during the years examined. In 2024, beneficiaries can choose from an average of 43 plans operating in their counties and have access to plans offered by an average of 8 insurers (latter data not shown).

Chart 9-4 Changes in enrollment vary among major plan types

Plan type	Total enrollees (in thousands)					Percent change 2023–2024
	2020	2021	2022	2023	2024	
Local CCPs	22,703	25,325	27,878	30,291	32,667	8%
Regional PPOs	1,170	1,003	756	534	385	–28
PFFS	87	61	48	37	32	–14

Note: CCP (coordinated care plan), PPO (preferred provider organization), PFFS (private fee-for-service). Local CCPs include HMOs and local PPOs.

Source: CMS health plan monthly summary reports, February 2020–2024.

> Almost all Medicare Advantage (MA) enrollees (over 99 percent) choose local CCPs (HMOs or local PPOs), which limit or discourage use of out-of-network providers (Chart 9-3). Though network requirements may be looser in regional PPOs and PFFS plans, enrollment in both types of plans has been declining for several years and dropped sharply in 2024, with enrollment in regional PPOs falling by 28 percent and enrollment in PFFS plans falling by 14 percent.

> Combined enrollment in the three types of plans grew by 7 percent from February 2023 to February 2024 (data not shown). Enrollment in local CCPs grew by 8 percent over the past year, and special needs plans (SNPs) accounted for 46 percent of this growth (latter data not shown). Local PPOs grew by 13 percent over the past year and accounted for more than two-thirds (69 percent) of the growth in local CCP enrollment (data not shown). Most enrollment growth among HMOs (99 percent) occurred in SNPs (data not shown). The growth in SNP and local PPO enrollment may be driven by increases in Medicare payments for extra benefits for MA enrollees.

Chart 9-5 MA and cost plan enrollment by state and type of plan, 2024

State or territory	All MA-eligible beneficiaries (in thousands)	Distribution (in percent) of beneficiaries by plan type					
		HMO	Local PPO	Regional PPO	PFFS	Cost	Total
U.S. total	61,136	30%	23%	1%	0%	0%	54%
Alabama	1,025	28	36	0	0	0	64
Alaska	103	0	2	0	0	0	2
Arizona	1,362	38	16	0	0	0	54
Arkansas	627	18	29	1	1	0	49
California	6,150	49	7	0	0	0	56
Colorado	933	36	21	0	0	0	57
Connecticut	674	18	43	0	0	0	61
Delaware	223	14	20	0	0	0	34
Florida	4,768	37	21	1	0	0	59
Georgia	1,763	16	42	2	0	0	60
Hawaii	264	20	41	0	0	0	61
Idaho	362	34	18	0	0	0	52
Illinois	2,167	14	29	0	0	0	43
Indiana	1,269	23	29	1	0	0	53
Iowa	635	18	19	0	0	2	39
Kansas	538	12	23	1	0	0	36
Kentucky	905	28	28	1	0	0	57
Louisiana	867	44	15	1	0	0	60
Maine	346	35	27	0	0	0	62
Maryland	981	16	12	0	0	0	28
Massachusetts	1,298	18	17	1	0	0	36
Michigan	2,091	24	39	0	0	0	63
Minnesota	1,056	16	42	0	0	6	64
Mississippi	596	19	25	1	0	0	45
Missouri	1,224	30	26	1	0	0	57
Montana	240	6	25	0	0	0	31
Nebraska	350	18	18	0	0	1	37
Nevada	537	45	11	0	0	0	56
New Hampshire	305	14	24	0	0	0	38
New Jersey	1,553	12	33	0	0	0	45
New Mexico	419	26	28	0	0	0	54
New York	3,540	32	22	2	0	0	56
North Carolina	2,059	29	29	1	0	0	59
North Dakota	134	0	27	0	0	9	36
Ohio	2,325	37	20	1	0	0	58
Oklahoma	729	20	23	0	0	0	43
Oregon	867	36	23	0	0	0	59
Pennsylvania	2,684	29	28	0	0	0	57
Puerto Rico	684	94	1	0	0	0	95
Rhode Island	216	45	14	0	0	0	59
South Carolina	1,132	12	35	1	0	0	48
South Dakota	181	2	19	0	0	17	38
Tennessee	1,361	37	20	0	0	0	57
Texas	4,296	33	23	2	0	0	58
Utah	416	38	19	0	0	0	57
Vermont	151	5	28	2	0	0	35
Virgin Islands	19	0	29	0	0	0	29
Virginia	1,501	26	15	1	0	0	42
Washington	1,374	34	19	0	0	0	53
Washington, D.C.	80	12	27	0	0	0	39
West Virginia	420	10	44	0	0	4	58
Wisconsin	1,222	31	25	0	0	3	59
Wyoming	116	0	17	0	1	0	18

