Medicare enrollment season reveals shift in insurers' coverage strategies

Analysis by Rebecca Adams
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More special needs coverage and fewer PPO plans are offered in insurance for seniors

Key Takeaways

A significant shift is underway with Medicare Advantage as open enrollment season begins Thursday. This period is a market barometer for the part of the program for seniors and other beneficiaries who use private plans.

Under the changes, plans that provide some coverage for out-of-network providers are declining. Since 2025, the number of Medicare Advantage Preferred Provider Organization options has fallen by almost 21 percent, as insurers favor network-tightening HMO models to rein in costs.

Special-needs plans are a growth engine for Medicare Advantage. These plans are growing rapidly and now cover roughly 1 in 4 Advantage enrollees.

Higher special needs plan payments raise fiscal concerns. Although the plans may improve care coordination and offer specialized networks, they typically generate larger margins for insurers and can amplify Medicare's budget impact.

Intro: Medicare's insurance market reset

The annual Medicare open enrollment period, which runs from Thursday through Dec. 7, offers seniors and people with disabilities a chance to reevaluate and change their health insurance for the following year. It also offers a snapshot of the market — where insurers see opportunities to thrive and where they feel pressure to scale back, not just geographically but also in the types of plans they offer.

Medicare Advantage, the private plans run by insurers such as UnitedHealthcare and Humana, grew in recent years as a competitor to the original Medicare program, which allows consumers to visit any doctor. Medicare Advantage plans operate networks of medical providers for consumers to use, and can require pre-authorization for seniors to get coverage for certain types of care.

A notable shift is underway within the Medicare Advantage program, according to a WP Intelligence review of federal data.

Insurance companies are scaling back their preferred provider organization (PPO) offerings, which typically give patients more flexibility by covering some costs from visits to out-of-network providers, unlike health maintenance organization (HMOs).

With fewer PPO options available, Medicare patients may be limited in the doctors or other providers they can see if they want insurance to pay for their care. Physicians, hospitals and other medical providers may face pressure to accept lower payments to be in an insurance plan's network.

Meanwhile, growth is continuing in a type of coverage known as a “special needs plan,” which could be offered as a PPO, HMO or other plan. Those plans get higher payments than regular Medicare Advantage plans for new enrollees and are targeted toward certain populations.

As some major insurers seek to maximize revenue by offering more special needs plans, that may boost insurers’ profits. But some analysts say that, ultimately, it may not be good for the federal Treasury. Taxpayer-funded Medicare spending, which is affected by the insurance options for seniors, is a major part of the ballooning federal budget and contributes to the $40 trillion national debt.

Analysis: Costs shift as out-of-network options decline, while more specialized coverage grows

Transfer in costs may hit taxpayers and consumers

The market shifts next year represent a transfer in costs — in some cases to taxpayers and, in others, to consumers. Specialized plans in particular can add to federal expenses. HMOs leave patients who need out-of-network care with heavier costs. Those changes are occurring as insurers also trim consumers’ benefits and raise their out-of-pocket costs in some places.

Private plans have become a major part of Medicare, with more than half of all enrollees now in the Medicare Advantage program. When the new year starts in January, that may drop slightly. Earlier this year, Medicare Advantage enrollment was projected to decline to about 34 million people next year — a drop of about 2 million people, after two decades of growth. But, after projections of decline last year, Medicare Advantage enrollment ended up growing, largely because of the expansion of special needs plans.

Enrollment in Medicare private plans climbed in the past two decades from about 19 percent of eligible enrollees in 2007 to 55 percent of beneficiaries this year, according to the nonpartisan health policy research, journalism and polling organization KFF.

Overall, patients in Medicare private plans cost the government more on average than those in the original Medicare fee-for-service program, according to the Medicare Payment Advisory Commission (MedPAC). Medicare spent about 14 percent more for Medicare Advantage enrollees than it would have if those beneficiaries were in original Medicare, a gap MedPAC projected would cost $76 billion this year.

