RUPRI Center for Rural Health Policy Analysis
Rural Policy Brief

Brief No. 2026-7 May 2026 http://ruprihealth.org

Medicare Advantage Enrollment Update 2025

Edmer Lazaro, DPT, MSHCA; Fred Ullrich, BA; Dan M. Shane, PhD; Keith Mueller, PhD

Purpose

This policy brief is part of the RUPRI Center's ongoing annual series analyzing Medicare Advantage (MA) enrollment trends. It examines both total and rural/urban (nonmetropolitan/metropolitan) enrollment patterns, as well as shifts in the types of MA plans selected by beneficiaries. The brief also explores how past policy changes may have influenced these enrollment dynamics.

Key Findings

- MA enrollment in 2025 grew 1.5 percent from 2024, marking the smallest annual increase in a decade. However, growth remained higher in nonmetropolitan counties (2.5 percent) than metropolitan counties (1.4 percent).
- Despite past projections, nonmetropolitan MA penetration did not exceed 50 percent in 2025. Instead, it reached 49.2 percent, compared to 56.8 percent in metropolitan counties.
- Much of the growth in nonmetropolitan MA enrollment remains in local preferred provider organization (PPO) plans.

Data and Methods

Monthly MA plan enrollment data for March 2025 were downloaded from Centers for Medicare & Medicaid Services (CMS) websites.[1] March enrollment data are used in this series of annual updates on plan type enrollment because it is the first month that reflects the impact of the open enrollment period[a]. Note that CMS does not report enrollment counts in any county and/or plan if the county or plan has fewer than 11 enrollees. Therefore, plan type enrollment figures derived from that data will be slightly undercounted. Monthly (overall) Medicare enrollment data were downloaded from a CMS website.[2] The resulting data provided enrollment

[a] CMS identified an issue in previous data releases where beneficiaries with multiple addresses were double counted. Corrected data dating back to 2017 were released and have been incorporated into this report. As a result, some of the numbers reported in this brief may not align with numbers reported in previous updates.

RHRC Rural Health Research & Policy Centers
Funded by the Federal Office of Rural Health Policy
www.ruralhealthresearch.org

This project was supported by the Federal Office of Rural Health Policy (FORHP), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (HHS) under cooperative agreement/grant #U1C RH20419. The information, conclusions and opinions expressed in this policy brief are those of the authors and no endorsement by FORHP, HRSA, HHS is intended or should be inferred.

RUPRI RURAL POLICY RESEARCH INSTITUTE
RUPRI Center for Rural Health Policy Analysis, University of Iowa College of Public Health, Health Management and Policy,
145 Riverside Dr., Iowa City, IA 52242-2007. (319) 384-3830
https://ruprihealth.org
E-mail: cph-rupri-inquiries@uiowa.edu

information from 3,138 counties[b] in the 50 United States and District of Columbia. Beneficiaries were classified as nonmetropolitan/metropolitan based on the county of their primary residence using 2024 Urban Influence Codes (metropolitan: 1, 4; nonmetropolitan: 2, 3, 5-9).

There are MA enrollees in all 50 states and the District of Columbia, but there are 23 counties with no MA enrollees reported. All those counties are classified as nonmetropolitan and all of them are in the most remote classification (i.e., noncore, not adjacent to a metropolitan area and no town of at least 5,000 residents). Ten of those counties are in Alaska and nine are in Kansas.

Medicare Advantage Plan Types[3]

Most MA plans can be classified into three types:

HMO (Health Maintenance Organization): These plans have a narrower network of contracted doctors, hospitals, and other health-care professionals who agree to provide services to the plan's members at a discounted rate. In return, beneficiaries must use network providers for medical care although there are exceptions for emergency care of out-of-area dialysis. HMO plans require you to select a primary care physician that will coordinate patient care and provide necessary referrals for specialty care. HMO-POS (Health Maintenance Organization-Point of Service) plans are similar to HMO plans, but they may offer some out-of-network benefits.

PPO (Preferred Provider Organization): PPOs also have networks of contracted health care providers, but these plans typically do not require beneficiaries to select a primary care provider. PPOs will typically provide benefits outside the plan's network although beneficiaries may have to pay higher coinsurance or copayments. PPOs are generally more flexible than MA HMO plans, but they are generally more expensive. PPOs are classified as "local" (serving one or more counties, or partial counties) or "regional" (serving a single state or multi-state areas).

PFFS (Private Fee-For-Service): These plans allow beneficiaries to see any provider who agrees to accept the plan's rules and payment terms. Some PFFS plans have networks of contracted providers, but the beneficiary is responsible for making sure that the provider will accept the plan's terms.

