RUPRI Center for Rural Health Policy Analysis
Rural Policy Brief

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Medicare Advantage Enrollment Update, 2026

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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 nonmetropolitan/metropolitan (rural/urban) 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

- Total MA enrollment in 2026 stood at 35.2 million Medicare beneficiaries (55.5 percent of enrollees with both Part A and Part B coverage).
- The rate of MA enrollment growth in 2026 was well under one percent (0.18 percent). This is, by far, the lowest increase in enrollment rates in at least 10 years.
- Between 2025 and 2026, the nonmetropolitan MA enrollment rate grew by 0.20 percent while the metropolitan rate grew by 0.18 percent. Prior to 2026, the annual growth rate of nonmetropolitan MA enrollment was frequently close to double the metropolitan rate.

Data and Methods

Monthly MA plan enrollment data for March 2026 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[1]. Note that CMS does not report enrollment counts in any county and/or plan if the county/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 also downloaded from a CMS website.[2] This document reports on the percent of

[1] CMS identified an issue in previous data releases where enrollees 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 RUPRI updates.

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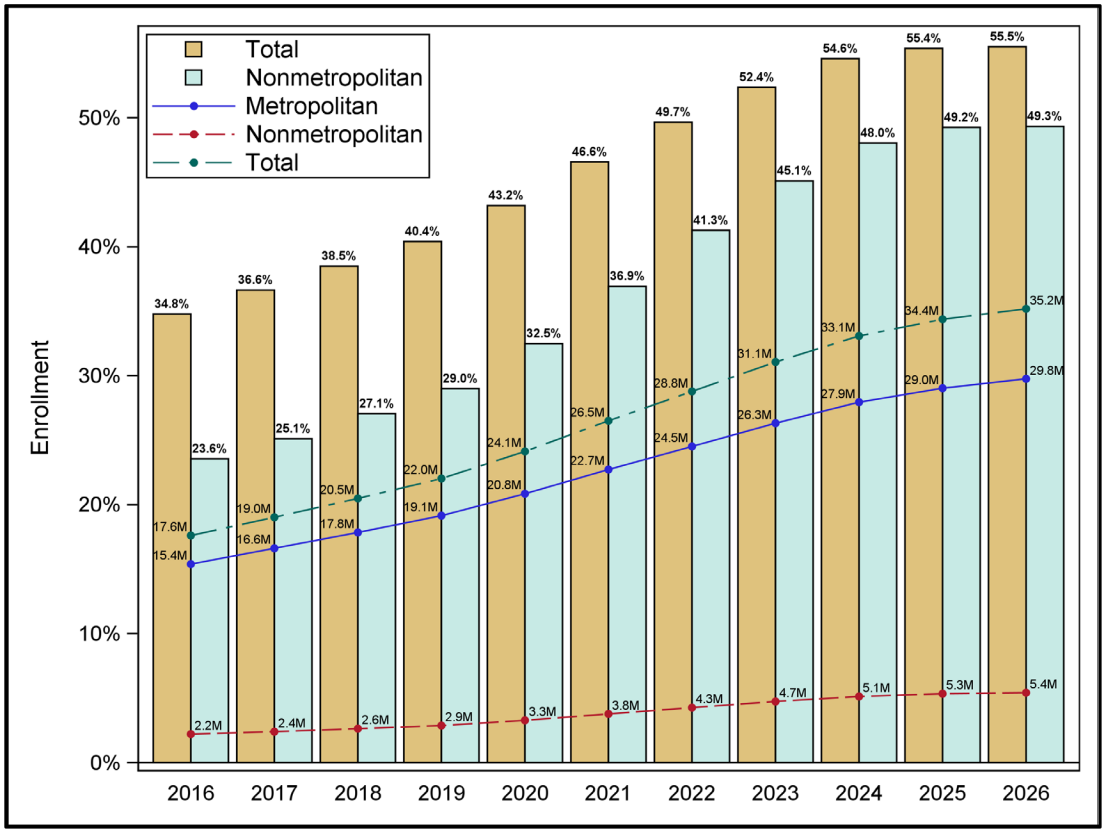
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'eligible' enrollees in MA plans – that is the proportion of enrollees with both Part A and B coverage. The resulting data provided enrollment information from 3,138 counties[2] in the 50 United States and District of Columbia. Enrollees were classified 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 24 counties with no MA enrollees reported. All those counties are classified as nonmetropolitan in the most remote classification (i.e., noncore, not adjacent to a metropolitan area and no town of at least 5,000 residents). Nine of those counties are in Alaska, and seven are in Kansas.