Medicare Advantage “is dramatically overpaid for the services that it provides,” said Anna Bonelli, the director of health policy for the nonpartisan Committee for a Responsible Federal Budget, a group that brings attention to the national debt. “And this trend of plans moving toward special needs plans is frankly just an exacerbation of that.”

If Medicare private plan spending rises, that raises costs for most people covered by Medicare, not just those in the private plans. Medicare premiums for outpatient care are tied to overall outpatient spending.

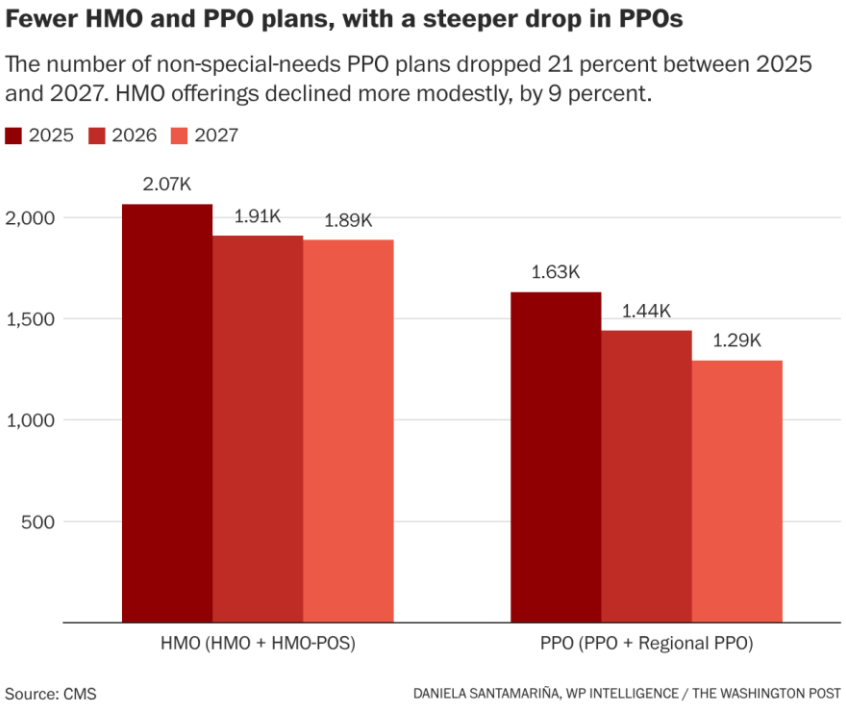
Health insurers see it differently, saying that consumers get better value and more benefits in Medicare Advantage than in original Medicare. A white paper released last month by the lobbying group representing insurers, the Better Medicare Alliance, also said that Medicare Advantage spends less on prescription drugs than original Medicare — and that MedPAC should change its methodology to include more components of Medicare spending.

Rising costs lead major insurers to shift away from PPOs

The number of Medicare PPOs available is down by almost 21 percent since 2025, according to a WP Intelligence analysis of federal data.

Insurance plan executives say that they need to manage the rising costs of an aging and less-healthy population that is using a lot of medical services. HMOs help manage costs in several ways, including by typically requiring patients who want to see a specialist to get a referral from a primary care doctor. PPOs generally do not require referrals.

“Our lean-in on HMOs is really important because of the need we have right now — I think, as an overall health care ecosystem — to get the primary care provider back in the driver’s seat of how they coordinate and manage care,” said Bobby Hunter, president of UnitedHealthcare, on a late-September call with reporters. HMOs “that enable that care management and care coordination are really critical as we work around affordability and bend the cost curve in health care, which is obviously one of the key charges that we have as an organization.”



“The trend away from PPOs is, I think, perhaps best explained by the plans’ desire to better control those costs,” said Casey Schwartz, senior counsel of the Medicare Rights Center, a group that helps seniors and others navigate Medicare.

The exact number of seniors that will be in different HMOs, PPOs or other types of plans in 2027 is not yet clear since open enrollment is just starting.

“Plans find that in order to meet their financial objectives, that is more feasible with an HMO model,” said Jeannie Fuglesten Biniek, deputy director for the KFF Program on Medicare Policy.