There are several other, less common, plan types, including MSAs (Medicare Savings Accounts) that are similar to the Health Savings Accounts (HSAs) that many employers sponsor. Special Needs Plans (SNPs) are limited to beneficiaries with specific chronic diseases or disabling conditions, those requiring institutional or nursing home care, and those with both Medicare and Medicaid coverage. Their eligibility restrictions make them less common than HMOs or PPOs, but they are growing and represent about 25 percent of MA enrollees.[4]

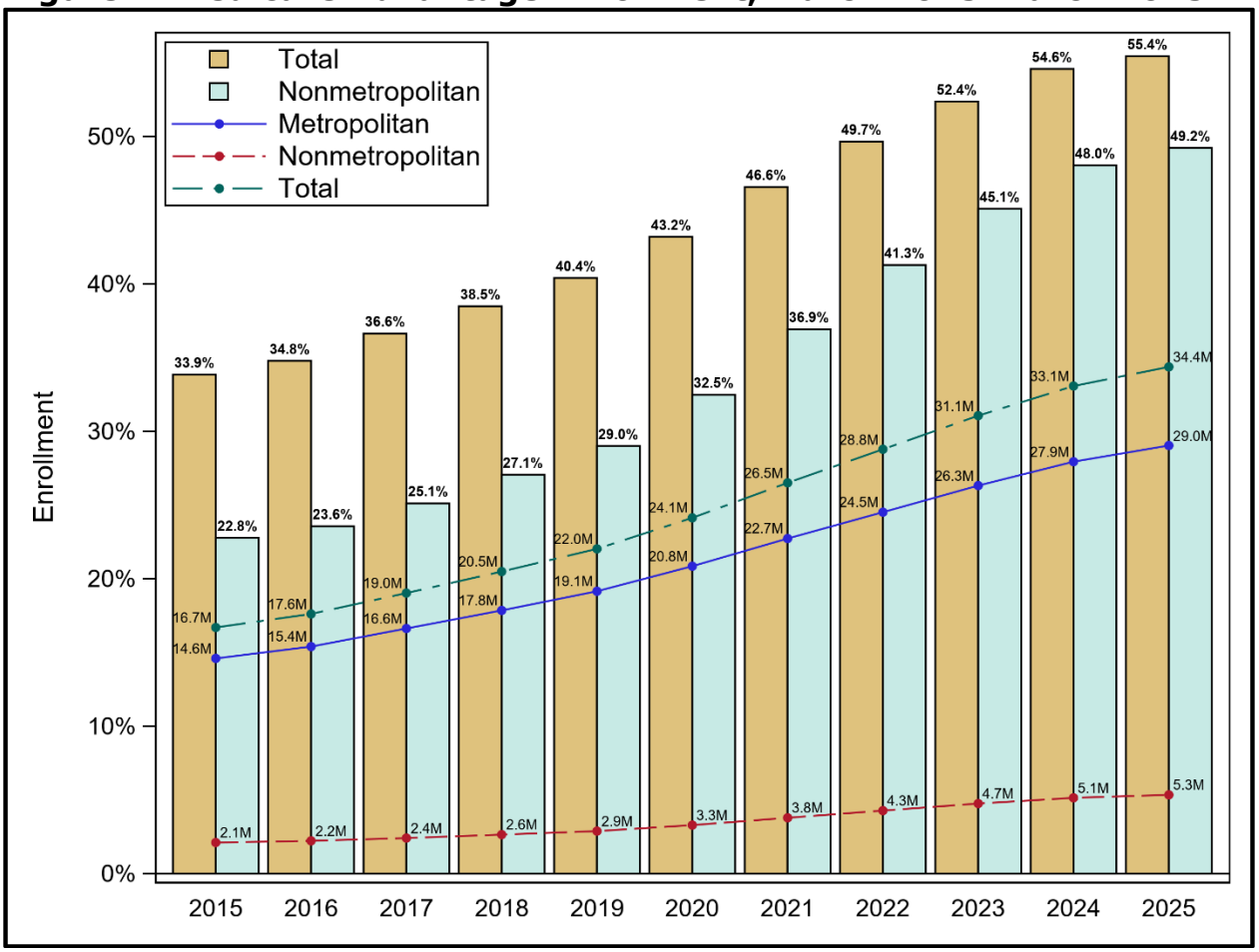
[b] The term "county" is used throughout this report, but in some cases, these are actually "county equivalents" – locales that are comparable to counties for administrative purposes but referred to by a different name. For example, Louisiana has parishes, Alaska has organized boroughs and census areas, and Connecticut has planning regions (reported in CMS data starting in 2022). To align data sources for enrollment counts, Connecticut planning regions were roughly apportioned to older county geographies.

Findings

In March 2025, 34.4 million Medicare beneficiaries (55.4 percent of eligible) were enrolled in an MA plan. This represents an enrollment increase of 1.5 percent over the previous year, which is the lowest percent increase in the last 10 years. As we have seen and reported in previous years, the rate of growth was higher in nonmetropolitan counties (2.5 percent) than in metropolitan counties (1.4 percent) with both of those increases also representing the slowest rate of growth in the last 10 years. As of March 2025, 49.2 percent of nonmetropolitan and 56.8 percent of metropolitan eligible beneficiaries are enrolled in an MA plan (figure 1 and tables 3a-c).

The RUPRI Center had previously predicted that nonmetropolitan MA penetration would exceed 50 percent this year.[5] But the reduction in last year's rates of enrollment growth render that prediction premature.

