RESEARCH LETTER

Forced Disenrollments Among Medicare Advantage Beneficiaries Following 2026 Plan Exits

Every year over the last 2 decades, the share of Medicare beneficiaries enrolling in Medicare Advantage has increased.[1] The number of plans available to Medicare Advantage beneficiaries has also increased year after year, doubling in number over the last 7 years.[2] As a result, Medicare Advantage beneficiaries have rarely had to contend with disruptions resulting from Medicare Advantage plans exiting the market (*forced disenrollment*), which may include adjustment to different provider networks, plan benefit packages, and supplementary benefits. However, recent reports suggest that many insurers will stop offering plans in 2026.[3,4] This study characterized the scale and impact of Medicare Advantage plan exits for beneficiaries.

Editorial

Supplemental content

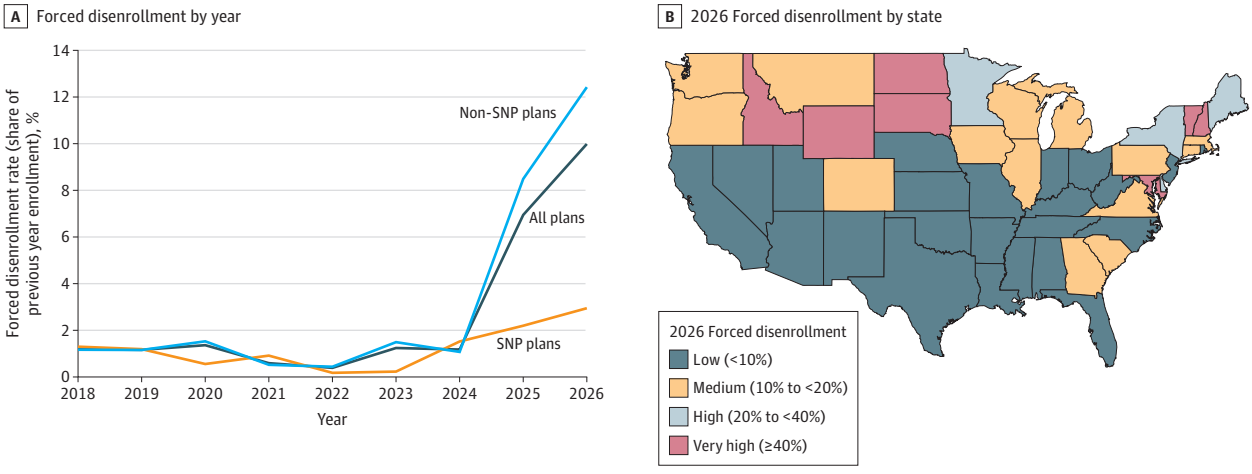
Methods | The sample was restricted to nonemployer health maintenance organization (HMO) and preferred provider organization (PPO) plans in the 50 US states and the District of Columbia. To identify beneficiaries in Medicare Advantage plans exiting the market, we linked the Centers for Medicare & Medicaid Services (CMS) county-level enrollment data in the previous year to the annual Plan Crosswalk file, which captures plan contract terminations and service area reductions, and the annual Landscape file, which documents county-level plan service areas. We used March enrollment data from 2017 through 2025 and Plan Crosswalk and Landscape files from 2018 to 2026. Beneficiaries facing forced disenrollment were enrolled in a plan that either terminated its contract or stopped service in their county.

Plan and county characteristics were obtained from CMS's annual Plan Benefit Package data, provider networks data were obtained from Ideon's 2024 provider network file, and county characteristics were obtained from multiple additional sources. Details on variable construction are provided in the eMethods and eTable in Supplement 1.

Forced disenrollment among Medicare Advantage beneficiaries was plotted from 2018 to 2026 overall, by whether enrolled in a special needs plan (SNP) or not, and by state for 2026. Then, we compared Medicare Advantage enrollees' plan and market characteristics between those with 2026 forced disenrollments vs the rest who may retain their plan. The analysis used plan county units with plan enrollment weights. All tests were 2-sided and statistical significance was defined based on an α of .05 (95% CI not overlapping 0). This study followed the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) reporting guideline. No institutional board review or informed consent waiver was required for this analysis of publicly available plan-level data.

Results | From 2017 to 2025, there were 752 091 plan county observations representing 192 675 082 enrollee-years (eFigure in Supplement 1). From 2018 to 2024, the mean forced disenrollment rate for Medicare Advantage beneficiaries was 1.0% (**Figure**, A), which increased to 6.9% in 2025 and to 10.0% in

Figure. Medicare Advantage Enrollee Annual Rate of Forced Disenrollment, 2018-2026



Based on data from Centers for Medicare & Medicaid Services annual Landscape files, monthly contract/plan/state/county enrollment data, and annual Plan Crosswalk files. Forced disenrollment occurs when enrollees lose access to their current plan due to contract termination or service area reduction. All rates are based on current year enrollment rates in health maintenance organization/preferred provider organization Medicare Advantage plans. SNP indicates special needs plan.

