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Trends Among Medicare Special Needs Plan Enrollment in Metropolitan and Nonmetropolitan Areas

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Purpose

The purpose of this policy brief is to examine recent trends in Special Needs Plan (SNP) enrollment by type and geographic variation across metropolitan and nonmetropolitan areas.

Key Findings

- In 2025, there were 6.9M beneficiaries enrolled in SNPs while there were 34.4M beneficiaries enrolled in regular MA plans. Total MA enrollees (all plans) represent 55.4 percent of total Medicare beneficiaries.
- Overall, SNP enrollment increased by 276.8 percent from 2016 to 2025 (from 1.8M to 6.9M beneficiaries). The proportion of Medicare beneficiaries enrolled in a SNP grew from 3.6 percent in 2016 to 11.1 percent in 2025.
- Enrollment in all three SNP types grew fairly consistently between 2016 and 2025. D-SNPs have regularly had much higher enrollment than either C-SNPs or I-SNPs. However, there was a dramatic increase in C-SNP enrollment (73.1 percent) from 2024 to 2025.
- Nonmetropolitan areas experienced more dramatic growth in total SNP enrollment than metropolitan areas. Between 2016 and 2025, nonmetropolitan SNP enrollment grew from 0.2M to 1.1M beneficiaries (530 percent) while metropolitan SNP enrollment grew from 1.6M to 5.8M beneficiaries (250 percent). As a share of MA enrollees, SNP enrollment grew from 7.9 percent to 20.7 percent (a 164.6 percent increase) in nonmetropolitan areas vs growth of 10.7 percent to 20.0 percent (an 88.8 percent increase) in metropolitan areas.

Background

SNPs "provide benefits and services to people with specific severe and chronic diseases, certain health care needs, or who also have Medicaid."[1] SNPs are Medicare Advantage (MA) plans, so they must include all Part A and Part B services and provide Part D coverage.[2] There are three SNP types for which beneficiaries are eligible based on meeting specific requirements: individuals living

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in a care facility (I-SNPs), individuals with dual enrollment in Medicare and Medicaid (D-SNPs), or individuals with a disabling chronic condition (C-SNPs).[2] A large majority of SNP enrollees are in D-SNPs. A small but growing proportion of SNP enrollees are in C-SNPs and an even smaller proportion are in I-SNPs.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 established SNPs, which began operating in 2006 with initial authority set to expire in 2008.[2] However, subsequent legislation, including the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Extension Act (2007), Medicare Improvements for Patients and Providers Act (MIPPA) (2008), and the Patient Protection and Affordable Care Act (ACA) (2010) extended the SNP program multiple times. These laws also lifted moratoriums and expanded the authority of the Center for Medicare & Medicaid Services (CMS) to approve and regulate SNPs.[2] Together, these legislative actions solidified SNPs as a permanent component of the MA program that enabled continued access to specialized care for high-need populations through MA plans. Although SNP enrollment has historically grown over time, the rate of enrollment has accelerated in recent years.[3]

Data

Data on MA monthly enrollment by contract/plan/state/county[4], Special Needs Plans[5], and Medicare enrollment[6] from 2016-2025 were downloaded from CMS websites. Data were limited to enrollees in the 50 U.S. states and the District of Columbia. Urban Influence Codes (UIC, 2024)[7] were used to classify counties as metropolitan (1,4) and nonmetropolitan (2,3,5,6,7,8,9) [*]. Note that count data for county SNP enrollment is censored for county/plans with fewer than 11 enrollees, so the enrollment totals presented in this report are undercounts.

Findings

Table 1 and Figure 1 show total counts of SNP enrollment and as a percent of beneficiaries with both Part A and Part B coverage. It also shows the count and proportion of MA enrollees in each SNP type. During this period (2016-2025), there has been a 276.8 percent increase in the number of SNP enrollees and a 208.3 percent increase in the proportion of all Medicare enrollees in a SNP. The proportion of MA enrollees in SNPs has nearly doubled during this period with much of that growth attributable to increased enrollment in D-SNPs. There was a dramatic increase in C-SNP enrollment (73.1 percent) from 2024 to 2025.

