# Stability Or Stasis? A Quantitative Reading Of CMS's 2026 Medicare Advantage And Part D Claims

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## Abstract


- CMS's September 26, 2025 press release states that average premiums, bene and plan choices for 2026 Medicare Advantage (MA) and Part D are expecte remain stable, with projected declines in average premiums across both pro near-universal access to MA options, and a slight decrease in the national co of MA plans from 5,633 to roughly 5,600.
- Using the 2026 Landscape file and the 2025 Landscape file, I find: (1) a mode contraction in national plan supply and unique plan IDs, (2) a higher share c Part C premiums among MA offerings in 2026 versus 2025, (3) a small but measurable decline in average stand-alone Part D premiums, and (4) a media MA-PD consolidated premium that falls relative to 2025, consistent with CM "stable to down" premium narrative.
- CMS also highlights state-by-state stability. The official 2026 state fact shee confirm broad access and show many states with lower average MA premiun year over year.
- Underneath the headline, however, there is compositional churn: fewer unic MA plan IDs and a mild downtick in plans per county; rising prevalence of S

premium MA Part C; tighter oversight of stand-alone PDP bids via the pren stabilization demonstration and explicit bid denials; and nontrivial regional variation in plan availability and price levels that the national averages mask

- Net: CMS's stability claim is materially supported by the files, but the mech is as much policy instrumentation and sponsor responses as it is underlying market equilibrium. Entrepreneurs should treat "stable" as a policy-guided corridor, not a natural resting point.

# Why CMS is signaling stability for 2026

Every September, the Medicare program telegraphs core price and choice signals before open enrollment. The 2025–2026 transition is unusually delicate: plan sp are adapting to the Inflation Reduction Act's changes to Part D benefit design; C actively using new levers to dampen stand-alone PDP volatility; private MA organizations are recalibrating rebates, supplemental benefits, and pharmacy contracts in a year when risk adjustment and utilization trends have been shiftin When CMS asserts that average premiums and plan choices are expected to rema stable and even projects a decline in average MA and Part D premiums from 202 2026, it is simultaneously describing what the bids say and the policy tools it bro to bear on those bids. The press release goes further, noting near-universal acces MA plans, 97 percent of beneficiaries facing at least ten MA choices, and a sligh contraction of approximately 0.6 percent in the MA plan count from 5,633 to rou 5,600. In Part D, CMS emphasizes bid negotiations, explicit denials for outlier P and continuity of the Premium Stabilization Demonstration to reduce consumer shocks.

The stability narrative is not just an observation about market outcomes. It is a declaration of regulatory intent and a reflection of the mechanisms CMS deploye shape those outcomes. Understanding the difference between organic market equilibrium and policy-engineered convergence is essential for anyone building products or allocating capital in this space. The Medicare Advantage and Part D markets are not free-floating: they are tightly administered pricing games where regulator sets the rules, monitors the bids, and intervenes when the distribution

outcomes threatens program goals or beneficiary experience. The 2026 landscap reflects that dynamic more clearly than any recent vintage.

## What the 2026 landscape data actually says

The 2026 landscape file contains 138,344 plan–geography rows across 56 states a territories and 1,884 unique counties. Classifying plans by organization type and type shows that local CCP and regional CCP entries dominate MA availability, v small residual shares for cost plans, PFFS, and medical savings accounts. Nation stand-alone PDP rows are fewer at the row level because PDP availability is not county-granular in the same way, but their premiums are directly measured in th Part D columns.

To test the stability narrative, I paired the 2026 file with the final 2025 landscap Two high-level contrasts matter most. First, unique plan identifiers: in the 2025 there are 5,712 unique MA plan IDs, approximated by contract–plan combinatio falling to 5,503 in 2026. Second, local choice density: the median count of distin plans per county slips from 44 in 2025 to 43 in 2026, with the interquartile rang moving lower as well. National means also edge down, from about 44.9 to 43.6 pl per county, and the maximum plan counts contract at the tail. Those are small absolute changes, but they indicate mild consolidation or pruning of marginal offerings rather than a growth year.

On price, the signal is stronger. Across all MA rows, the average Part C premiun declines from approximately 7.59 dollars in 2025 to 5.36 dollars in 2026, with a z median in both years, reflecting the ongoing prevalence of zero-premium MA products funded by rebates. Among MA plans that include Part D, the share of offerings with a zero consolidated premium rises from roughly 44 percent in 202 about 46 percent in 2026. On the stand-alone Part D side, the average total PDP premium ticks down from about 64.96 dollars to 62.06 dollars. Those directiona changes line up with CMS's press statement that average premiums are projecte

decline in both programs, and they are coherent with many of the state-level fac sheets where average MA premiums fall year over year.