Note: MA (Medicare Advantage), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service). Cost plans are not MA plans; they submit cost reports rather than bids to CMS. "U.S. total" includes beneficiaries in U.S. territories but does not include beneficiaries residing in foreign areas. Sum of beneficiaries by state does not equal U.S. total due to rounding. We report MA enrollment as a share of MA-eligible beneficiaries (Medicare beneficiaries with both Part A and Part B coverage).

Source: CMS enrollment and population data, February 2024.

Chart 9-6 MA enrollment patterns, by age, dual-eligibility status, and ESRD status, June 2023

	All MA-eligible beneficiaries		FFS		MA		MA enrollment as a share of total MA-eligible category
	Enrollment, in millions	Share of total	Enrollment, in millions	Share of total	Enrollment, in millions	Share of total	
Total	59.1	100%	28.3	100%	30.8	100%	52%
Aged (65 or older)	52.1	88	25.2	89	26.9	87	52
Under 65	7.0	12	3.1	11	3.9	13	56
Non–dual eligible	47.1	80	23.8	84	23.3	76	50
Aged (65 or older)	44.3	75	22.5	80	21.8	71	49
Under 65	2.8	5	1.3	4	1.5	5	55
Full dual eligibility	8.7	15	3.7	13	5.0	16	58
Aged (65 or older)	5.5	9	2.1	8	3.3	11	61
Under 65	3.2	5	1.5	5	1.7	5	52
Partial dual eligibility	3.3	6	0.8	3	2.5	8	76
Aged (65 or older)	2.3	4	0.5	2	1.8	6	78
Under 65	1.0	2	0.3	1	0.7	2	62
Enrollment subcategories, all ages							
ESRD	0.4	1	0.2	1	0.2	1	47
Beneficiaries with partial dual eligibility							
QMB only	1.7	3	0.4	2	1.3	4	75
SLMB only	1.0	2	0.2	1	0.8	2	77
QI	0.6	1	0.1	<1	0.5	2	77

Note: MA (Medicare Advantage), ESRD (end-stage renal disease), FFS (fee-for-service), QMB (qualified Medicare beneficiary), SLMB (specified low-income beneficiary), QI (qualifying individual). Data for 2024 were not available as of the date of publication. Data exclude cost plans, plans under the Program of All-Inclusive Care for the Elderly (PACE), and Medicare–Medicaid Plans participating in CMS's financial alignment demonstration. MA-eligible beneficiaries are Medicare beneficiaries with both Part A and Part B coverage. Dual-eligible beneficiaries are eligible for Medicare and Medicaid. Data exclude Puerto Rico because enrollment data undercount dual-eligible categories. In 2023, Puerto Rico had about 654,000 Medicare beneficiaries enrolled in MA plans, and about 302,000 were enrolled in dual-eligible special needs plans. Figures may not sum to totals due to rounding.

Source: MedPAC analysis of 2023 common Medicare environment files.