[*] In 2022, the US Census Bureau formally recognized Connecticut's Councils of Government (COG) as county equivalents. During the period of the data in this report, CMS reported Connecticut Medicare enrollment by county until 2022 when it switched to reporting by COG. CMS data on Connecticut SNP enrollment has always been reported by county. We chose to retain all Connecticut data, using UIC data from 2013 to define metropolitan (UIC: 1,2) / nonmetropolitan (UIC: 3,4,5,6,7,8,9,10,11,12) for Connecticut counties prior to 2022.

Table 1. Total SNP Enrollment, 2016-2025

Year	SNP Enrollees		SNP Plan Type Enrollment*					
			C-SNP		D-SNP		I-SNP	
	(% of Medicare†)	(% of MA◊)		(% of MA◊)		(% of MA◊)		(% of MA◊)
2016	1.8M (3.6%)	(10.3%)	302,303	(1.7%)	1,460,976	(8.3%)	55,329	(0.3%)
2017	2.0M (3.8%)	(10.5%)	304,670	(1.6%)	1,632,488	(8.6%)	60,260	(0.3%)
2018	2.3M (4.3%)	(11.1%)	325,818	(1.6%)	1,872,638	(9.1%)	70,091	(0.3%)
2019	2.6M (4.8%)	(11.8%)	332,440	(1.5%)	2,190,197	(9.9%)	80,988	(0.4%)
2020	3.0M (5.4%)	(12.6%)	352,789	(1.5%)	2,590,588	(10.7%)	98,617	(0.4%)
2021	3.6M (6.2%)	(13.4%)	367,647	(1.4%)	3,100,629	(11.7%)	83,576	(0.3%)
2022	4.3M (7.4%)	(14.9%)	367,383	(1.3%)	3,835,796	(13.3%)	92,690	(0.3%)
2023	5.4M (9.0%)	(17.3%)	437,812	(1.4%)	4,824,158	(15.5%)	102,030	(0.3%)
2024	6.2M (10.3%)	(18.8%)	639,458	(1.9%)	5,476,931	(16.6%)	114,202	(0.3%)
2025	6.9M (11.1%)	(19.9%)	1,107,569	(3.2%)	5,626,961	(16.4%)	117,648	(0.3%)

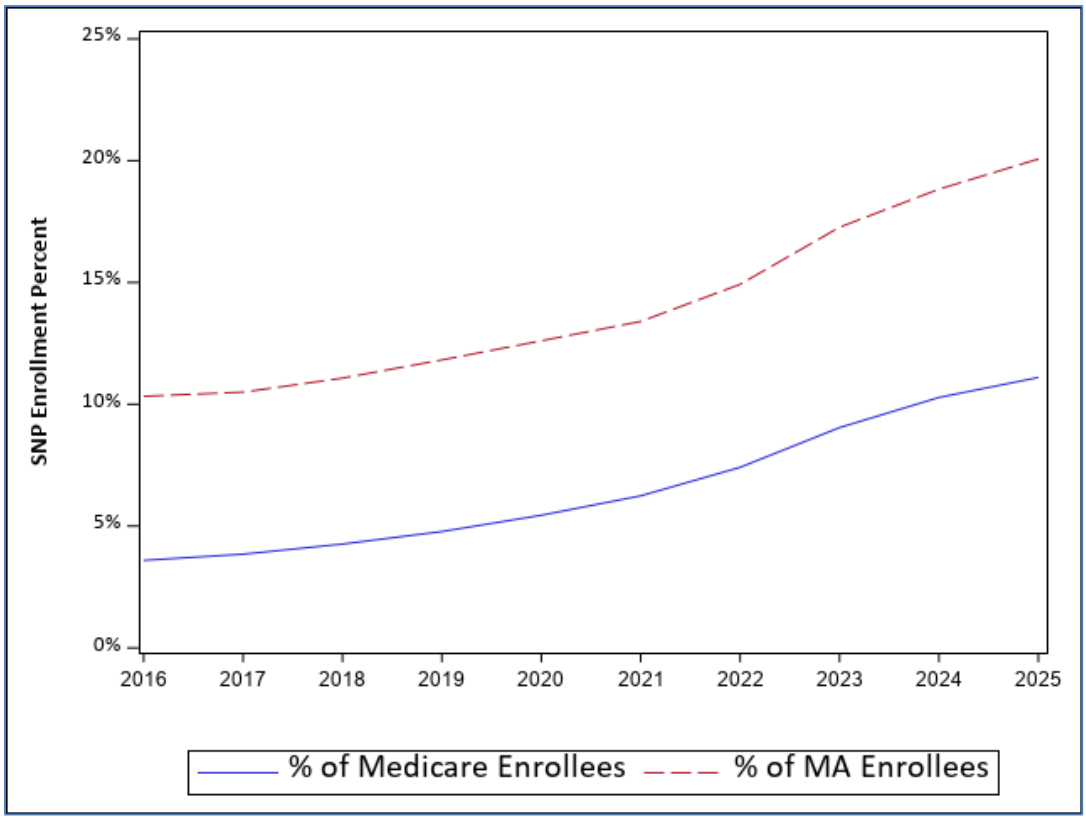
* C-SNP: Chronic or Disabling Conditions; D-SNP: Dual Eligible; I-SNP: Institutional.