Major retailers including Costco and Walmart are also planning to offer HMOs in the Medicare Advantage market.

Walmart plans to launch an HMO plan and a special needs plan that are co-branded with SCAN Health Plan. The plans are expected to be available to more than 2 million Medicare consumers in Texas and Arizona, the companies said.

Costco will partner with SCAN on an HMO in 17 counties in California and two counties in Nevada.

The largest Medicare insurer, UnitedHealthcare, is both reducing the number of PPOs it offers and ramping up its special needs plans in an effort to improve the bottom line.

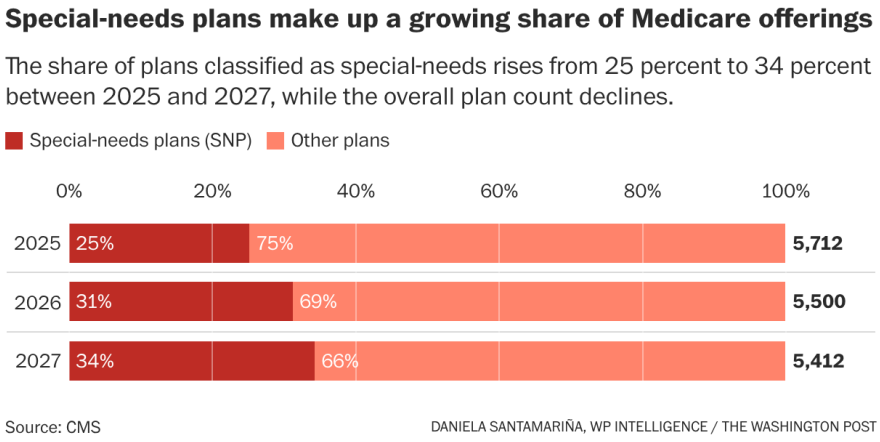
“There are some real opportunities for smart, durable growth in the marketplace right now,” said Hunter on an Tuesday earnings call. “We are particularly focused on the dual special needs plan offerings, the chronic special needs plan offerings and then some of the high-value HMOs. And I think we’re better positioned to capture that growth in some of those key areas … than we have been in recent years.”

UnitedHealth Group, which includes UnitedHealthcare and is the world’s largest health care company by revenue, is leveraging all of the parts of its vast business umbrella in its Medicare plans. The company is involved with networks of doctors; pharmacy benefit management; data analytics; tech and operations services; pharmacy services; and value-based care.

“When I think about the overall capabilities of the enterprise, the capabilities that we bring to bear, our emphasis on value-based care, I do think we have an incredible opportunity to make an impact for the members that are on these” types of special needs and HMO plans, said Hunter on the earnings call.

Special needs plans make up most of program’s recent growth

An increasing number of Medicare Advantage members — nearly 1 in 4 this year — are in a special needs plan.