> Medicare beneficiaries with Medicaid benefits are more likely to enroll in MA than beneficiaries without Medicaid. Beneficiaries who have full dual eligibility with Medicaid (i.e., those who have coverage of their Medicare out-of-pocket costs (premiums and cost sharing) as well as coverage for services such as long-term care services and supports) are less likely to enroll in MA plans than beneficiaries with "partial" dual eligibility (i.e., those who receive assistance only with Medicare premiums and, in some cases, with cost sharing). Fully dual-eligible beneficiaries have coverage through state Medicaid programs, including certain QMBs (i.e., QMB-Plus) and certain SLMBs (i.e., SLMB-Plus) who also have Medicaid coverage for services. Beneficiaries with partial dual eligibility (such as QIs or SLMBs) have coverage for Medicare premiums or premiums and Medicare cost sharing (such as QMBs).

> Medicare plan enrollment among the dually eligible continues to increase. In 2023, 58 percent of fully dual-eligible beneficiaries were in MA plans (up from 52 percent in 2022), and 76 percent of partially dual-eligible beneficiaries were in MA plans (up from 71 percent in 2022) (2022 data not shown). QI and SLMB-only beneficiaries have the highest rates of MA enrollment among partial dual eligibles (77 percent). About 50 percent of Medicare beneficiaries who are not dually eligible for Medicaid were enrolled in an MA plan.

> A substantial share of the dually eligible population (35 percent; data not shown) are under the age of 65 and entitled to Medicare on the basis of disability or ESRD. Beneficiaries under age 65 who are fully dual eligible are less likely than aged fully dual-eligible beneficiaries to enroll in MA (52 percent vs. 61 percent, respectively). A higher share of MA enrollees is fully dual eligible compared with FFS enrollees (16 percent vs. 13 percent, respectively).

> ESRD beneficiaries had higher rates of plan enrollment in 2023 (47 percent) compared with 2022 (42 percent; data not shown).

Chart 9-7 MA plan benchmarks, bids, and Medicare program payments relative to FFS spending, 2024

	Share of FFS spending in 2024		
	Benchmarks	Bids	Payments
Overall estimate	132%*	101%*	122%
Estimated before coding and selection	108*	82*	100
Estimated coding effect	+14	+11	+13
Estimated selection effect	+10	+7	+9

Note: MA (Medicare Advantage), FFS (fee-for-service). "Benchmarks" are the maximum Medicare program payments for MA plans and incorporate plan quality bonuses. We use CMS's projected FFS spending estimates by county from the 2024 MA rate book. Although MA enrollees must be enrolled in both Part A and Part B, the FFS spending denominator used in the MA rate book includes all Part A and Part B spending (including spending on beneficiaries covered only by Part A). To assess the impact of that discrepancy, for each year from 2016 through 2021 (when necessary data were available), we retrospectively compared overall Medicare spending on MA with actual FFS spending for beneficiaries enrolled in both Part A and Part B and found that the results of those retrospective comparisons were similar (within 1 percentage point) compared with our prospective analyses that use CMS's projected FFS spending estimates. Therefore, we concluded that the inclusion of Part A–only enrollees in the FFS spending denominator did not have a meaningful impact on the estimates for the years we analyzed. We also removed spending related to the remaining double payment for indirect medical education payments made to teaching hospitals.

To incorporate our most recent estimate of the effect of coding on payments (13 percent), we estimated what overall benchmarks, bids, and payments would be if the risk-adjusted spending differences between MA and FFS did not include any effect of differential coding. The coding effect accounts for CMS's annual coding adjustment. We project coding intensity based on the annual trend from 2017 through 2021, an increase of 1.5 percentage points per year. For 2024, we reduced the annual trend by 0.67 percentage points to account for one-third of an estimated 2 percentage point reduction in coding intensity associated with the introduction of the version 28 risk-adjustment model, which is being phased in over three years.