† Proportion of Medicare beneficiaries with both Part A and Part B coverage that are enrolled in a SNP.

◊ Proportion of MA enrollees that are enrolled in a SNP.

Data source: MA monthly enrollment by contract/plan/state/county data, Special Needs Plan data, and Medicare enrollment data

Figure 1. SNP Enrollment as Percent of Traditional Medicare and Medicare Advantage, 2016-2025



Data source: MA monthly enrollment by contract/plan/state/county data, Special Needs Plan data, and Medicare enrollment data

Table 2 and Figure 2 show SNP enrollment broken down by metropolitan/nonmetropolitan beneficiary residence. The table shows the same significant growth in enrollment seen in Table 1, but with some important differences. During this period, metropolitan SNP enrollment counts grew by 250.0 percent from 1.6 million to 5.8 million. But, nonmetropolitan SNP enrollment counts grew by 530.0 percent from 173,658 to 1.1 million. As a proportion of MA beneficiaries, metropolitan SNP enrollment grew by 88.8 percent and nonmetropolitan SNP enrollment grew by 164.6 percent. In 2016, less than 10 percent of SNP enrollees lived in a nonmetropolitan area. By 2025, that had grown to 16 percent (Table 2).

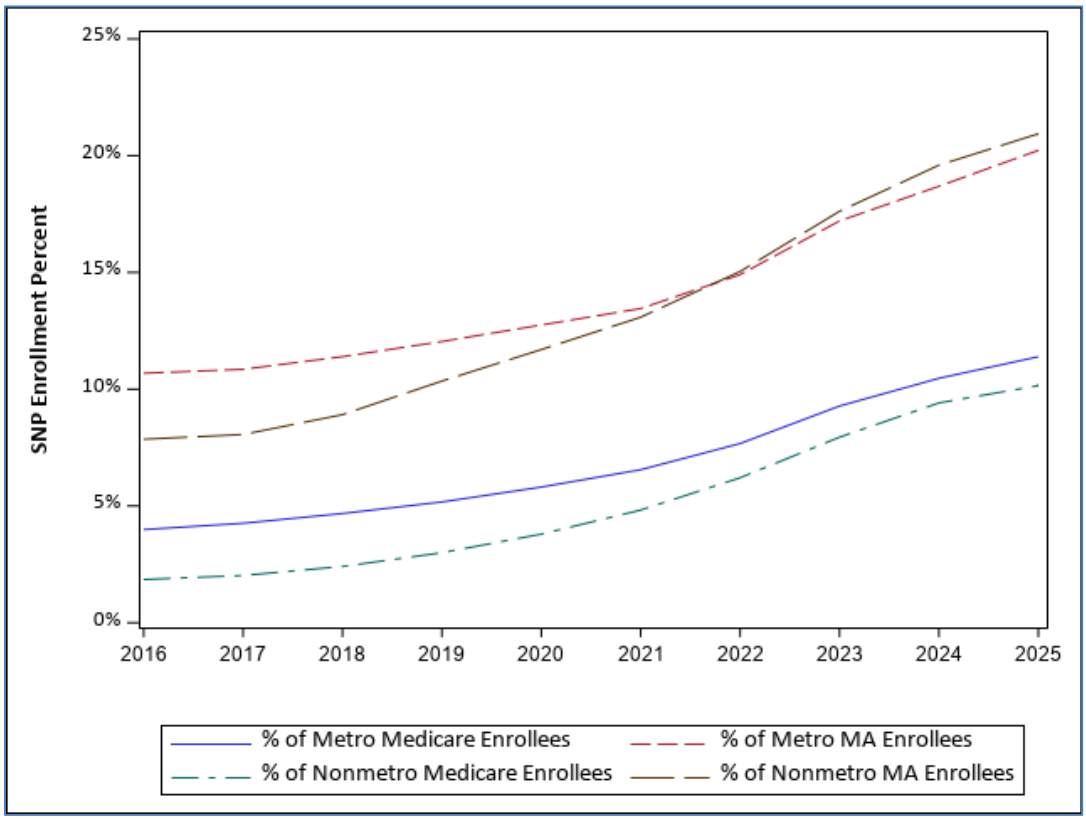
Table 2. Metropolitan/Nonmetropolitan SNP Enrollment, 2016-2025