Findings

Figure 1. Medicare Advantage Enrollment, March 2016 – March 2026

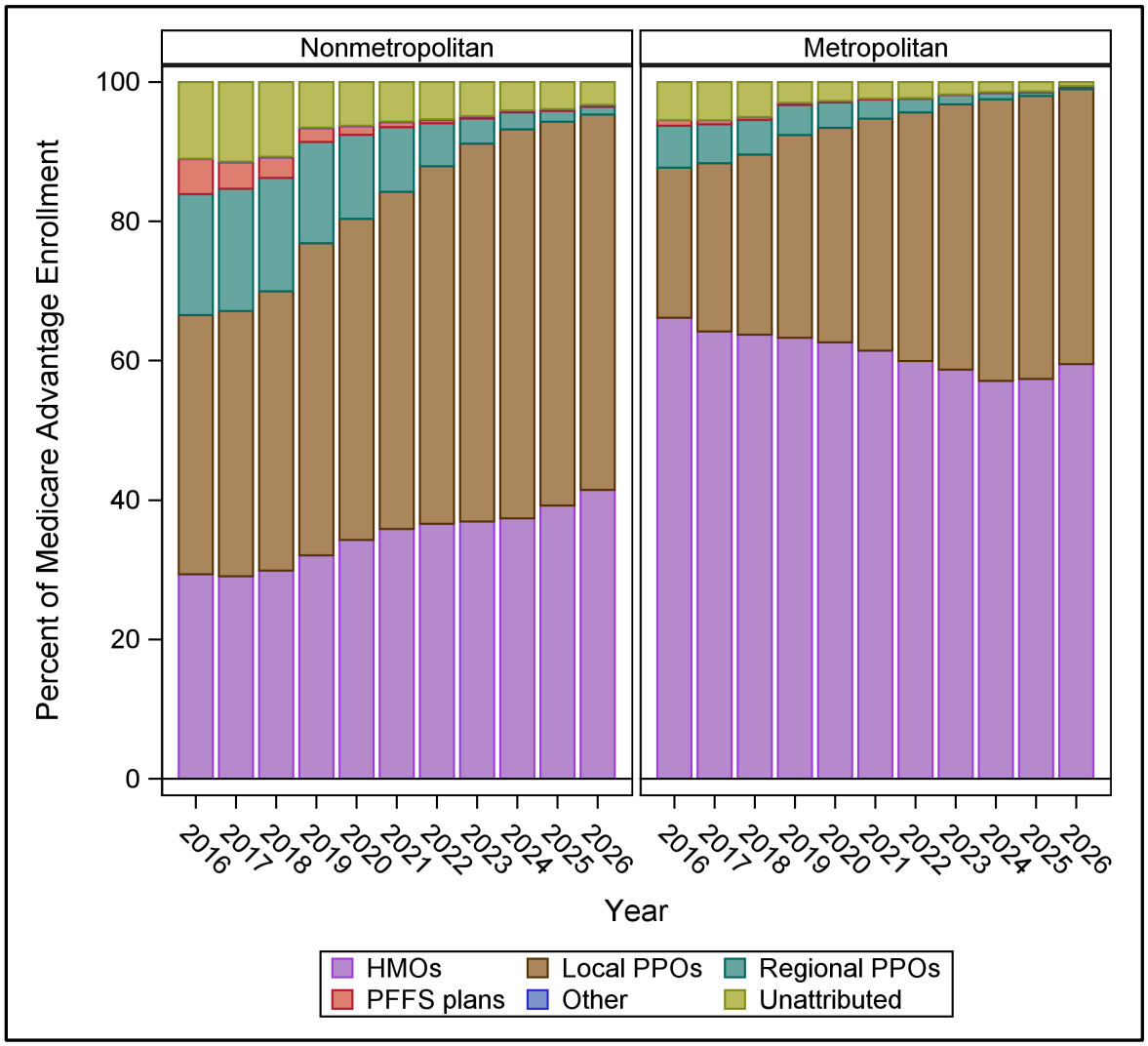


Note: Percentages are based on the total number of Medicare enrollees with both Part A and B coverage.
Source: RUPRI Center for Rural Health Policy Analysis, analysis of Centers for Medicare & Medicaid Services' Medicare Advantage enrollment data. Tabular data is available in the Appendix.