Figure 1. Medicare Advantage Enrollment, March 2015-March 2025

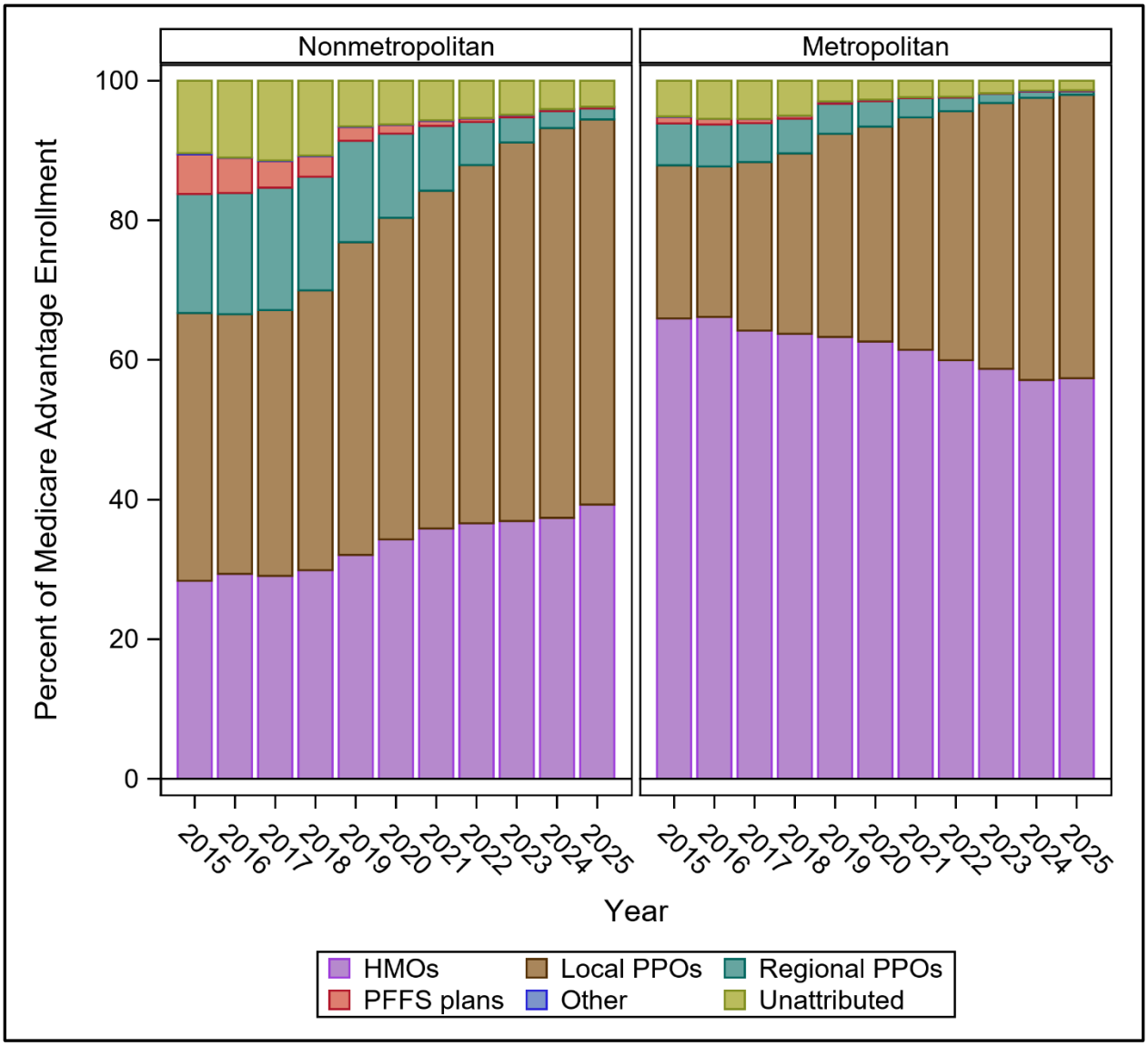


Source: RUPRI Center for Rural Health Policy Analysis, analysis of Centers for Medicare & Medicaid Services' Medicare Advantage enrollment data. Tabular data is available in the appendix.

Figure 2 shows that there has been a very gradual increase in the proportion of nonmetropolitan MA enrollees in HMO plans (39.3 percent in 2025), continuing a trend that has been nearly constant since 2017. In contrast, the proportion of metropolitan MA enrollees in such plans has declined steadily since 2016. While enrollment in local PPO plans is high in both metropolitan and nonmetropolitan counties, the enrollment growth rate has slowed in both geographies and even

declined slightly in nonmetropolitan counties in 2025. Regional PPO plans had a substantial presence in 2015, but their enrollment rates have steadily declined in both metropolitan counties (0.5 percent in 2025) and nonmetropolitan counties (1.6% percent in 2025).

Figure 2. Medicare Advantage Enrollment by Plan Type*, March 2015-March 2025



Source: RUPRI Center for Rural Health Policy Analysis, analysis of Centers for Medicare & Medicaid Services' Medicare Advantage enrollment data.