Favorable selection accounts for the estimated lower risk-standardized spending that MA enrollees would have had in FFS without any plan intervention (e.g., utilization management, provider network, or beneficiary incentives). We assume that the 2024 effect of selection would be the same as our 2019 estimate of selection (before the coronavirus pandemic). More details on our coding and selection analyses are found in Chapter 13 of our March 2024 report to the Congress. Components of the bid column do not sum to the total due to rounding.

For more information, see the Commission's March 2023 and March 2024 reports to the Congress.

*Specified estimates of benchmarks and bids relative to FFS spending do not include employer plans.

Source: MedPAC analysis of data from CMS on plan bids, enrollment, benchmarks, FFS expenditures, and risk scores.

> Since 2006, plan bids have partly determined the Medicare payments that plans receive. Plans bid to offer Part A and Part B coverage to Medicare beneficiaries (Part D coverage is bid separately). The bid includes plan administrative cost and profit. CMS bases the Medicare payment for a private plan on the relationship between its bid and its applicable benchmark.

> The benchmark is a bidding target in each county and is set by means of a statutory formula based on percentages (ranging from 95 percent to 115 percent) of CMS's projections of each county's per capita, risk-standardized Medicare FFS spending. Plans with quality ratings of 4 or more stars typically have their benchmarks raised by up to 5 percent (and up to 10 percent in some counties).

(Chart continued next page)

Chart 9-7 MA plan benchmarks, bids, and Medicare program payments relative to FFS spending, 2024 (continued)

> The risk-adjustment model used by Medicare to adjust payments to plans is based on FFS data and therefore reflects the expected spending and diagnostic coding patterns in FFS Medicare. The model accounts for differences in demographics and recorded diagnoses. The Commission's comparisons use that risk-adjustment model as a starting point to standardize MA and FFS spending. However, Medicare's risk-adjustment model does not account for the effects of coding intensity (i.e., the extent to which the same beneficiary could have more diagnoses recorded in MA, and thus a higher risk score, than they would in FFS) or favorable selection (i.e., the extent to which the risk-adjustment model used to standardize spending overpredicts spending for MA enrollees even for beneficiaries who have diagnoses coded with the same level of intensity). Therefore, the Commission's final comparisons of MA payments and FFS spending incorporate adjustments for coding and selection to account for those ways in which Medicare's risk-adjustment model overstates what FFS spending would have been for MA beneficiaries.