[2] 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.

In March 2026, 35.2 million Medicare enrollees (55.5 percent of eligible enrollees) were enrolled in an MA plan. This represents an enrollment rate increase of only 0.18 percent over the previous year, which is the lowest percent increase in more than 10 years. As we have seen and reported in previous years, the rate of growth was higher in nonmetropolitan counties (0.20 percent) than in metropolitan counties (0.18 percent) with both of those increases also representing the slowest rate of growth in over 10 years. Prior to 2026, the annual growth in the rate of nonmetropolitan MA enrollment frequently was close to double the metropolitan rate. As of March 2026, 49.3 percent of nonmetropolitan and 55.5 percent of metropolitan eligible enrollees are in an MA plan (Figure 1 and Appendix Tables 3a-c).

Figure 2. Medicare Advantage Enrollment by Plan Type*, March 2016-2026



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), Program of All-inclusive Care for the Elderly (PACE), Cost, and Private Fee-For-Service (PFFS) plans and Demonstrations. 'Unattributed' refers to enrollees who could not be assigned to a plan type because of CMS reporting restrictions on county/plans with 10 or fewer enrollees.

Figure 2 shows that there has been a gradual increase in the proportion of nonmetropolitan MA enrollees in HMO plans (41.5 percent in 2026), continuing a trend that has been nearly constant since 2017 (see the Appendix for a description of the various MA plan types). The proportion of metropolitan MA enrollees in HMO plans also grew in 2025 and 2026, reversing a steady decline since at least 2016. While enrollment in local PPO plans was high in both metropolitan and nonmetropolitan counties and had seen nearly continuous growth since at least 2016, the enrollment growth rate declined in both geographies in 2026. Regional PPO plans had a substantial presence in 2016, but their enrollment rates have steadily declined in both metropolitan counties (0.3 percent in 2026) and nonmetropolitan counties (1.1 percent in 2026).

Table 1 shows the MA enrollment in plan types using 5-year intervals, comparing the data from 2016, 2021, and 2026. This approach allows for clearer demonstration of the changes in enrollment by plan type. Again, there has been substantial growth in enrollment in HMO plans and in Local PPO plans, both in nonmetropolitan counties and in the nation overall. The proportion of Medicare enrollees in Private Fee-For-Service (PFFS) and Other MA plans has been nearly 0 percent for a number of years. Again, Regional PPO enrollment was notable in 2016 (2.6 percent nationally), but it fell to only 0.2 percent in 2026. Conversely, the proportion of MA enrollees in Local PPO plans has grown steadily during this time with 23.1 percent of enrollees in such plans in 2026.

Table 1. Enrollment in Medicare Advantage and Other Prepaid Plans, by Location of Residence and by Type of Plan, 2016-2026

	March 2016		March 2021		March 2026	
Type of Plan	**Nonmet.**	**Total**	**Nonmet.**	**Total**	**Nonmet.**	**Total**
Medicare Advantage*	**1,971,382**	**16,525,856**	**3,565,416**	**25,755,301**	**5,246,365**	**34,840,539**
HMOs/POS	650,241	10,836,332	1,355,084	15,320,855	2,248,847	19,961,126
PFFS	111,515	234,042	27,439	58,216	14,343	34,360
Local PPO	824,118	4,131,375	1,828,766	9,395,872	2,921,622	14,667,368
Regional PPO	384,517	1,311,613	350,986	972,808	59,976	155,387
Other MA plans**	991	2,504	3,141	7,550	1,577	22,298
Not attributable***	**243,757**	**1,083,671**	**213,778**	**750,619**	**177,216**	**344,306**
Total	**2,215,139**	**17,609,527**	**3,779,194**	**26,505,920**	**5,423,581**	**35,184,845**
	% Medicare Pop.		**% Medicare Pop.**		**% Medicare Pop.**	
Medicare Advantage*	**21.0%**	**32.6%**	**34.8%**	**45.3%**	**47.7%**	**55.0%**
HMOs/POS	6.9%	21.4%	13.2%	26.9%	20.5%	31.5%
PFFS	1.2%	0.5%	0.3%	0.1%	0.1%	0.1%
Local PPO	8.8%	8.2%	17.9%	16.5%	26.6%	23.1%
Regional PPO	4.1%	2.6%	3.4%	1.7%	0.5%	0.2%
Other MA plans**	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Not attributable***	**2.6%**	**2.1%**	**2.1%**	**1.3%**	**1.6%**	**0.5%**
Total	**23.6%**	**34.8%**	**36.9%**	**46.6%**	**49.3%**	**55.5%**