* 'Other' plans include MSA, PSO, Limited Income Newly Eligible Transition (LI NET), PACE, Cost, and PFFS plans and Demonstrations. 'Unattributed' refers to beneficiaries who could not be assigned to a plan type because of CMS reporting restrictions on county/plans with 10 or fewer enrollees.

Table 1 shows the distribution of MA enrollees in plan types using 5-year intervals, comparing the data from 2015, 2020, and 2025. This approach allows for clearer demonstration of the changes in plan type distribution and uptake. Again, there has been substantial growth in enrollment in HMO plans and in Local PPO plans, both in rural counties and in the nation overall. By 2025, other types of MA plans (e.g., PFFS, Regional PPOs, and Other MA plans) have approached 0 percent of Medicare enrollment.

Table 1. Enrollment in Medicare Advantage and Other Prepaid Plans, by Location of Residence and by Type of Plan, 2015-2025

	March 2015		March 2020		March 2025	
Type of Plan	**Rural**	**Total**	**Rural**	**Total**	**Rural**	**Total**
Medicare Advantage*	**1,882,796**	**15,727,851**	**3,076,865**	**23,362,879**	**5,137,704**	**33,779,842**
HMOs	595,686	10,219,630	1,125,244	14,184,348	2,096,011	18,758,671
PFFS	118,834	256,084	40,762	82,940	13,693	37,530
Local PPO	806,141	4,006,848	1,512,563	7,931,853	2,944,075	14,736,188
Regional PPO	358,325	1,233,095	395,939	1,157,374	82,901	226,446
Other MA plans**	3,810	12,194	2,357	6,364	1,024	21,007
Not attributable***	**218,092**	**964,329**	**205,276**	**767,973**	**197,924**	**594,484**
Total	**2,100,888**	**16,692,180**	**3,282,141**	**24,130,852**	**5,335,628**	**34,374,326**
	% Medicare Pop.		**% Medicare Pop.**		**% Medicare Pop.**	
Medicare Advantage*	**20.4%**	**31.9%**	**30.4%**	**41.8%**	**47.4%**	**54.5%**
HMOs	6.5%	20.7%	11.1%	25.4%	19.3%	30.3%
PFFS	1.3%	0.5%	0.4%	0.1%	0.1%	0.1%
Local PPO	8.7%	8.1%	15.0%	14.2%	27.2%	23.8%
Regional PPO	3.9%	2.5%	3.9%	2.1%	0.8%	0.4%
Other MA plans**	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Not attributable***	**2.4%**	**2.0%**	**2.0%**	**1.4%**	**1.8%**	**1.0%**
Total	**22.8%**	**33.9%**	**32.5%**	**43.2%**	**49.2%**	**55.4%**

Source: RUPRI Center for RURAL Health Policy Analysis, based on CMS data as of March 2025

*HMO = health maintenance organization; PFFS = private fee-for-service; PPO = preferred provider organization.

**Other MA plans include 1876 Cost, HCPP-1833 Cost, National PACE, MSAs, Limited Income Newly Eligible Transition (LI NET) plans.

***CMS does not report enrollment counts in any county/plan if the plan enrolls 10 or fewer beneficiaries in that county. "Not attributable" includes beneficiaries that could not be attributed to a type of plan.

Table 2 shows average MA enrollment as a percent of eligible beneficiaries and the average number of MA plans available in nonmetropolitan and metropolitan counties by Census region. Much of that data is also depicted in figures 3a and 3b. The MA enrollment rate in nonmetropolitan counties is higher than that in metropolitan counties in the Northeast region and lower in the other regions (much lower in the West region). However, the average number of MA plans in nonmetropolitan counties is lower than that in metropolitan counties in all regions. The lowest enrollment rate and average number of plans are in nonmetropolitan counties in the West region.

Table 2. Nonmetropolitan and Metropolitan Medicare Advantage Enrollment as a percent of eligible beneficiaries and plans, March 2025, by U.S. Census Region*

	Nonmetropolitan		Metropolitan	
Region	**MA Enrollment as Percent of Eligible**	**Avg. # MA Plans**	**MA Enrollment**	**Avg. # MA Plans**
Midwest	49.0%	23.9	58.8%	39.3
Northeast	51.6%	38.8	49.6%	42.2
South	52.8%	27.5	56.8%	35.8
West	32.7%	9.3	58.1%	26.4

Source: RUPRI Center for Rural Health Policy Analysis, analysis of CMS Medicare Advantage landscape data.

* Excludes Connecticut owing to data inconsistencies between UIC and MA landscape data. Excludes Cost plans.