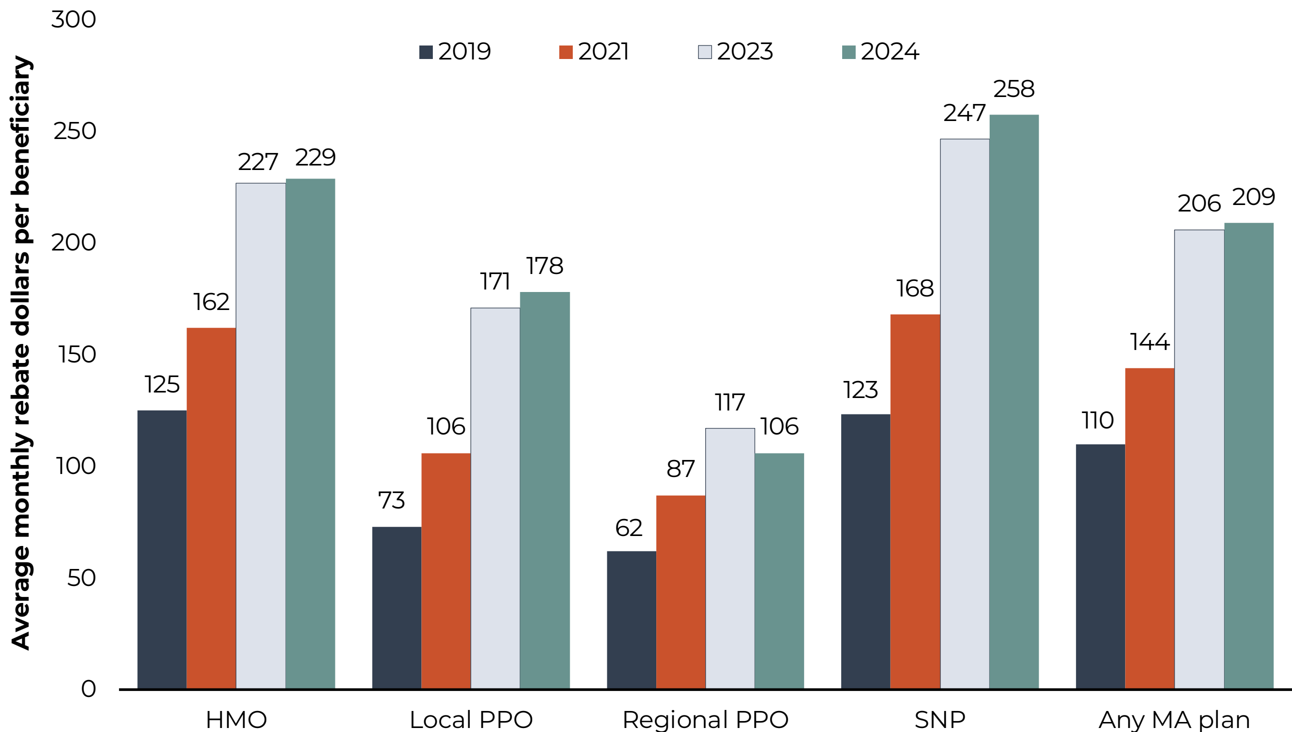
> If a plan's bid is below the benchmark, the plan receives its bid plus a "rebate," defined by law as a percentage of the difference between the plan's bid and its benchmark. The percentage is based on the plan's quality rating, and it is typically 65 percent or 70 percent. After accounting for administrative expenses and profit, plans must return rebates to enrollees in the form of lower cost sharing, supplemental benefits not covered by FFS Medicare, or lower premiums. (If a plan's bid is above the benchmark, then the plan receives the benchmark amount as payment from Medicare and enrollees have to pay an additional premium that equals the difference; however, bidding over the benchmark is rare. For 2023, virtually all plans bid below their benchmarks).

> Using CMS's projections of FFS spending that do not fully account for the effects of coding or selection, we estimate that benchmarks will be an average of 108% of FFS spending in 2024. After accounting for the effects of coding and selection, we estimate that MA benchmarks in 2024 will average 132 percent of FFS spending.

> Plans have generally bid below benchmarks since the current system began, and the difference between bids and benchmarks has grown in recent years. We estimate plans' enrollment-weighted bids to be slightly higher (101 percent), on average, than FFS spending for 2024. Not accounting for coding or selection, plan bids are estimated to average about 18 percent below FFS spending.

> Altogether, we estimate that MA payments are 22 percent higher than what Medicare would have spent to cover the same group of enrollees in FFS. That estimate incorporates adjustments for the effects of coding and selection. Before accounting for those effects, we estimate that payments to MA plans are about equal to FFS spending.

Chart 9-8 Average monthly rebate dollars, by plan type, 2019–2024



Note: HMO (health maintenance organization), PPO (preferred provider organization), SNP (special needs plan), MA (Medicare Advantage). Employer group waiver plans are excluded. SNPs are a subset of HMO and PPO plans. Dollar amounts are nominal figures, not adjusted for inflation.

Source: MedPAC analysis of bid data from CMS.

> The average rebate, which plans receive to provide additional benefits that are not covered under Medicare Part A and Part B, is an important summary measure of plan generosity. Plans are awarded rebates for bidding under their benchmarks. The rebates must be returned to the plan members in the form of extra benefits (after accounting for plan margins and administrative costs). The extra benefits can include lower cost sharing, supplemental benefits not covered by Medicare, or lower premiums. The average rebate for all nonemployer, non–special needs plans slightly increased to $209 per month per beneficiary for 2024.

> HMOs have had, by far, the highest rebates because they tend to bid lower than other types of plans. Average rebates for HMOs are $229 per month per beneficiary for 2024.