Note: Percentages are based on the total number of Medicare enrollees with both Part A and B coverage.

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 enrollees in that county. "Not attributable" includes enrollees that could not be attributed to a type of plan.

In 2016, there were 74 counties (nearly all nonmetropolitan) in ten states with no MA enrollees. By 2026, those counts had reduced to 24 counties (all nonmetropolitan) in five states with no MA enrollees. Table 2 shows total MA enrollment as a percent of eligible enrollees and the average number of MA plans available in nonmetropolitan and metropolitan counties by Census region in March 2016 and March 2026. Figures 3a and 3b show MA enrollment by Census region and state. In 2016, MA enrollment in nonmetropolitan counties was much lower than in metropolitan counties in all Census regions. The same is largely true in 2026 (enrollment is much lower in the West region) although the difference in the South region is small and the difference in the Northeast region is negligible. The average number of MA plans in nonmetropolitan counties in 2016 was much lower than that in metropolitan counties in all regions, and that difference remained in 2026. In both 2016 and 2026, the lowest enrollment rate and average number of plans is in nonmetropolitan counties in the West region.

Table 2. Nonmetropolitan and Metropolitan Medicare Advantage Enrollment as a percent of eligible enrollees and plans, March 2016 and 2026, by U.S. Census Region*

	Nonmetropolitan		Metropolitan	
Region	MA Enrollment as Percent of Eligible 2016 / 2026	Avg. # MA Plans 2016 / 2026	MA Enrollment 2016 / 2026	Avg. # MA Plans 2016 / 2026
Midwest	26.2% / 49.0%	8.3 / 19.9	36.1% / 58.4%	16.6 / 34.9
Northeast	28.5% / 49.8%	15.0 / 31.3	34.8% / 49.9%	24.8 / 37.4
South	22.4% / 54.3%	7.8 / 27.2	34.8% / 57.2%	13.6 / 35.3
West	16.1% / 31.8%	3.1 / 7.2	45.4% / 57.9%	13.0 / 21.7
Nationwide	23.6% / 49.3%	7.6 / 21.6	37.3% / 56.8%	15.5 / 33.7

Note: Percentages are based on the total number of Medicare enrollees with both Part A and B coverage.

