Key insights into 2025 Medicare Advantage D-SNP landscape

D-SNP market experiencing slower growth amid broader Medicare Advantage market and regulatory changes

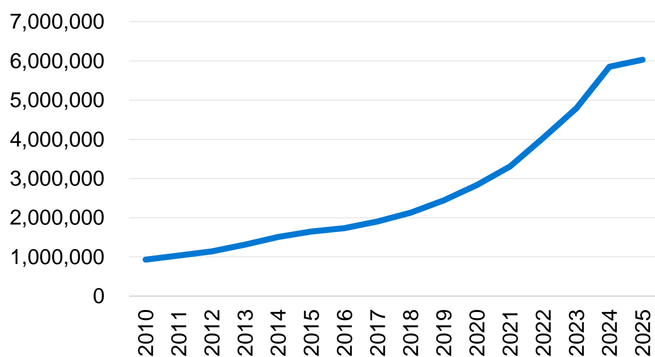
Nick Johnson, FSA, MAAA
Annie Hallum, FSA, MAAA
Nick Gipe, ASA, MAAA
Logan Blank, ASA, MAAA

Recently released calendar year (CY) 2025 Medicare Advantage (MA) data show slowed growth in dual eligible special needs plan (D-SNP) enrollment and plan count. This white paper discusses historical and current growth, recent policies impacting D-SNPs, and additional key insights into the CY 2025 D-SNP landscape.

Dual eligible special needs plans, or D-SNPs, are Medicare Advantage (MA) plans that only enroll beneficiaries who are dually eligible and enrolled in both Medicare and Medicaid. D-SNPs are popular among both MA organizations (MAOs) and dual eligible beneficiaries because of their ability to tailor benefit designs to the needs of this population. Recent federal regulations and state Medicaid policies related to D-SNPs, largely guided by a Centers for Medicare and Medicaid Services (CMS) goal of promoting integrated care through aligned Medicare and Medicaid products, have helped to grow and shape the D-SNP landscape in recent years.[1]

Figure 1 shows D-SNP January enrollment from CY 2010 to CY 2025. Enrollment has increased steadily over that time period and averaged 15% annual growth in the decade preceding 2025. D-SNP enrollment growth slowed to 3% in CY 2025, which is the lowest growth seen since CY 2016 and is the first significant deceleration in growth since CY 2016.

FIGURE 1: D-SNP ENROLLMENT (CY 2010–CY 2025)

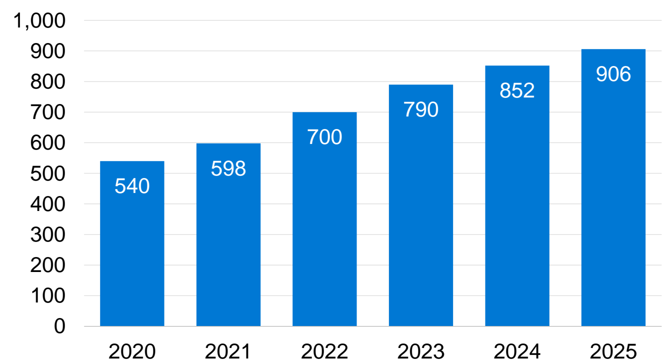


CMS recently released information about CY 2025 MA plan offerings, including D-SNPs.[2] The remainder of this paper discusses key takeaways from a review of CY 2025 D-SNP plan offering data and Milliman's Medicare Advantage Competitive Value Added Tool (Milliman MACVAT®).

1. The D-SNP market growth rate continues to slow

The number of D-SNPs is increasing by 6% in CY 2025. Figure 2 shows the growth in D-SNPs over the past five years.