> Local PPOs' rebates have risen sharply in recent years, more than doubling since 2019.

> In recent years, rebates have grown the most for SNPs, a subset of HMOs and PPOs that offer benefit packages tailored to specific populations (beneficiaries who are dually eligible for Medicare and Medicaid, are institutionalized, or have certain chronic conditions). Average rebates for SNPs rose to $258 per month in 2024 (up from $247 per month in 2023). The relatively large rebates for SNPs coincide with historically higher reported margins than conventional MA plans (data not shown) and higher relative coding intensity for beneficiaries who are dually eligible for Medicaid (see Chart 9-9).

Chart 9-9 **Impact of diagnostic coding intensity on MA risk scores was larger for enrollees eligible for partial or full Medicaid benefits, 2022**

Beneficiary group	Coding intensity relative to FFS Medicare
All MA enrollees	17.8%
New enrollees	N/A
Long-term institutional	13.2
No Medicaid benefits	17.6
Partial Medicaid benefits	29.9
Full Medicaid benefits	20.6

Note: MA (Medicare Advantage), FFS (fee-for-service), N/A (not applicable). In this analysis, we first determined whether a beneficiary was a new enrollee, then we determined long-term institutional status (based on the presence of a 90-day Minimum Data Set assessment for nursing home residents), and then Medicaid eligibility. New enrollees have a risk score based only on demographic factors and therefore do not exhibit diagnostic coding intensity. Analysis uses the demographic estimate of coding intensity (DECI) method, which is the MA-to-FFS CMS hierarchical condition (HCC) risk-score ratio divided by the MA-to-FFS demographic risk-score ratio, estimated separately for each beneficiary group. MedPAC's DECI estimate for all MA enrollees accounts for differing shares of MA and FFS enrollment across the beneficiary groups by weighting MA enrollment for each group to calculate overall average MA and FFS CMS–HCC risk scores and demographic risk scores. See Chapter 13 of our March 2024 report to the Congress for more information about our analysis using the DECI method.

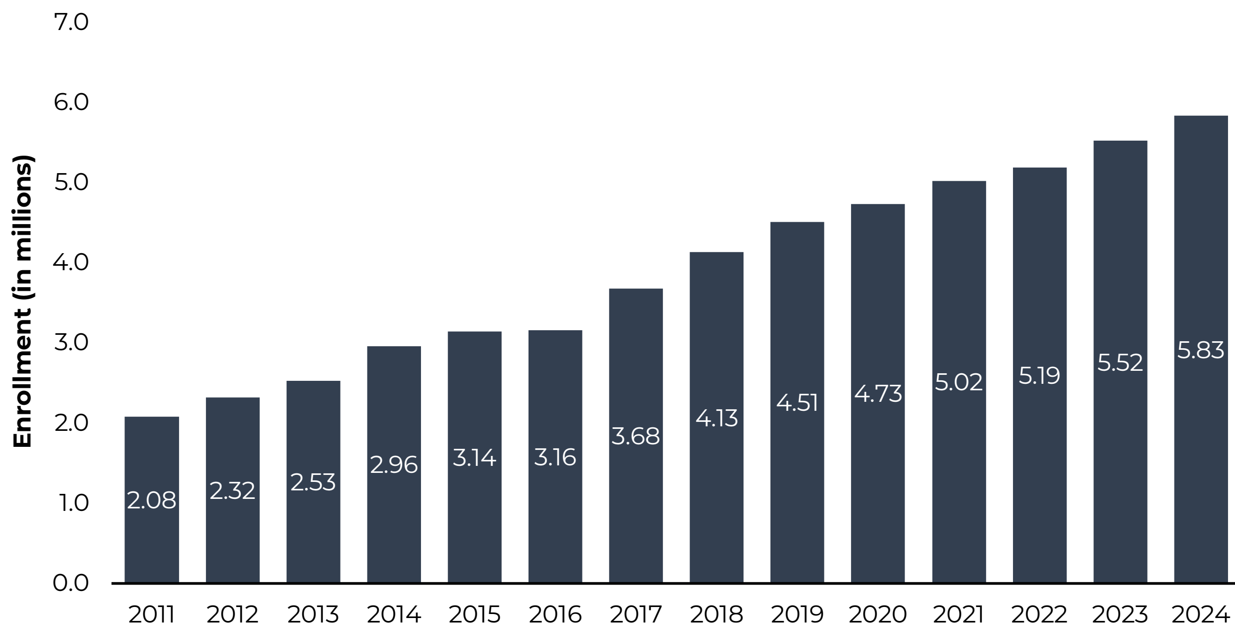
Source: MedPAC analysis of CMS enrollment and risk score files, 2021 and 2022.