Table. Medicare Advantage Enrollees' Plan and Market Characteristics Among Those With 2026 Forced Disenrollments vs Those Who May Retain Their Current Plan[a]

Characteristic	HMO and PPO (28.6 million enrollees)		
	May retain coverage (25.8 million)	Forced disenrollment (2.9 million)	Difference (95% CI)[b]
No. of unique plans[c]	4401	1348	
No. of unique plan counties	116 103	22 022	
PPO, %	30.88	49.35	18.47 (17.62 to 19.32)
SNP, %	20.97	5.08	−15.88 (−16.60 to −15.17)
D-SNP	17.66	3.89	−13.78 (−14.44 to −13.11)
Other	3.31	1.20	−2.11 (−2.42 to −1.79)
Carrier, %			
UnitedHealthcare	22.64	13.85	−8.79 (−9.54 to −8.04)
Humana	18.24	2.21	−16.03 (−16.71 to −15.36)
Elevance Health	8.72	8.17	−0.55 (−1.06 to −0.04)
CVS Health	7.86	8.65	0.79 (0.30 to 1.28)
Cigna Healthcare	5.24	3.64	−1.60 (−2.00 to −1.20)
Kaiser Permanente	4.33	3.00	−1.33 (−1.70 to −0.96)
Blue Cross Blue Shield	2.94	8.88	5.93 (5.60 to 6.27)
Centene	2.95	2.79	−0.16 (−0.47 to 0.15)
Other	27.08	48.82	21.74 (20.92 to 22.56)
Star rating, %			
<4	37.39	42.10	4.71 (3.83 to 5.60)
≥4	61.15	56.43	−4.72 (−5.61 to −3.83)
Plan features			
Has part B premium reduction, %	34.21	21.02	−13.19 (−14.04 to −12.33)
In-network out-of-pocket maximum, mean, $	5531.35	5680.35	148.99 (105.42 to 192.57)
Physician network breadth, mean, %	44.04	45.31	1.27 (0.95 to 1.59)
Household income <$60 000 per county, mean, %	46.20	44.82	−1.38 (−1.56 to −1.20)
Rural, %	15.07	28.04	12.97 (12.30 to 13.64)
Medicare market characteristics[d]			
Fee-for-service HCC risk score, mean	1.03	0.99	−0.04 (−0.04 to −0.04)
Medicare Advantage county participation rate, mean, %	51.59	46.99	−4.60 (−4.82 to −4.37)
Carrier-level HHI			
<0.25	41.71	42.67	0.96 (0.06 to 1.86)
0.25 to <0.50	55.34	53.42	−1.91 (−2.82 to −1.01)
≥0.50	2.96	3.91	0.95 (0.64 to 1.26)

Abbreviations: D-SNP, dual special needs plan; HCC, Hierarchical Condition Categories; HHI, Herfindahl-Hirschman Index; HMO, health maintenance organization; PPO, preferred provider organization.

[a] Based on 2025-2026 CMS Medicare Advantage data and Landscape files, 2024 Ideon provider network files, 2021 American Community Survey data, 2021 IQVIA OneKey data, 2023 Medicare Geographic Variation data, and 2023 Rural-Urban Continuum Codes.

[b] Values represent plan county enrollment-weighted differences between renewals and disenrollments.

[c] Plans with service area reductions are represented in both columns.

[d] Values exclude Connecticut because the state transitioned from county to planning region geographic definitions.

2026 (12.4% among non-SNPs). In 12 states, more than 20% of Medicare Advantage enrollees face forced disenrollment, including 92.2% of enrollees in Vermont (Figure, B).

Medicare Advantage beneficiaries facing forced disenrollment in 2026 were more likely to be enrolled in PPOs, non-SNPs, smaller carrier plans, and lower star-rated plans and living in rural areas and in markets with lower 2025 Medicare Advantage penetration (**Table**). There were no differences based on county income, fee-for-service Hierarchical Condition Categories risk score, or Medicaid eligibility.

Discussion | Results of this study show that, in 2026, approximately 1 in 10 beneficiaries in HMO or PPO Medicare Advantage plans will be forced to disenroll from their current plan due to their plan exiting the market. Drivers of higher plan exit may include changes to plan payments and risk adjustment, as well as unanticipated increases in health care use among Medicare Advantage enrollees.[3,4] The uptick in forced disenrollment began in 2025, when many of these changes were first observed. Beneficiaries in PPO plans, small insurance carrier plans, and lower star-rated plans and those living in rural areas face a higher rate of forced disenrollment.

This study has limitations. The welfare implications of forced disenrollments, which will vary across enrollees depending on their preferences for other remaining Medicare Advantage plans and traditional Medicare, were not assessed.

Millions of Medicare Advantage enrollees will be forced to either find new plans or switch to traditional Medicare in 2026,

which may disrupt access to providers and benefits and potentially limit competition in Medicare Advantage.

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