Year	Metropolitan SNP Enrollees	(% all SNP enrollees)	(% of Medicare*)	(% of MA◊)	Nonmetropolitan SNP Enrollees	(% all SNP enrollees)	(% of Medicare*)	(% of MA◊)
2016	1,644,950	(90.5%)	(4.0%)	(10.7%)	173,658	(9.5%)	(1.9%)	(7.9%)
2017	1,804,106	(90.3%)	(4.3%)	(10.9%)	193,312	(9.7%)	(2.0%)	(8.1%)
2018	2,034,222	(89.7%)	(4.7%)	(11.4%)	234,325	(10.3%)	(2.4%)	(8.9%)
2019	2,306,975	(88.6%)	(5.2%)	(12.0%)	296,650	(11.4%)	(3.0%)	(10.3%)
2020	2,659,320	(87.4%)	(5.8%)	(12.7%)	382,674	(12.6%)	(3.8%)	(11.7%)
2021	3,058,989	(86.1%)	(6.6%)	(13.5%)	492,863	(13.9%)	(4.8%)	(13.1%)
2022	3,653,839	(85.1%)	(7.7%)	(14.9%)	642,030	(14.9%)	(6.2%)	(15.0%)
2023	4,527,960	(84.4%)	(9.3%)	(17.2%)	836,040	(15.6%)	(7.9%)	(17.6%)
2024	5,224,676	(83.9%)	(10.5%)	(18.7%)	1,005,915	(16.1%)	(9.4%)	(19.6%)
2025	5,758,207	(84.0%)	(11.3%)	(20.0%)	1,093,971	(16.0%)	(10.1%)	(20.7%)

* Proportion of Medicare beneficiaries with both Part A and Part B coverage that are enrolled in a SNP.
◊ Proportion of MA enrollees that are enrolled in a SNP.
Data source: CMS MA monthly enrollment by contract/plan/state/county data, CMS Special Needs Plan data, and CMS Medicare enrollment data

Table 3 provides more detail than Table 2 by showing SNP plan type enrollment counts and percentages of MA enrollees by metropolitan/nonmetropolitan beneficiary residence. Metropolitan and nonmetropolitan enrollment rates in C-SNPs have been quite comparable since 2022, with a sharp increase in both areas between 2024 and 2025. It is worth noting that enrollment rates in D-SNPs declined during the same time. As seen earlier, there is higher enrollment in D-SNPs than in other SNPs. The metropolitan D-SNP enrollment rate was higher in 2016, but the nonmetropolitan D-SNP enrollment rate is higher in 2025. Enrollment in I-SNPs has been quite low between 2016 and 2025 and has shown very little variation.