Figure 3a. Nonmetropolitan Medicare Advantage Enrollment by Census Region and State

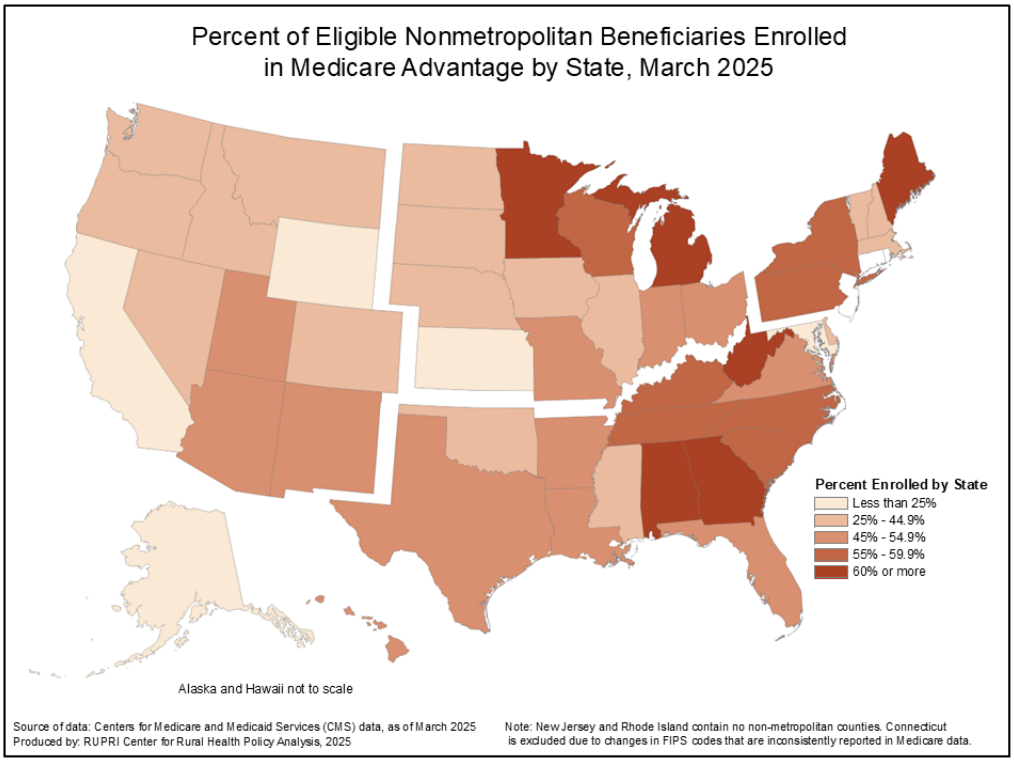
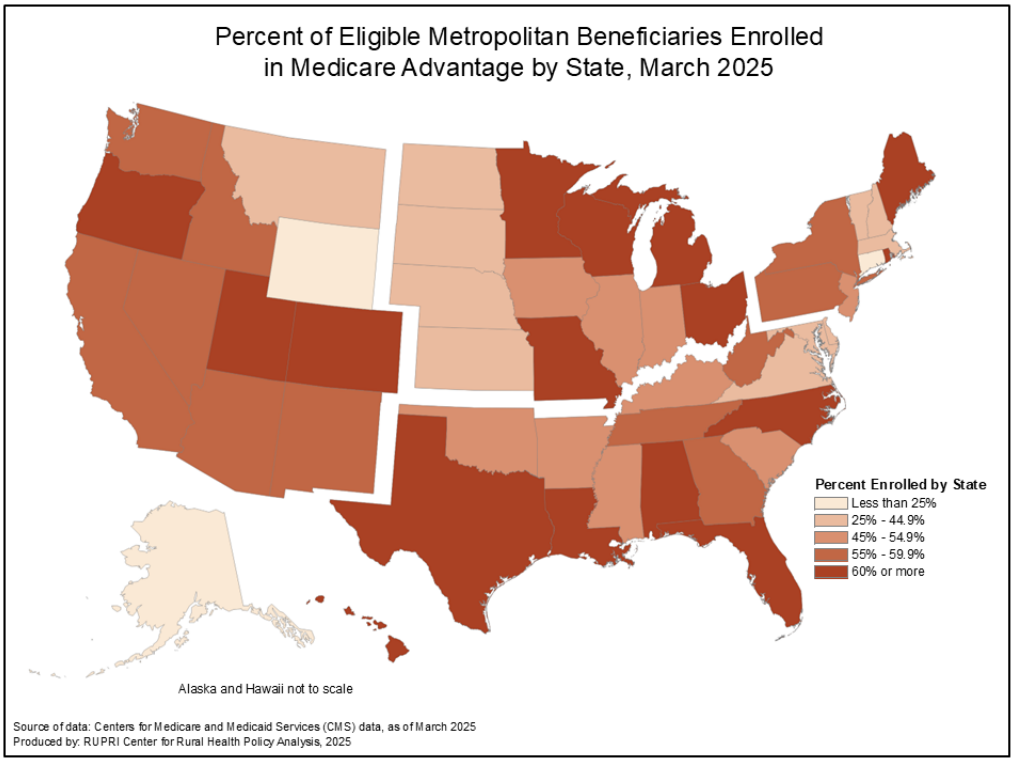