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

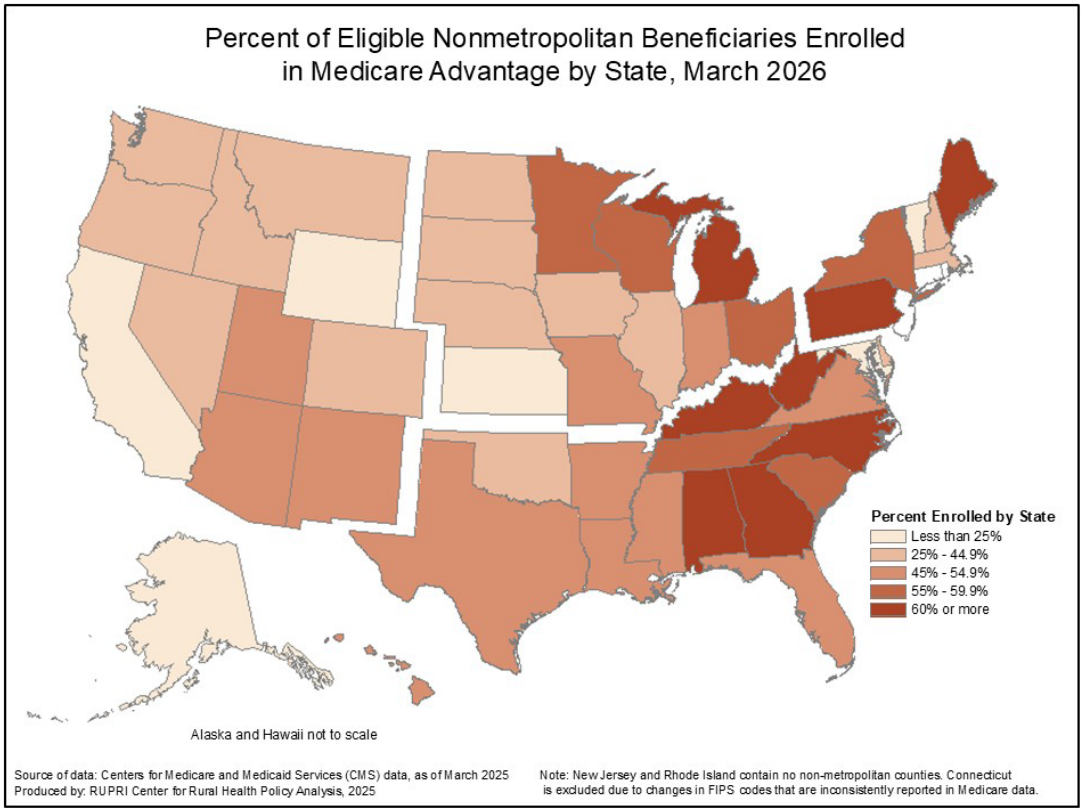
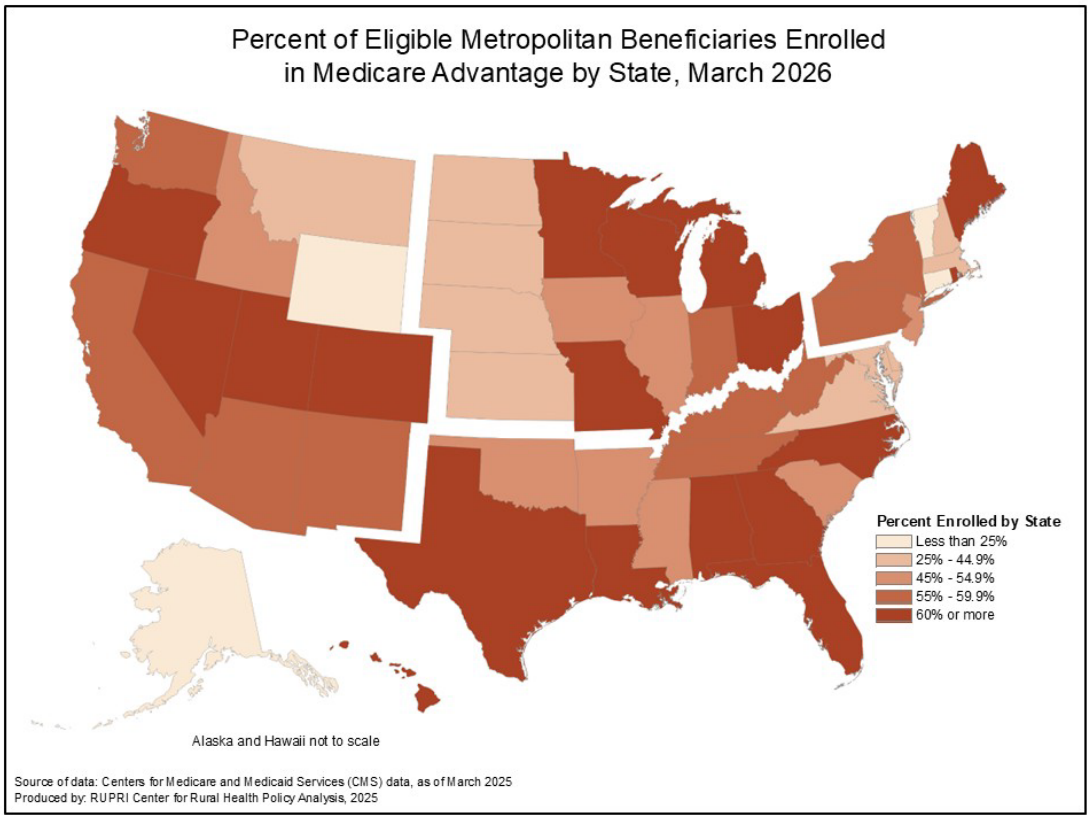


Figure 3b. Metropolitan Medicare Advantage Enrollment by Census Region and State



Discussion

MA has seen continuous enrollment growth for at least the last 15 years. Before 2025, the rate of annual MA enrollment growth had routinely exceeded 5 percent, with nonmetropolitan annual growth rates occasionally exceeding 10 percent. But enrollment growth in 2026 was nearly flat. A variety of factors – including Federal rules, payer and provider business decisions, and beneficiary behavior – have likely contributed to the relatively abrupt halt in the growth in MA enrollment.