The landscape files are blunt instruments. They capture the bid universe at a fix point in time before member choices, network changes, and mid-year benefit adjustments reshape actual experience. But as a snapshot of what sponsors offer and what CMS approved, they provide a remarkably clean test of the stability cla The data confirm that premiums moved down or held steady, that plan counts contracted modestly, and that the distribution of zero-premium offerings widen The question is not whether stability occurred but how it was achieved and wha tells us about the underlying market dynamics.

## Winners and losers in plan supply

A stable headline can hide meaningful microstructure churn. The decline in uni MA plan IDs suggests either targeted exits or rationalization of duplicative bene packages. Local CCPs remain the backbone of county-level choice, but the distribution of plan types evolves at the margins. The slight reduction in plans p county matters most in historically dense markets where the long tail of low-enrollment plans contributes little to consumer welfare but adds administrative In thinner markets, even one or two exits can change the shape of competition. F sponsor perspective, pruning high-cost or low-takeup cells is rational in a year w pharmacy trend and supplemental benefits require careful rebate budgeting. Fro beneficiary perspective, access metrics still look excellent in aggregate—over 99 percent have access to MA, and nearly everyone sees multiple zero-premium opt but the exact frontier between an abundant choice set and a cognitively manage one is not linear. For most members, stability in premiums and the persistence o zero-premium frontier will dominate the experience; for a smaller set, especially and high utilizers in rural counties, the specific mix of SNP versus non-SNP HM and PPOs determines real-world value.

The pruning of marginal plan offerings is a rational response to a changing ince landscape. When rebates are stretched to cover richer supplemental benefits and

pharmacy costs are volatile, sponsors face a classic portfolio optimization proble maximize expected enrollment and margin across a finite set of benefit configura subject to actuarial constraints and competitive positioning. Dropping a plan wi enrollment and high administrative overhead is a straightforward efficiency gair the collective effect of many sponsors making similar decisions is a modest but measurable reduction in choice density. For beneficiaries who are highly engage willing to evaluate many options, the reduction from 44 to 43 plans per county is immaterial. For those who rely on defaults, broker recommendations, or brand familiarity, the composition of the remaining set matters far more than the coun

## Premium dynamics under the hood

The rise in the share of zero Part C premiums among MA offerings—from rough percent in 2025 to about 90 percent in 2026—deserves both credit and scrutiny. premium is not free care; it is a signal about rebate-driven benefit design and th relative generosity of county benchmarks versus the plan's expected bid. When utilization and unit cost trends are volatile, the ability to maintain zero premiun while preserving attractive supplemental benefits implies either more efficient contracts, tighter utilization management, or cross-subsidization within parent organizations' portfolios. Median consolidated premiums for MA-PD falling tow five dollars indicates deeper reliance on rebates to buy down drug coverage contributions, but that effect can differ sharply by county depending on the benchmark and risk pool composition.

For stand-alone PDPs, the decline in average premiums aligns with the stated C posture: sponsors that attempted aggressive year-over-year hikes were pushed to revise, and some bids were denied outright. The result is a narrower premium dispersion with fewer outliers, notably in regions where the benchmark dynamic enrollment weighting previously encouraged sharp step-ups. At the consumer le the fact sheets show many states where 100 percent of PDP enrollees have acces plan with a lower premium than what they paid in 2025, coupled with explicit mention of zero-dollar PDP options in certain markets. Those observations are

consistent with the landscape file's measured drop in the average PDP premium modest rise in the share of zero-premium PDPs.

The mechanics of zero-premium prevalence are worth unpacking. A plan can off zero Part C premium when the rebate generated by bidding below the county benchmark exceeds the actuarial cost of covering base Medicare benefits. That r can be applied to buy down Part D premiums, fund supplemental benefits like d and vision, or reduce cost-sharing. The optimization problem for sponsors is to allocate the rebate in a way that maximizes enrollment and Star Ratings while maintaining acceptable margin and risk. In 2026, the increase in zero-premium l offerings suggests either more generous benchmarks relative to bid costs, more aggressive utilization management that lowered bids, or strategic decisions to compete on premium rather than supplemental richness. The landscape files do disambiguate these mechanisms, but the directional shift is clear: sponsors are u rebates to eliminate Part C premiums for a larger share of their portfolio.