FIGURE 2: NUMBER OF D-SNPS (CY 2020–CY 2025)

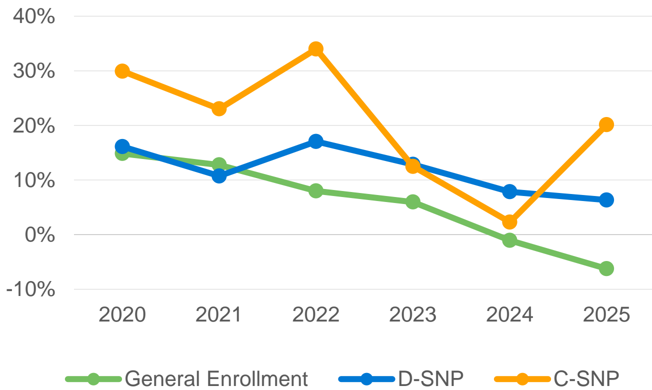


In CY 2025, the pace of growth of offered D-SNPs (6.3%) remains relatively high, but CY 2025 is the lowest year of growth since 2016 and represents a continued moderation relative to the five consecutive years of double-digit growth from 2019 to 2023. While maintaining strong positive growth, this pattern somewhat mirrors recent general enrollment plan offering trends, where the

growth rate has slowed in each of the past six years. Unlike D-SNP plan growth, which remains positive, general enrollment plan growth has been negative for two consecutive years, with decreases of 1.1% and 6.2% in 2024 and 2025, respectively.

Figure 3 shows the average annual growth in MA plans by year from 2020 through 2025 separately for D-SNPs, C-SNPs, and general enrollment plans. C-SNPs are included to illustrate the high growth in 2025 (20% increase in plan offerings). C-SNP enrollment grew by 66% from January 2024 to January 2025. Some of the C-SNP plan and enrollment growth may be a result of carriers finding new avenues to offer plans that are attractive to dual eligible beneficiaries in response to state and federal policies, such as prohibition of general enrollment D-SNP look-alike plans. These policies are discussed further in Section 6.

FIGURE 3: ANNUAL GROWTH IN NUMBER OF PLANS BY PLAN TYPE (CY 2020–CY 2025)



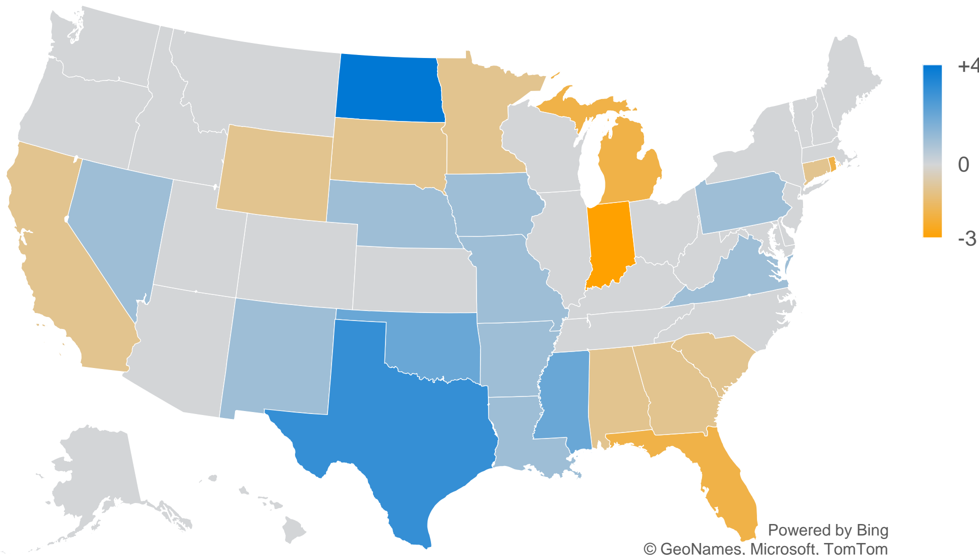
In 2025, 13 states had an increase in the number of MAOs offering D-SNPs from 2024, while 12 states had reductions—double the number in 2024. Figure 4 shows the change in number of unique MAOs offering D-SNPs in each state from 2024 to 2025.