The CMS 2025 Medicare Advantage and Part D final rule established guidelines to address abusive marketing practices by marketing organization brokers and agents.[3] It also required MA plans to issue annual "Mid-Year Enrollee Notification of Unused Supplemental Benefits" documents personalized to each enrollee, reporting the supplemental benefits they had not accessed during the first six months of the year.[4] These changes increase enrollee awareness of benefits offered and used, and prohibit misleading advertising. The CMS 2026 Medicare Advantage (Part C) and Medicare Prescription Drug Benefit (Part D) Final Rule did not introduce broad new coverage requirements but instead focused on operational updates and codification of the Inflation Reduction Act for prescription drug coverage.[5] It included requirements for $0 cost-sharing for adult vaccinations, insulin cost-sharing caps, clarification of appeals and approvals rights, changes to risk adjustments and payments, and other updates.[6] CMS also raised the average MA payment rate by 5.06 percent, but the additional funding was likely to be offset by "continued adjustments from the risk model and normalization factors."[7] While the impact of the provisions in both final rules on MA payers and enrollment cannot be directly assessed, it would seem that the regulatory attempts to shield enrollees might have cooled the enthusiasm for MA.

Historically, MA plans have been associated with "favorable selection" – the notion that healthier enrollees tended to enroll in MA.[8] However, recent studies have found evidence that as the MA population has grown, it has become more demographically diverse and slightly more clinically complex.[9] The combination of the Final Rule changes to payments to Medicare Advantage organizations (MAOs) and the changes in beneficiary profile have led a number of MAOs to pull back on the number and locations where MA plans would be offered. [10] A recent study estimated that about one in 10 MA enrollees (approximately 2.9 million enrollees) will be forced to disenroll from their plan in 2026 as a result of MA plans leaving the market.[11] In addition to exiting markets, some payers have cut supplemental benefits and dropped entire product lines.[12] Carriers are also prioritizing plan designs like HMOs that have more limited provider networks, giving them greater cost control but limiting enrollee physician options.[13]

While many payers are reducing their MA footprint, some hospitals and health systems[14] are also dropping their participation in MA plans. Providers cite slow and low reimbursement, resistance to authorizing patient care, and other factors in decisions to leave MA contracts. Those termination decisions can have a major impact on enrollees in MA plans no longer contracting with their local hospitals and

clinics as they will likely either face higher prices for care or need to travel to in-network facilities.[15]

A significant area of MA enrollment increase is in Special Needs Plans (SNPs), which are limited to enrollees with specific chronic diseases or disabling conditions, those requiring institutional or nursing home care, or those with both Medicare and Medicaid coverage. Many MAOs may see opportunity for growth with these plans because the same market dynamics that may account for slowing the growth in MA generally – an aging Medicare population with more demand for services, increases in the prevalence of chronic conditions – may make SNPs a more attractive product for MAOs. In February 2026, there were over 8 million beneficiaries enrolled in SNPs, which accounted for nearly 23 percent of all Medicare Advantage enrollees`.[16] RUPRI Center analysis in 2025 showed that there were fewer than 2 million SNP enrollees in 2016 and that much of the SNP growth in the subsequent 10 years was owed to increased enrollment in D-SNPs (designed for enrollees dually eligible for Medicare and Medicaid). In the past two years, there has also been substantial growth in C-SNPs (designed for enrollees with designated chronic conditions).[17] RUPRI's analysis also showed that the number of available SNPs started growing rapidly after the Bipartisan Budget Act of 2018 made SNPs a permanent part of the MA program. The more generous benefit packages available in SNPs are also cited as a possible reason for the growth in SNP enrollment.[18]

There appear to be changes in the dynamics of MA offerings and enrollment in recent years, with the overall growth slowing while the rate of growth in SNPs has increased. In the past two years, national MAOs have reduced the number of counties in which they offer plans (from 96.1 percent to 92.8 percent of all counties)[19]. These changes may have implications for participation by nonmetropolitan enrollees and subsequently impacts on nonmetropolitan healthcare organizations, which future research can explore.