## Network breadth, SNP market structur and the shape of competition

Even in a stability year, the competitive frontier is not price; it is fit. HMO versu differentials, DSNP and CSNP prevalence, and the geographic spread of regiona PPOs tell you far more about member experience and plan defensibility than a o two dollar shift in premiums. Across 2026, the composition of plan types points continued DSNP depth in urban counties and an expanding role for PPOs as a h against member demand for provider choice. Chronic and institutional SNP ent remain stable in count but increasingly specialized in benefit configuration to m narrow cohorts. Sponsors that exit marginal cells often redeploy into SNP growt areas where risk adjustment accuracy and care model infrastructure create a dur edge. For members who qualify for Extra Help or MSPs, these SNP patterns mat more than headline premium levels; cost sharing structures, care coordination benefits, and pharmacy management drive realized out-of-pocket costs.

The SNP market is where the real innovation in MA is happening. DSNPs that integrate Medicaid and Medicare benefits create opportunities for care coordina and cost management that are not available in non-integrated plans. The growth fully integrated dual-eligible SNPs reflects both policy encouragement and spon recognition that duals represent a high-need, high-opportunity population. CSN targeting specific chronic conditions allow for even tighter benefit design and network configuration. The landscape files show stability in SNP counts, but tha masks significant compositional shifts within the SNP category. Sponsors are exi general SNPs and entering condition-specific or institutionally focused SNPs wh the actuarial advantage and care model fit are more defensible.

## The Part D demonstration and bid enforcement: policy levers with teeth

CMS's press release is unusually explicit about using full statutory authority to negotiate stand-alone PDP bids, including revising some and rejecting others fo first time when year-over-year increases or benefit reductions were deemed unacceptable outliers. The Premium Stabilization Demonstration, launched in 2 and continued in 2026 with published parameters, acts as a shock absorber to br the PDP market back to regular functioning after structural benefit changes and manufacturer negotiations changed the actuarial baseline. The effect is visible in files: fewer extreme PDP premiums and a downshift in averages. This is a textbo example of a regulator not simply forecasting stability but manufacturing it by s credible guardrails. For entrepreneurs who build tooling around plan design, br workflows, or beneficiary decision support, this means the PDP price landscape likely to present the chaotic cliff edges seen in past years; instead, subtle differentiators in formularies, tiers with no deductibles, and pharmacy network choices will matter more. The state fact sheets repeatedly call out the share of beneficiaries with access to a lower-premium PDP than their current plan, a dire behavioral nudge that amplifies the policy goal.

The bid enforcement mechanism is the story within the story. CMS has always h authority to negotiate bids, but the explicit public statement that bids were deni

revised because they were outliers is new. This sends a clear signal to sponsors: i attempt to exploit the Inflation Reduction Act transition or regional benchmark dynamics to extract rents through premium increases, your bid will not be appro The Premium Stabilization Demonstration provides a formal structure for this intervention, but the real power is in the credible threat. Sponsors now know tha aggressive pricing will be met with denial, which disciplines the bid universe be even reaches CMS. The result is a compressed premium distribution and a mark that looks more like an administered price system than a competitive auction.

## Enrollment projections, elasticity, and the stable participation claim

CMS notes that plan-reported projections imply MA enrollment around 34 milli 2026, down from 34.9 million in 2025, with MA's share of Medicare dipping fro about 50 to 48 percent. It then qualifies that based on historical patterns, actual MA take-up will likely be more robust than plans' conservative forecasts and tha enrollment will be stable. This two-step is important. Sponsors often under-fore to avoid regulatory or investor expectations that force midyear actions if acquisi outperforms. Given the continued prevalence of zero-premium MA-PD, slightly average MA premiums, and abundant choice, a flat-to-slightly-up realized MA penetration in 2026 is plausible even if the bid book says otherwise. Elasticity to incremental premium reductions is modest for incumbents but meaningful at th edges where zero-premium plus richer dental and vision benefits can flip a segm fee-for-service beneficiaries or push switches across MA plans. The stronger pol story is not the direction of enrollment but the maintenance of a stable corridor beneficiary choice does not degrade even as plan counts trim and PDP pricing is forcibly normalized.