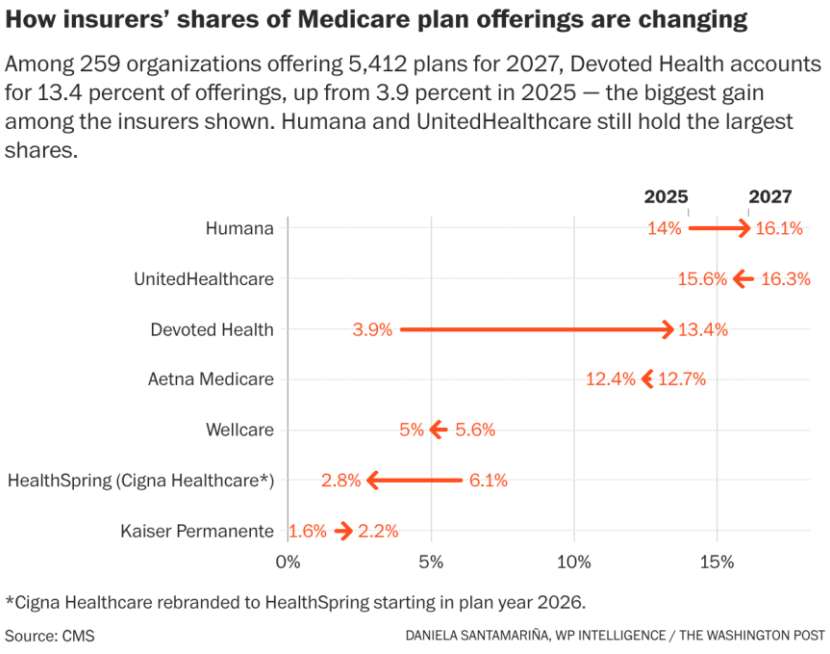


Those plans fit into three categories of specific populations: people who are dually eligible for Medicare and Medicaid; those who are institutionalized; or those with certain chronic conditions.

Rapid enrollment growth is being seen in the category that enrolls only people with chronic conditions.

While the group focused on dually eligible Medicare-Medicaid members is the largest, federal regulations have tightened recently — and more plans are growing their enrollment in the plans that serve people with chronic conditions such as diabetes or heart conditions.

One company co-founded by a former federal official is significantly expanding. Devoted Health is expanding by entering 342 counties next year, according to KFF. The company was founded by Todd Park, the chief technology officer during the Obama administration, and his brother Ed Park in 2017.



Still, special needs plans enrollment is dominated by large for-profit companies. KFF found last year that UnitedHealth Group and Humana plans composed over half of total SNP enrollment.

Some analysts say more information is needed to assess their value.

“They can coordinate care hopefully better than a regular standard [Medicare Advantage] plan, but their performance as actually improving people’s health is sort of in debate. It’s not necessarily clear that they have better health outcomes than regular MA plans, but they are able to garner higher margins than other MA plans, which is concerning,” said Bonelli. The plans “use their specialized networks and so on to earn even higher margins than other MA plans, but the federal budget doesn’t benefit from that efficiency.”

Lookahead

Medicare open enrollment will run through Dec. 7 for plans that commence in January.

Changes in the type of plans offered are part of a number of Medicare Advantage market adjustments that will affect consumers, medical providers, other insurers and insurance brokers next year. Millions of consumers — more than 10 percent of enrollees, by one estimate — are expected to have to switch plans next year because their current insurance will no longer be offered in their area. As some insurers scale back, other plans will absorb some enrollment. Some insurers also are trimming benefits and shifting costs onto enrollees through higher deductibles or caps on annual costs.

Most Medicare beneficiaries still have at least one Advantage plan with prescription drug coverage available in their area for next year. About 638,000 people do not, according to KFF. That’s slightly over 2 percent of consumers in the Medicare private plans.

Insurance companies and the Centers for Medicare and Medicaid Services typically release more enrollment data throughout the year.

Recommendations

Keep an eye on enrollment trends to see if projections come true. CMS often releases data in February that will offer the first look at enrollment figures. Last year, projections showed that the number of people in Medicare Advantage plans would decline for the first time in years, but, in the end, enrollment rose again by more than 1 million consumers, almost all driven by the growth in special needs plans. CMS officials said two weeks ago that the agency “expects actual 2027 MA enrollment to again be more robust than current plan projections indicate.”

Hospitals can create protocols that meet plan metrics to qualify for higher Medicare payments. Aligning clinical pathways with those incentives can boost margins and improve outcomes.

Investors and competitors should expect continued investment in high-margin special needs plans and HMOs. Retail entrants such as Walmart are expected to leverage existing retail loyalty and pharmacy data to design tailored products. Retail brands may

differentiate their Medicare plans by aligning health incentives with consumer habits, driving enrollment.

Midsize and regional insurers may differentiate themselves by preserving coverage options that offer consumers more flexibility in underserved markets where demand may remain high.

Medicare beneficiaries should conduct a plan-comparison audit early in the enrollment window. Use the online CMS Plan Finder and independent calculators to examine out-of-pocket costs, network restrictions, and drug formularies' impact on prices. With PPO options shrinking, a lack of research and an ill-suited choice could lock consumers into a narrow network or higher deductibles.