> Payments to MA plans are risk adjusted to account for differences in health status. Risk adjustment increases payments to plans for enrollees with higher expected Medicare spending. An enrollee's risk score is based on demographic information and diagnoses that plans submit to CMS. Documenting additional diagnosis codes raises plan enrollees' risk scores, generating two distinct benefits for MA plans: (1) increasing plans' monthly payments and (2) increasing the rebates plans use to provide extra benefits to enrollees. Plans that document relatively more diagnosis codes therefore have a competitive advantage over other plans. In contrast, the payment policies in FFS Medicare offer relatively little incentive to code all diagnoses. This difference in coding incentives results in higher risk scores when a beneficiary enrolls in MA than if the same beneficiary had enrolled in FFS Medicare. As a result of higher MA coding intensity, the Medicare program pays more, on average, when a beneficiary enrolls in MA than it would if the same beneficiary were in FFS Medicare. This phenomenon is true both for beneficiaries who have higher than average and lower than average spending.

> In 2022, MA risk scores on average were 17.8 percent higher than risk scores for comparable FFS beneficiaries.

> MA enrollees who were eligible for full or partial Medicaid benefits had higher coding intensity relative to FFS than enrollees who were not eligible for Medicaid. Risk scores for MA enrollees who were eligible for partial Medicaid benefits were 29.9 percent higher than the scores for FFS beneficiaries who were eligible for partial Medicaid benefits. Risk scores for MA enrollees who were eligible for full Medicaid benefits were 20.6 percent higher than the scores for FFS beneficiaries who were eligible for full Medicaid benefits. By contrast, risk scores for MA enrollees who were not eligible for Medicaid were 17.6 percent higher than the scores for their FFS counterparts, and risk scores for MA enrollees with long-term institutional status were 13.2 percent higher than the scores for their FFS counterparts.