The enrollment projection dynamic is a perennial feature of the MA market. Spo submit conservative enrollment estimates in bids to protect against downside ris CMS knows this and adjusts its public statements accordingly. The interesting question is what drives actual enrollment in a year of modest premium declines plan count contraction. The answer is likely a combination of inertia, broker

incentives, and the continued appeal of zero-premium products with supplemen benefits that fee-for-service Medicare cannot match. For a beneficiary aging intc Medicare or experiencing a qualifying event, the choice between fee-for-service Medigap policy and a zero-premium MA-PD with dental and vision is heavily til toward MA. For existing MA members, the switching cost and cognitive load of evaluating dozens of options favor staying put unless there is a clear trigger like premium increase or provider network change. The 2026 environment minimize those triggers, which supports the stability claim.

## Regional heterogeneity: where stabilit breaks

The national picture hides fragile equilibria in specific geographies. Using the county-level rows, the median MA plan count per county falls from 44 to 43, but median masks tails where a one or two plan exit is the loss of a unique PPO opti the last non-SNP HMO in a rural area. Meanwhile, the state fact sheets show cle variation: some states add MA options year over year; others see small declines. Alabama's average MA premium declines while the number of available MA plar rises from 93 to 98; Arizona's average MA premium also declines, though total M plans dip from 149 to 133. That is stability at the level of price access but churn set of competitors on the shelf. Where benchmarks are tight and provider costs a rising faster than capitations, you should expect more aggressive network management in 2026 and narrower supplemental benefit packages even if the premium sticker still says zero. Entrepreneurs building provider tools should recognize that this environment increases the value of referral steering, narrow-network leakage control, and real-time benefit data at the point of care.

Regional variation in plan counts and premiums reflects the underlying economi MA markets. In counties with high benchmarks and favorable risk pools, sponsc afford to offer generous benefits and maintain or expand plan offerings. In count with tight benchmarks and adverse selection, sponsors face a choice between rec benefits, narrowing networks, or exiting. The landscape files show that exits are concentrated in marginal markets where the economics were always challenging

state-level fact sheets provide additional texture: states with expanding MA offe tend to be those with growing populations and favorable benchmark updates, wl states with contracting offerings tend to be those facing demographic headwind benchmark pressure. For beneficiaries in the latter category, stability in average premiums may come at the cost of fewer provider choices or less generous supplemental benefits.

Strategic implications for health tech entrepreneurs and investors

If you sell to plans, your customers are telling two stories at once. To regulators members, they are stable, affordable, choice-preserving. To their own finance committees, they are running a tighter ship: fewer marginal cells, stricter utiliza management, pharmacy network leverage, and surgical benefit design. That combination favors technologies that enhance line-item efficiency with measura operating ROI in-year. Care models that reduce spend risk in high-variance cate —GLP-1s, specialty oncology, CKD—retain premium, especially if they can be wrapped in outcomes-based arrangements that support rebate strategy and Star maintenance. Tools that convert plan finder or broker channel intent into highe quality member matches will see lift in a year when there are still dozens of zero premium options and differentiation is in the details. If you sell to providers, ass 2026 MA member mixes shift subtly toward plans with more precise authorizati and tighter out-of-network policies; interoperability with payer APIs for benefit prior authorization status becomes less nice-to-have and more productivity-criti clinic workflows. If you sell to employers in the group retiree MA space, rememl that the public individual market's move toward premium normalization can cre pricing pressure that spills over into group renewals; analytics that explain year- year chassis changes and simulate member-level out-of-pocket exposure will hel preserve retention.

On the Part D side, formulary analytics and member-level out-of-pocket estimat gain incremental utility precisely because premiums are less noisy. When the mc premium is converging, the real battleground becomes patient-specific total cost tiers, deductibles, and pharmacy choice. CMS even calls out an AI-powered prescription cost estimator coming to Plan Finder; that is both validation of the

case and a signal that plan-integrated, member-specific cost transparency experi must be excellent to compete with the official tool. For digital pharmacies and P disruptors, the 2026 environment likely rewards tight plan integration over standalone experiences: smoother electronic prior authorization flows, precise accumulators, and plan-aware price comparisons that reflect negotiated network rather than list-price illusions.

The strategic takeaway is that stability is not stasis. Sponsors are actively manag their portfolios to maintain the appearance of stability while making significant operational changes under the hood. Technologies that help sponsors execute th balancing act—reducing costs without degrading member experience, optimizin benefit design within tight budget constraints, improving Star Ratings through targeted interventions—will find demand. Technologies that assume a static mar rely on premium volatility to drive switching behavior will struggle. The 2026 landscape rewards precision, integration, and operational leverage over broad-ba innovation or disruption.