States with the largest changes include:

- **Indiana:** The number of organizations offering D-SNPs was reduced from six to three (Elevance, Humana, and UnitedHealthcare) as the state now limits D-SNPs to only those offered by MAOs with a companion Medicaid managed long-term services and supports (MLTSS) contract.
- **North Dakota:** D-SNPs will be offered for the first time in North Dakota in 2025 with four market entrants (Humana, Medica, Sanford, and UnitedHealthcare).
- **Texas:** Three organizations (Alignment, Devoted, and Shared Health) will now be offering D-SNPs in Texas.

Like all MA plans, D-SNP service area is defined at the county level. Consistent with recent years, D-SNP availability at the local level continues to be strong. Based on our analysis of the plan data and CMS dual eligible beneficiary enrollment data, over 98% of full benefit dual eligible beneficiaries have access to a D-SNP or Medicare-Medicaid Plan (MMP) in 2025, and 96% have access to at least three D-SNP or MMP options.[3] MMPs are plan types distinct from D-SNPs and are excluded from D-SNP totals throughout this paper, but they share many characteristics with D-SNPs, including enrolling only dual eligible beneficiaries. These amounts both increased by less than 1% from 2024. By comparison, 95% of full benefit dual eligible beneficiaries had access to a D-SNP in 2020, and 80% had access to at least three D-SNP or MMP options.

FIGURE 4: CHANGE IN NUMBER OF MAOS OFFERING D-SNPS BY STATE (CY 2024–CY 2025)



2. National MAOs continue to dominate landscape, but their footprints are shrinking

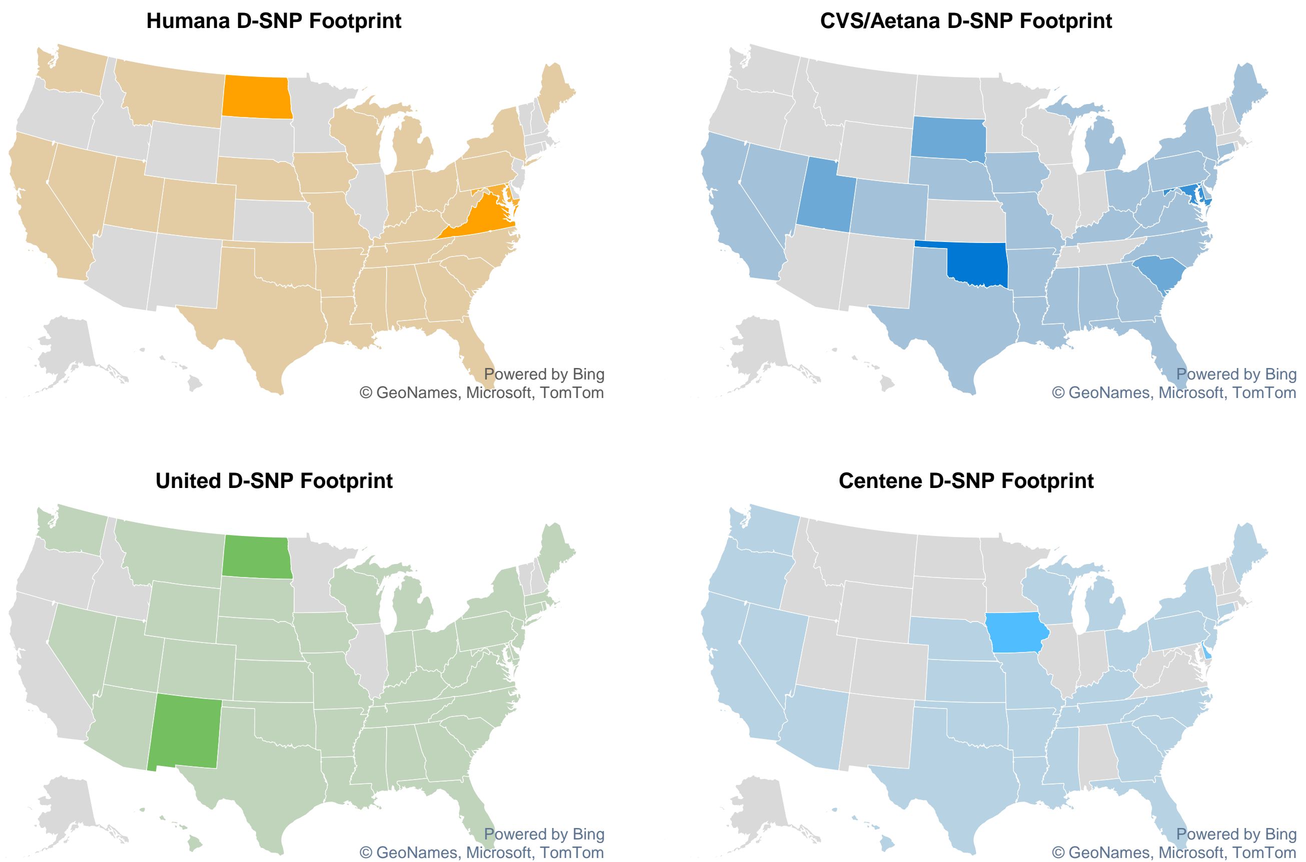
UnitedHealthcare continues to offer D-SNPs in more states and cover more D-SNP beneficiaries than any other MAO. The four MAOs with the largest D-SNP footprints are described below. For the first time since this annual paper has been published, all four are exiting at least one state relative to the previous year:

- **UnitedHealthcare** offers D-SNPs in 43 states (one more than CY 2024, entering New Mexico and North Dakota, exiting Michigan) and covers 2.2 million D-SNP beneficiaries (37% of nationwide D-SNP enrollment) as of January 2025.
- **Humana** offers D-SNPs in 33 states (two fewer than CY 2024, exiting Connecticut and Delaware) and covers 0.8 million D-SNP beneficiaries (14% of nationwide D-SNP enrollment) as of January 2025.
- **Centene** (Allwell) offers D-SNPs in 30 states (three fewer than CY 2024, entering Iowa and exiting Alabama, Indiana, New Mexico, and Rhode Island).
- **Aetna** (CVS Health) offers D-SNPs in 31 states (one fewer than in CY 2024, entering Oklahoma and exiting Indiana and Kansas).

Other MAOs offering D-SNPs in at least 10 states include Elevance, Molina, and CIGNA. CIGNA has a pending merger with HCSC, which would expand their D-SNP portfolio into two additional states, New Mexico and Oklahoma. Figure 5 shows the four MAOs mentioned above with the largest D-SNP footprints. Shaded states represent current footprint, and darkest shading indicates most recent additions (2022 through 2025).

Despite relatively minimal expansion at the state level for the largest D-SNP MAOs, these MAOs have historically driven increases in the number of D-SNPs by offering D-SNPs in

FIGURE 5: NATIONAL MAO D-SNP FOOTPRINTS (CY 2025)



different service areas within a given state or differentiated D-SNP products within the same service area, e.g., health maintenance organization (HMO) and preferred provider organization (PPO), separate plans for full and partial duals, or plans with different benefit packages. In 2025, UnitedHealthcare increased the number of D-SNP plans offered by 28% while other large MAOs had a range of smaller increases or decreases. UnitedHealthcare, Aetna, and Humana each offer over 100 D-SNP plans. Centene decreased plan offerings by about 15%, driven by their exit from several states.

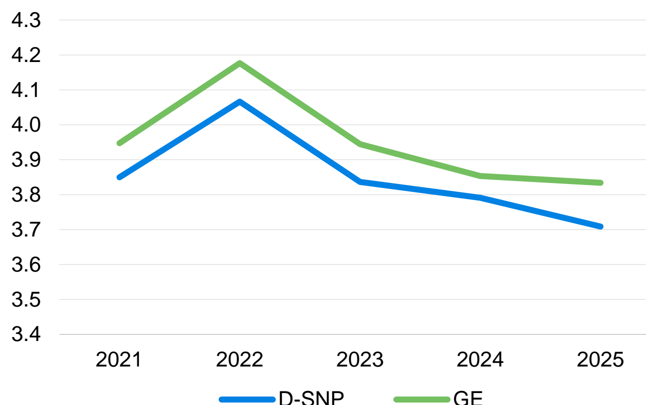
3. Rich D-SNP supplemental benefits decreasing