Figure 2. Metropolitan/Nonmetropolitan SNP Enrollment, 2016-2025



Data source: MA monthly enrollment by contract/plan/state/county data, Special Needs Plan data, and Medicare enrollment data

Table 3. Metropolitan and Nonmetropolitan SNP Enrollment Proportion by Plan Type*, 2016-2025

Year	C-SNP				D-SNP				I-SNP			
	Metropolitan		Nonmetro.		Metropolitan		Nonmetro.		Metropolitan		Nonmetro.	
		(% of MA◊)		(% of MA◊)		(% of MA◊)		(% of MA◊)		(% of MA◊)		(% of MA◊)
2016	243,402	(1.6%)	58,901	(2.7%)	1,347,932	(8.8%)	113,044	(5.1%)	53,616	(0.3%)	1,713	(0.1%)
2017	241,995	(1.5%)	62,675	(2.6%)	1,504,263	(9.0%)	128,225	(5.3%)	57,848	(0.4%)	2,412	(0.1%)
2018	259,754	(1.5%)	66,064	(2.5%)	1,708,750	(9.6%)	163,888	(6.2%)	65,718	(0.4%)	4,373	(0.2%)
2019	266,683	(1.4%)	65,757	(2.3%)	1,965,325	(10.3%)	224,872	(7.8%)	74,967	(0.4%)	6,021	(0.2%)
2020	283,233	(1.4%)	69,556	(2.1%)	2,284,530	(11.0%)	306,058	(9.4%)	91,557	(0.4%)	7,060	(0.2%)
2021	299,722	(1.3%)	67,925	(1.8%)	2,682,820	(11.8%)	417,809	(11.1%)	76,447	(0.3%)	7,129	(0.2%)
2022	307,616	(1.3%)	59,767	(1.4%)	3,262,102	(13.3%)	573,694	(13.4%)	84,121	(0.3%)	8,569	(0.2%)
2023	376,845	(1.4%)	60,967	(1.3%)	4,059,739	(15.4%)	764,419	(16.1%)	91,376	(0.3%)	10,654	(0.2%)
2024	548,329	(2.0%)	91,129	(1.8%)	4,574,779	(16.4%)	902,152	(17.6%)	101,568	(0.4%)	12,634	(0.2%)
2025	941,755	(3.2%)	165,814	(3.1%)	4,713,288	(16.2%)	913,673	(17.1%)	103,164	(0.4%)	14,484	(0.3%)

* C-SNP: Chronic or Disabling Conditions; D-SNP: Dual Eligible; I-SNP: Institutional.

◊ Proportion of MA enrollees that are enrolled in a SNP.

Data source: MA monthly enrollment by contract/ plan/state/county data, Special Needs Plan data, and Medicare enrollment data

Table 4 shows the total number of SNPs and the average number of SNPs per county that beneficiaries were enrolled in by metropolitan/nonmetropolitan residence and SNP type. CMS SNP directory data does not offer county-level plan

availability, so it is not possible to determine where plans are actually offered. This table shows the number of plans with any reported enrollment. County SNP enrollment counts are censored for county/plans with fewer than eleven enrollees, and therefore, the counts presented here are likely an undercount of actual plan availability. Between 2016 and 2025, the total number of SNP plans increased by 158.6 percent. The average number of plans in metropolitan counties grew by 210.9 percent from 9.1 to 28.3 plans, while the number of plans in nonmetropolitan counties grew by 482.6 percent from 2.3 to 13.4 plans. The average number of plans with enrollees, both overall and across all plan types and both geographies, saw substantial, nearly constant, growth during the period. However, there were fewer plans with enrollees in nonmetropolitan counties than in metropolitan counties across all years and plan types.