Figure 3b. Metropolitan Medicare Advantage Enrollment by Census Region and State



Discussion

The 2025 MA enrollment data signal a deceleration in the rate of enrollment for eligible beneficiaries following a decade of rapid growth, rising only 1.5 percent over the previous year. While overall MA penetration has seen continuous growth for at least the last 15 years, that growth has not been universal. For example, between 2020 and 2024, a small number of counties (between 0.9 percent and 1.6 percent) saw a decrease in the MA enrollment rate. But in 2025, nearly 13 percent (12.9 percent, n=405) of U.S. counties saw a decline in their rate of MA enrollment. While many of those counties saw a relatively small dip in their MA enrollment rates, eight reported decreases of 10 points or more. More than two-thirds (68.4 percent) of the counties that saw a decline in MA enrollment in 2025 were nonmetropolitan. Similarly, no states saw a decline in the MA enrollment rate between 2020 and 2024. But in 2025, six states saw enrollment declines ranging from 0.1 to 1.6 percentage points.

Several interrelated factors help explain the reduction in enrollment rates between 2024 and 2025. Market saturation may be a limiting factor. Nationally, more than 55 percent of eligible Medicare beneficiaries are enrolled in MA plans; enrollment is 56.8 percent in metropolitan areas and 49.2 percent in nonmetropolitan areas. As the share of eligible non-participants continues to shrink, further expansion becomes increasingly difficult.[6] Consolidation and strategic plan exits resulted in a reduction in available plan options, with some insurers withdrawing offerings in counties where enrollment was low or where reduced profitability was seen. For example, insurers such as UnitedHealthcare and Humana narrowed their coverage options, which may have facilitated plan switching and lower enrollment growth.[5] Policy and regulatory pressures may make insurers more cautious. CMS heightened audit scrutiny around the Risk Adjustment Data Validation process, expanded audit requirements, implemented broker compensation caps and marketing limits, and changed star ratings methodology. Those steps may significantly influence MA enrollment as well as plan design, insurer behavior, and consumer experience.[7]

MA enrollment in rural areas has grown steadily, particularly for local PPO plans, which have grown more rapidly than any other plan type.[5] MA plans may offer attractive benefits like lower premiums and supplemental services.[5] Growth in enrollment from 2020 through 2025 may be influenced by such benefits. However, rural beneficiaries often face limited plan choices and narrower provider networks compared to their urban counterparts. Moreover, recent benchmark adjustments used to set MA payment may affect a health plan's decision to include certain benefits.[8] Restricted access to providers and certain benefits can reduce continuity of care and place added burdens on rural beneficiaries who must travel farther for services. MA plans also reimburse providers at lower rates than Traditional Medicare, placing financial strain on already vulnerable rural hospitals, some of which have terminated their MA plan contracts or closed entirely.[9]

The market dynamics of Medicare Advantage plans and the evolving enrollment patterns among Medicare-eligible beneficiaries continue to shape the rural health landscape in complex ways. As MA enrollment grows, particularly in underserved regions, concerns mount regarding the long-term sustainability of rural health care

infrastructure and the potential widening of differences in access and outcomes. Rural beneficiaries do not have access to the same scope of benefits and services available in metropolitan areas. To address this, policymakers should consider comprehensive strategies that strengthen access to care, promote insurer accountability, and support the financial viability of rural providers.

National and state-specific maps and tables of MA enrollment can be found at http://ruprihealth.org/maupdates/nstablesmaps.html

References

1. Centers for Medicare & Medicaid Services. (2025). *Monthly MA enrollment by state/county/contract*. Accessed March 14, 2025, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-MA-Enrollment-by-State-County-Contract
2. Centers for Medicare & Medicaid Services. (2025). *Medicare Monthly Enrollment Data* [Data set]. Accessed June 30, 2025, https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment/data
3. Porretta A. "The Different Types of Medicare Advantage Plans." 2022. Accessed May 30, 2025, https://www.ehealthinsurance.com/medicare/parts/the-different-types-of-medicare-advantage-plans/
4. Centers for Medicare & Medicaid Services. (2024, September 27). *Medicare Advantage and Medicare Prescription Drug Programs to remain stable as CMS implements improvements to the programs in 2025* [Fact sheet]. U.S. Department of Health & Human Services. https://www.cms.gov/newsroom/fact-sheets/medicare-advantage-and-medicare-prescription-drug-programs-remain-stable-cms-implements-improvements
5. Ullrich, F., & Mueller, K. (2025). *Medicare Advantage enrollment update 2024* (RUPRI Center for Rural Health Policy Analysis Brief No. 2025-1). RUPRI Center for Rural Health Policy Analysis. https://rupri.public-health.uiowa.edu/publications/policybriefs/2025/2024%20MA%20Enrollment%20Update.pdf
6. Chartis (HealthScape Advisors). (2025, March 25). *Medicare Advantage market growth slows amid intensified headwinds*. Accessed April 10, 2025, https://www.chartis.com/insights/medicare-advantage-market-growth-slows-amid-intensified-headwinds
7. Centers for Medicare & Medicaid Services. (2024) *Contract Year 2025 Medicare Advantage and Part D Final Rule (CSM-4205-F).* Accessed May 28, 2025, https://www.cms.gov/newsroom/fact-sheets/contract-year-2025-medicare-advantage-and-part-d-final-rule-cms-4205-f
8. Lazaro E, Shane DLM, Ullrich F, and Mueller K. "Medicare Advantage Plan Growth in Rural America: Availability of Supplemental Benefits." Rural Policy Brief (2024). RUPRI Center for Rural Health Policy Analysis. Accessed July 17, 2025, https://rupri.public-health.uiowa.edu/publications/policybriefs/2024/MA_Plan_Growth.pdf
9. Zionts, A. (2025, April 8). *Rural hospitals question whether they can afford Medicare Advantage contracts*. KFF Health News. Accessed May 28, 2025, https://kffhealthnews.org/news/article/rural-hospitals-private-medicare-advantage-contracts-reimbursements/