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

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Appendix

Medicare Advantage Plan Types[20]

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, urgent care, or 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, or 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 20 percent of MA enrollees.[17]

Appendix Tables 3a-c show that there has been a very gradual increase in the proportion of nonmetropolitan MA enrollees in HMO plans (41.5 percent in 2026), continuing a trend that has been nearly constant since 2017. The proportion of metropolitan MA enrollees in HMO plans ticked up slightly in 2025 and substantially in 2026 (59.5 percent) halting a constant decline since at least 2016. While enrollment in local PPO plans is high in both metropolitan and nonmetropolitan counties, the enrollment growth rate has declined slightly in nonmetropolitan counties in 2025 and 2026 and in metropolitan counties in 2026. Although Regional PPO plans had a substantial presence in the early teens (previous RUPRI reports showed total Regional PPO enrollment topping out at 9.6 percent in 2011 [2020 brief], their enrollment rates have steadily declined in both

nonmetropolitan counties (1.1 percent in 2026) and metropolitan counties (0.3 percent in 2026).

Table 3a. Overall Medicare Advantage Enrollment by Plan Type[i], March 2016-March 2026

Year	Total[ii] Medicare Enrolled	Total MA Enrollees	% Total Enrolled	HMO	Local PPO	Regional PPO	PFFS Plan	Other	Unat-tributed Other Prepaid[ii]
2026	63,393,172	35,184,845	55.5%	56.7%	41.7%	0.4%	0.1%	0.1%	1.0%
2025	62,073,009	34,378,258	55.4%	54.6%	42.9%	0.7%	0.1%	0.1%	1.7%
2024	60,602,533	33,081,964	54.6%	54.0%	42.8%	1.1%	0.1%	0.1%	1.9%
2023	59,324,175	31,064,706	52.4%	55.4%	40.5%	1.7%	0.1%	0.0%	2.3%
2022	57,963,667	28,783,697	49.7%	56.5%	38.0%	2.6%	0.2%	0.0%	2.7%
2021	56,905,626	26,505,920	46.6%	57.8%	35.4%	3.7%	0.2%	0.0%	2.8%
2020	55,869,203	24,130,854	43.2%	58.8%	32.9%	4.8%	0.3%	0.0%	3.2%
2019	54,512,798	22,025,456	40.4%	59.2%	31.2%	5.6%	0.5%	0.0%	3.4%
2018	53,229,823	20,486,377	38.5%	59.4%	27.7%	6.4%	0.7%	0.0%	5.7%
2017	51,930,271	19,025,912	36.6%	59.8%	25.9%	7.1%	1.0%	0.0%	6.2%
2016	50,622,655	17,609,527	34.8%	61.5%	23.5%	7.4%	1.3%	0.0%	6.2%

Table 3b. Nonmetropolitan Medicare Advantage Enrollment by Plan Type[i], March 2016-2026

Year	Total[ii] Medicare Enrolled	Total MA Enrollees	% Total Enrolled	HMO	Local PPO	Regional PPO	PFFS Plan	Other	Unat-tributed Other Prepaid[ii]
2026	10,994,848	5,423,581	49.3%	41.5%	53.9%	1.1%	0.3%	0.0%	3.3%
2025	10,852,629	5,344,798	49.2%	39.2%	55.1%	1.6%	0.3%	0.0%	3.9%
2024	10,686,018	5,133,328	48.0%	37.4%	55.8%	2.4%	0.3%	0.0%	4.1%
2023	10,521,961	4,745,357	45.1%	36.9%	54.2%	3.6%	0.3%	0.0%	4.9%
2022	10,342,394	4,268,672	41.3%	36.6%	51.3%	6.2%	0.5%	0.1%	5.3%
2021	10,233,817	3,779,194	36.9%	35.9%	48.4%	9.3%	0.7%	0.1%	5.7%
2020	10,105,188	3,282,142	32.5%	34.3%	46.1%	12.1%	1.2%	0.1%	6.3%
2019	9,915,164	2,876,079	29.0%	32.1%	44.8%	14.5%	2.0%	0.1%	6.5%
2018	9,748,843	2,638,221	27.1%	29.9%	40.1%	16.3%	2.9%	0.1%	10.7%
2017	9,574,741	2,404,204	25.1%	29.1%	38.1%	17.6%	3.8%	0.1%	11.4%
2016	9,399,424	2,215,139	23.6%	29.4%	37.2%	17.4%	5.0%	0.0%	11.0%