Table 4. SNP Plan Counts, Overall and by Metropolitan/Nonmetropolitan and Type* 2016-2025

		Metropolitan County Avg. Plans				Nonmetro. County Avg. Plans			
Year	Total SNP Count	All Plans	C-SNP	D-SNP	I-SNP	All Plans	C-SNP	D-SNP	I-SNP
2016	548	9.1	1.6	6.6	0.9	2.3	0.7	1.6	0.1
2017	562	9.8	1.5	7.3	0.9	2.4	0.6	1.8	0.1
2018	610	11.5	1.6	8.7	1.2	3.0	0.6	2.2	0.3
2019	695	12.1	1.5	9.0	1.5	3.4	0.5	2.5	0.4
2020	828	14.0	1.7	10.6	1.8	4.3	0.6	3.3	0.4
2021	945	15.7	1.8	11.9	2.1	5.2	0.6	4.1	0.5
2022	1,126	20.6	2.4	15.8	2.5	7.1	0.7	5.7	0.6
2023	1,256	23.8	2.8	18.4	2.6	9.1	1.0	7.4	0.7
2024	1,313	26.4	3.5	20.1	2.8	11.3	1.3	9.0	0.9
2025	1,417	28.3	4.7	20.7	2.9	13.4	2.0	10.1	1.3

* C-SNP: Chronic or Disabling Conditions; D-SNP: Dual Eligible Special Needs Plans; I-SNP: Institutional.
Data source: MA monthly enrollment by contract/plan/state/county data, Special Needs Plan data, and Medicare enrollment data

Discussion

Between 2016 and 2025, the number of Medicare beneficiaries with both Part A and Part B (i.e., beneficiaries eligible to enroll in any MA plan) coverage grew by 21.1 percent (data not shown), so it should not be surprising that the number of SNP enrollees has also grown. What is noteworthy is that the rates of SNP enrollment growth are substantially higher than the rate of growth in total Medicare enrollment. The rate of SNP enrollment growth (276.8 percent) between 2016 and 2025 was also much higher than the rate of enrollment growth in MA plans (57.2 percent) between 2016 and 2024 (latest data available)[8].

The total number of SNP plans grew from 548 to 1,417 between 2016 and 2025. SNP enrollment increased substantially in both metropolitan and nonmetropolitan areas, with far greater growth rates in nonmetropolitan regions (530 percent vs. 250 percent). Similarly, nonmetropolitan counties saw a much greater increase than metropolitan counties in the average number of SNPs with enrollees.

However, the rate of enrollment and number of SNP plans available in nonmetropolitan counties still lags those in metropolitan counties.

SNP enrollment requires meeting specific enrollment eligibility requirements, and the plans are not available to all MA enrollees. SNPs often offer supplemental benefits not typically found in standard Medicare Advantage plans, such as over-the-counter allowances, meal benefits, and transportation services, which may enhance their appeal among high-need beneficiaries.[9] Recent federal and state policies have reshaped the D-SNP landscape to increase Medicare-Medicaid integration for dual-eligible beneficiaries through efforts such as aligned enrollment and enhanced Medicaid care coordination support, service alignment, and accountability, which may be contributing to the growth in plans and enrollment. It should be noted that the proportion of the Medicare Part A and Part B population eligible to receive both Medicare and Medicaid benefits (i.e., "dual-eligibles") hovered around 20% between 2016 and 2025. During the same period, the proportion of dual-eligibles enrolled in a D-SNP grew from 14.1 percent to 47.1 percent (data not shown).

The specific reasons for SNP enrollment growth are not fully understood. Insurance companies may be increasing offerings and marketing efforts to increase C-SNP enrollment as a source of continued growth in the MA market. It is estimated that nearly 80 percent of Medicare-eligible adults have at least two chronic conditions.[10] It is also suggested that the end of the Value-Based Insurance Design model may have changed the attractiveness of D-SNP plans and shifted some of that enrollment into C-SNPs.[11]

These findings highlight the rapidly evolving role of SNPs within the Medicare Advantage landscape, particularly in rural areas, where growth has far outpaced that of Traditional Medicare enrollment even though actual enrollment is lower. As enrollment continues to shift toward more integrated and tailored models of care, understanding geographic and plan-type variation becomes essential for informing future policy. RUPRI will continue to monitor these trends across metropolitan and nonmetropolitan counties, illuminating how regulatory changes, demographic shifts, and market forces interact to shape access to care for high-need Medicare beneficiaries. Continued monitoring will be vital to evaluating the long-term impact of federal and state policies, particularly as SNPs become an increasingly central mechanism for serving dually eligible and medically complex populations.

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