Chart 9-10 Enrollment in employer group MA plans, 2011–2024



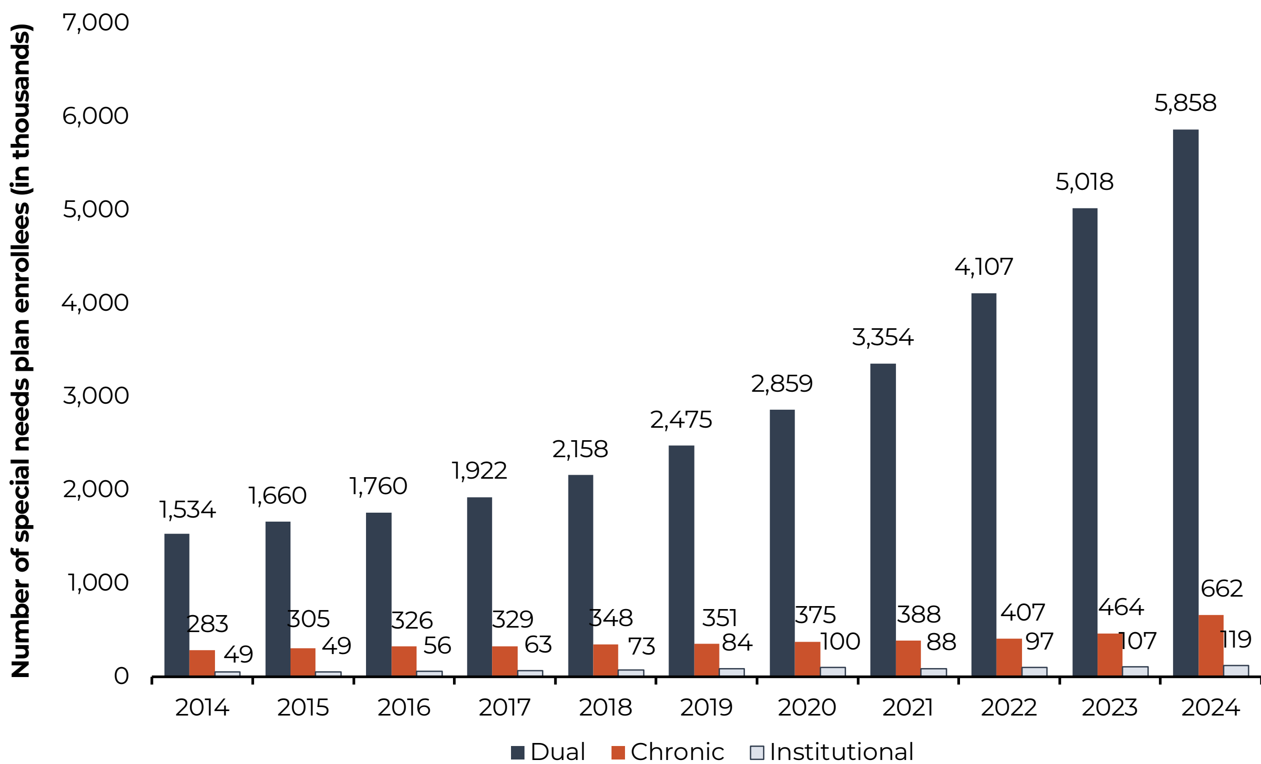
Note: MA (Medicare Advantage).

Source: CMS enrollment data, February 2011–2024.

> While most MA plans are available to any Medicare beneficiary residing in a given area, some MA plans are available only to retirees whose Medicare coverage is supplemented by their former employer or union. These plans are called employer group plans. Such plans are usually offered through insurers and are marketed to groups formed by employers or unions rather than to individual beneficiaries.

> As of February 2024, about 5.8 million enrollees were in employer group plans, or about 18 percent of all MA enrollees. Employer plan enrollment grew by 6 percent from 2023 and has more than doubled since 2013.

Chart 9-11 Number of special needs plan enrollees, 2014–2024



Source: CMS special needs plans comprehensive reports, February 2014–2024.

> Special needs plans (SNPs) offer benefit packages that are tailored to specific populations. Dual-eligible SNPs enroll only beneficiaries dually entitled to Medicare and Medicaid, chronic condition SNPs enroll only beneficiaries who have certain chronic or disabling conditions, and institutional SNPs enroll only beneficiaries who reside in institutions or are nursing-home certified.

> The vast majority of SNP enrollees are in dual-eligible SNPs. Enrollment in dual-eligible SNPs has tripled since 2014, exceeding 5.8 million—about 19 percent of all MA enrollees—in 2024.

> Enrollment in chronic condition SNPs has grown at varying rates as plan requirements have changed, but it has generally risen annually since 2014. In 2024, about 662,000 beneficiaries (about 2 percent of all MA enrollees) were enrolled in chronic condition SNPs.

> Enrollment in institutional SNPs increased to its highest level ever in 2024 but accounts for less than 1 percent of all MA enrollees.

> The number of SNPs increased by 4 percent from February 2023 to February 2024 (data not shown). Dual-eligible SNPs increased by 7 percent, institutional SNPs decreased by 8 percent, and the number of chronic condition SNPs increased by 1 percent (data not shown).