Table 3c. Metropolitan Medicare Advantage Enrollment by Plan Type[i], March 2016-2026

Year	Total[ii] Medicare Enrolled	Total MA Enrollees	% Total Enrolled	HMO	Local PPO	Regional PPO	PFFS Plan	Other	Unat-tributed Other Prepaid[ii]
2026	52,398,324	29,761,264	56.8%	59.5%	39.5%	0.3%	0.1%	0.1%	0.6%
2025	51,220,380	29,033,460	56.7%	57.4%	40.6%	0.5%	0.1%	0.1%	1.3%
2024	49,916,515	27,948,636	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	46,671,809	22,726,726	48.7%	61.5%	33.3%	2.7%	0.1%	0.0%	2.4%
2020	45,764,015	20,848,712	45.6%	62.6%	30.8%	3.7%	0.2%	0.0%	2.7%
2019	44,597,634	19,149,377	42.9%	63.3%	29.1%	4.3%	0.3%	0.0%	3.0%
2018	43,480,980	17,848,156	41.0%	63.7%	25.9%	5.0%	0.4%	0.0%	5.0%
2017	42,355,530	16,621,708	39.2%	64.2%	24.1%	5.6%	0.6%	0.0%	5.5%
2016	41,223,231	15,394,388	37.3%	66.2%	21.5%	6.0%	0.8%	0.0%	5.5%

i. 'Other' plans include MSA, PSO, Limited Income Newly Eligible Transition (LI NET), Program of All-inclusive Care for the Elderly (PACE), and Cost plans and Demonstrations. 'Unatt. Other Prepaid' includes enrollees 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 enrollee counts and the sum of enrollees 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 for general enrollment (i.e., SNPs are excluded) from 2022-2026 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 in metropolitan counties. The number of Local PPO plans in nonmetropolitan counties started declining in 2025.

Table 4a. Medicare Advantage Plans Over Time

	2022		2023		2024		2025		2026	
Total Plans*	3,726		3,965		3,917		3,686		3,350	
HMO	2,226	59.7%	2,289	57.7%	2,181	55.7%	2,035	55.2%	1,889	56.4%
Local PPO	1,407	37.8%	1,593	40.2%	1,661	42.4%	1,586	43.0%	1,402	41.8%
Regional PPO	52	1.4%	52	1.3%	51	1.3%	43	1.2%	38	1.1%
Other	41	1.1%	31	0.8%	24	0.6%	22	0.6%	21	0.6%

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

	2022		2023		2024		2025		2026	
Total Plans*	2,184		2,385		2,418		2,303		2,104	
HMO	1,068	48.9%	1,139	47.8%	1,130	46.7%	1,046	45.4%	977	46.4%
Local PPO	1,025	46.9%	1,164	48.8%	1,214	50.2%	1,193	51.8%	1,069	50.8%
Regional PPO	51	2.3%	51	2.1%	50	2.1%	42	1.8%	37	1.8%
Other	40	1.8%	31	1.3%	24	1.0%	22	1.0%	21	1.0%

Table 4c. Metropolitan Medicare Advantage Plans Over Time

	2022		2023		2024		2025		2026	
Total Plans*	3,636		3,863		3,822		3,611		3,287	
HMO	2,177	59.9%	2,233	57.8%	2,134	55.8%	1,999	55.4%	1,859	56.6%
Local PPO	1,366	37.6%	1,549	40.1%	1,614	42.2%	1,549	42.9%	1,371	41.7%
Regional PPO	52	1.4%	52	1.4%	51	1.3%	43	1.2%	38	1.2%
Other	41	1.1%	29	0.7%	23	0.6%	20	0.5%	19	0.6%

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

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

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