Preferred Citation

Lazaro, E; Ullrich, F; Shane, DM; Mueller K. **Medicare Advantage Enrollment Update 2025**, RUPRI Center for Rural Health Policy Analysis; Brief No. 2025-7.

Appendix

Appendix Tables 3a-c show that there has been a very gradual increase in the proportion of nonmetropolitan MA enrollees in HMO plans (39.3 percent in 2025), continuing a trend that has been nearly constant since 2017. There has been a nearly constant decrease in the proportion of metropolitan MA enrollees in such plans since 2016 (57.4 percent in 2025). While enrollment in local PPO plans is high in both metropolitan and nonmetropolitan counties, the enrollment growth rate has slowed in both geographies and even declined slightly in nonmetropolitan counties in 2025. Although Regional PPO plans had a substantial presence in 2015, their enrollment rates have steadily declined in both metropolitan counties (0.5 percent in 2025) and nonmetropolitan counties (1.6% percent in 2025).

Table 3a. Overall Medicare Advantage Enrollment by Plan Type[i], March 2015-March 2025

Year	Total[ii] Medicare Enrolled	Total MA Enrollees	% Total Enrolled	HMO	Local PPO	Regional PPO	PFFS Plan	Other	Unatt. Other Prepaid
2025	61,995,621	34,374,326	55.4%	54.6%	42.9%	0.7%	0.1%	0.1%	1.7%
2024	60,580,601	33,073,285	54.6%	54.1%	42.8%	1.1%	0.1%	0.1%	1.8%
2023	59,323,459	31,064,679	52.4%	55.4%	40.5%	1.7%	0.1%	0.0%	2.3%
2022	57,962,863	28,783,678	49.7%	56.5%	38.0%	2.6%	0.2%	0.0%	2.7%
2021	56,905,974	26,505,919	46.6%	57.8%	35.4%	3.7%	0.2%	0.0%	2.8%
2020	55,869,512	24,130,852	43.2%	58.8%	32.9%	4.8%	0.3%	0.0%	3.2%
2019	54,513,003	22,025,463	40.4%	59.2%	31.2%	5.6%	0.5%	0.0%	3.4%
2018	53,230,019	20,486,377	38.5%	59.4%	27.7%	6.4%	0.7%	0.0%	5.7%
2017	51,930,454	19,025,912	36.6%	59.8%	25.9%	7.1%	1.0%	0.0%	6.2%
2016	50,622,845	17,609,527	34.8%	61.5%	23.5%	7.4%	1.3%	0.0%	6.2%
2015	49,306,404	16,692,180	33.9%	61.2%	24.0%	7.4%	1.5%	0.1%	5.8%

Table 3b. Nonmetropolitan Medicare Advantage Enrollment by Plan Type[i], March 2015-2025

Year	Total[ii] Medicare Enrolled	Total MA Enrollees	% Total Enrolled	HMO	Local PPO	Regional PPO	PFFS Plan	Other	Unatt. Other Prepaid
2025	10,840,036	5,335,628	49.2%	39.3%	55.2%	1.6%	0.3%	0.0%	3.7%
2024	10,683,981	5,132,915	48.0%	37.4%	55.8%	2.4%	0.3%	0.0%	4.1%
2023	10,521,245	4,745,330	45.1%	36.9%	54.2%	3.6%	0.3%	0.0%	4.9%
2022	10,341,590	4,268,653	41.3%	36.6%	51.3%	6.2%	0.5%	0.1%	5.3%
2021	10,233,896	3,779,194	36.9%	35.9%	48.4%	9.3%	0.7%	0.1%	5.7%
2020	10,105,258	3,282,141	32.5%	34.3%	46.1%	12.1%	1.2%	0.1%	6.3%
2019	9,915,254	2,876,095	29.0%	32.1%	44.8%	14.5%	2.0%	0.1%	6.5%
2018	9,748,887	2,638,221	27.1%	29.9%	40.1%	16.3%	2.9%	0.1%	10.7%
2017	9,574,796	2,404,205	25.1%	29.1%	38.1%	17.6%	3.8%	0.1%	11.4%
2016	9,399,471	2,215,140	23.6%	29.4%	37.2%	17.4%	5.0%	0.0%	11.0%
2015	9,227,126	2,100,888	22.8%	28.4%	38.4%	17.1%	5.7%	0.2%	10.4%