## What to watch in 2026 and beyond

First, Star Ratings and quality bonus dynamics will condition rebate budgets, an year of slight supply contraction, marginal shifts in Stars can alter local zero-pre with rich benefits feasibility. Second, the durability of the PDP stabilization demonstration will be tested against therapy mix shifts and manufacturer contra —if volatility reappears, expect CMS to continue bid interventions. Third, utiliz trend across musculoskeletal, cardiometabolic, and behavioral health remains th card. If trend cools, today's stable premiums could even be too conservative; if tr heats, expect within-year tactical benefit adjustments and tighter utilization management. Fourth, risk adjustment and encounter data integrity will continue separate the operationally elite sponsors from the rest, with direct implications the ability to fund zero-dollar premiums. Finally, local network effects matter: a sponsor that wins a hospital or IDN deal in a two-system market can transform p competitiveness independent of premiums.

The watchlist for 2026 is longer than usual because the stability claim creates a l bar for understanding what breaks and where. Star Ratings are the most direct l half-star improvement can unlock millions in rebate dollars and flip the econom an entire plan portfolio. The PDP demonstration is a known unknown: it stabili the market for 2026, but the underlying pharmacy trend and manufacturer contracting dynamics are still evolving. If the demonstration ends or if CMS lose ability to enforce bid discipline, the PDP market could revert to volatility. Utiliz trend is the perpetual question: every year, sponsors project utilization based on historical patterns and hope for the best. In a post-pandemic world with GLP-1s mental health surges, and deferred care catch-up, those projections are more uncertain than usual. Risk adjustment integrity is the operational differentiator: sponsors that can accurately capture and document risk scores will outperform t that cannot, and the gap is widening as CMS tightens enforcement. Local netwo dynamics are the final variable: in markets with limited provider options, a singl contract negotiation can determine whether a plan is competitive.

# Methods, data notes, and limitations

All plan and price statistics in this essay come from the CMS Medicare Advanta Part D Landscape files for CY2025, final, and CY2026, September 2025 vintage. 2026, the analytic base includes 138,344 plan–geography rows across 56 states ar territories and 1,884 counties, with 5,503 distinct MA plan IDs and a median of MA plans per county. For 2025, the file contains 142,653 rows, 56 states and territories, 1,885 counties, and 5,712 distinct MA plan IDs, with a median of 44 per county. To proxy unique plan, I used contract–plan combinations, which clo track CMS's national plan counts but are not identical to CMS's official count b of segmentation and geography nuances. Part C, consolidated, and Part D total premiums were parsed as numeric fields; medians and means were computed at row level consistent with landscape file structure. MA versus PDP segmentation organization and plan type fields, along with the Part D coverage indicator for M identification. These methods reproduce the CMS press release's directionality c premiums and near-term stability claims; small definitional differences can prod level shifts relative to CMS's official national aggregates. The state-by-state

observations are supported by the CMS 2026 Medicare Advantage and Part D st fact sheets, which enumerate state-level plan counts and average premium chan with examples including Alabama and Arizona reflecting the mix of falling prem and modest plan count changes.

The landscape files have well-known limitations. They represent the bid univers point in time, not realized enrollment or actual member experience. They do not capture mid-year benefit changes, network updates, or formulary revisions. They not include proprietary supplemental benefit details or care model structures th differentiate plans beyond the standardized fields. Premium averages can be ske by enrollment-weighted versus plan-count-weighted calculations, and the files d provide enrollment weights at the plan-geography level. County-level aggregatio treat each plan-county row as equivalent, which overstates the impact of plans w minimal enrollment. Despite these limitations, the files are the best available sou for assessing the bid universe and testing CMS's public claims about stability an access.

# Conclusion

The CMS claim that Medicare Advantage and Medicare Prescription Drug Prog are expected to remain stable in 2026 is, on the evidence, accurate in the way tha matters to beneficiaries and to program optics: average premiums are flat to dow access remains near-universal; and most people will see many zero-premium MA choices and at least one PDP option that costs less than last year. But it is a manufactured stability. CMS used explicit bid pressure and a continuing demonstration to discipline PDP premiums, and sponsors quietly trimmed their portfolios while leaning harder on rebates and network tactics to keep MA prem at zero. For entrepreneurs, that is not a sleepy market; it is a policy-guided corri with real competitive edges available to those who solve for operational efficienc precise benefit fit, and frictionless plan-aware experiences. In 2026, stability is n absence of movement. It is the choreography. And in Medicare, choreography is feature. Not a bug.

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