Table 3c. Metropolitan Medicare Advantage Enrollment by Plan Type[i], March 2015-2025

Year	Total[ii] Medicare Enrolled	Total MA Enrollees	% Total Enrolled	HMO	Local PPO	Regional PPO	PFFS Plan	Other	Unatt. Other Prepaid
2025	51,155,585	29,038,698	56.8%	57.4%	40.6%	0.5%	0.1%	0.1%	1.4%
2024	49,896,620	27,940,370	56.0%	57.1%	40.4%	0.9%	0.1%	0.1%	1.4%
2023	48,802,214	26,319,349	53.9%	58.7%	38.1%	1.3%	0.1%	0.0%	1.8%
2022	47,621,273	24,515,025	51.5%	60.0%	35.7%	2.0%	0.1%	0.0%	2.3%
2021	46,672,078	22,726,725	48.7%	61.5%	33.3%	2.7%	0.1%	0.0%	2.4%
2020	45,764,254	20,848,711	45.6%	62.6%	30.8%	3.7%	0.2%	0.0%	2.7%
2019	44,597,749	19,149,368	42.9%	63.3%	29.1%	4.3%	0.3%	0.0%	3.0%
2018	43,481,132	17,848,156	41.0%	63.7%	25.9%	5.0%	0.4%	0.0%	5.0%
2017	42,355,658	16,621,707	39.2%	64.2%	24.1%	5.6%	0.6%	0.0%	5.5%
2016	41,223,374	15,394,387	37.3%	66.2%	21.5%	6.0%	0.8%	0.0%	5.5%
2015	40,079,278	14,591,292	36.4%	66.0%	21.9%	6.0%	0.9%	0.1%	5.1%

i. 'Other' plans include MSA, PSO, Limited Income Newly Eligible Transition (LI NET), PACE, and Cost plans and Demonstrations. 'Unatt. Other Prepaid' includes beneficiaries that could not be assigned to a plan type because of CMS reporting restrictions on county/plans with 10 or fewer enrollees. It also includes the difference between CMS total MA beneficiary counts and the sum of beneficiaries reported in CMS state/county penetration data.

ii. Count of Medicare beneficiaries enrolled in Hospital Insurance (or Part A) and Supplementary Medical Insurance (or Part B).

Tables 4a-4c show the total number of MA plans available from 2021-2025 as broken down by type of plan for all counties and separately for nonmetropolitan and metropolitan counties. HMO plans and Local PPO plans have consistently represented more than 95% of the available plans. In general, the total number of plans had been growing until 2024, when it started to decline. Much of that decline can be attributed to fewer HMO plans (254 fewer plans in 2025 compared to 2023).

Table 4a. Medicare Advantage Plans Over Time

	2021		2022		2023		2024		2025	
Total Plans*	3,452		3,726		3,965		3,917		3,686	
HMO	2,181	63.2%	2,226	59.7%	2,289	57.7%	2,181	55.7%	2,035	55.2%
Local PPO	1,181	34.2%	1,407	37.8%	1,593	40.2%	1,661	42.4%	1,586	43.0%
Regional PPO	52	1.5%	52	1.4%	52	1.3%	51	1.3%	43	1.2%
Other	38	1.1%	41	1.1%	31	0.8%	24	0.6%	22	0.6%

Table 4b. Nonmetropolitan Medicare Advantage Plans Over Time**

	2021		2022		2023		2024		2025	
Total Plans*	1,914		2,184		2,385		2,418		2,303	
HMO	988	51.6%	1,068	48.9%	1,139	47.8%	1,130	46.7%	1,046	45.4%
Local PPO	837	43.7%	1,025	46.9%	1,164	48.8%	1,214	50.2%	1,193	51.8%
Regional PPO	51	2.7%	51	2.3%	51	2.1%	50	2.1%	42	1.8%
Other	38	2.0%	40	1.8%	31	1.3%	24	1.0%	22	1.0%

Table 4c. Metropolitan Medicare Advantage Plans Over Time

	2021		2022		2023		2024		2025	
Total Plans*	3,361		3,636		3,863		3,822		3,611	
HMO	2,126	63.3%	2,177	59.9%	2,233	57.8%	2,134	55.8%	1,999	55.4%
Local PPO	1,145	34.1%	1,366	37.6%	1,549	40.1%	1,614	42.2%	1,549	42.9%
Regional PPO	52	1.5%	52	1.4%	52	1.4%	51	1.3%	43	1.2%
Other	38	1.1%	41	1.1%	29	0.7%	23	0.6%	20	0.5%

Source: RUPRI Center for Rural Health Policy Analysis, analysis of Centers for Medicare & Medicaid Services' Medicare Advantage landscape data.

* Excludes Cost plans. 'Other' includes MSA and PFFS plans.

** Excludes Connecticut owing to data inconsistencies between UIC and MA landscape data.