All MA plans, including D-SNPs, typically offer supplemental benefits not covered by traditional Medicare. Most D-SNPs offer dental, vision, and hearing benefits, as well as over-the-counter (OTC) benefit cards. Many offer other supplemental benefits, including special supplemental benefits for chronically ill enrollees (SSBCI). A large number of D-SNPs currently offer no cost sharing for Part D drugs through the value-based insurance design (VBID) program, although this program will end after 2025.[4] As discussed in more detail in a separate Milliman white paper, the average value-added benefit decreased from CY 2024 to CY 2025, a change in direction from prior trends.[5] Benefit reductions may be a reaction to increased regulatory pressure facing the MA industry, including but not limited to star rating reductions, Part D changes associated with the Inflation Reduction Act (IRA), MA payment rates, or other drivers impacting financial performance, such as medical trends.

4. The average star rating for D-SNPs fell again in CY 2025

The average star rating among D-SNPs decreased for the third consecutive year in CY 2025 (impacting payment year 2026). The recent trends in D-SNP star ratings are generally consistent with those observed in general enrollment plans, though the average is consistently lower, and the most recent year marks a larger decrease in D-SNP ratings than general enrollment ratings. The general downward trend is at least partially attributable to methodological changes in star rating calculations.[6] Figure 6 illustrates the change in average D-SNP star ratings over the last five years.

FIGURE 6: AVERAGE D-SNP STAR RATING BY YEAR (CY 2021–CY 2025)



Approximately 48% of D-SNPs achieved star ratings of 4.0 or greater:

- UnitedHealthcare, the largest carrier by plan offerings, has about 70% of D-SNPs achieving 4.0 star rating or greater, a decrease from about 75% of D-SNPs in 2024 and over 90% of D-SNPs in 2023.
- Aetna, the second largest, has about 80% of D-SNPs achieving the same benchmark, an increase from 67% in the prior year.
- Humana, the third largest, dropped to 27% of D-SNPs achieving 4.0 stars or greater in 2025 from 94% of D-SNPs in 2024.

Note that star ratings are assigned at the contract level, and MA contracts may contain other plans, including general enrollment and other SNP types. Therefore, star ratings for D-SNPs may be influenced by performance of non-D-SNP plans within the same contract. Some states are beginning to require state-specific and/or D-SNP only contracts to achieve state policy goals, including greater transparency into D-SNP quality and financial performance. In 2025, California, Idaho, Massachusetts, Minnesota, and Virginia have state-specific D-SNP contracts. Additional states are expected to follow in 2026.[7] Because star ratings are calculated at the contract level, state-specific D-SNP contracts may have implications on star ratings, including the ability of MAOs to satisfy minimum social risk factor (SRF) enrollee percentages required for impending health equity index (HEI) rewards.

5. D-SNP integration requirements have largely been met through coordination rather than integration

Beginning in CY 2021, D-SNPs are required to meet new minimum integration standards through at least one of the three avenues shown in Figure 7:

- Fully Integrated D-SNP (FIDE SNP)
- Highly Integrated D-SNP (HIDE SNP)
- An acute event notification process ("coordination-only") between the D-SNP and the state Medicaid agency.[8,9]

FIGURE 7: D-SNP INTEGRATION OPTIONS

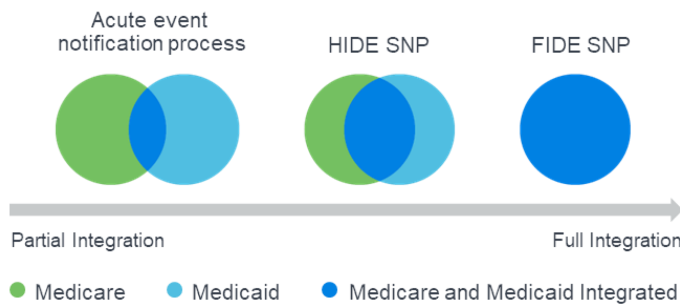
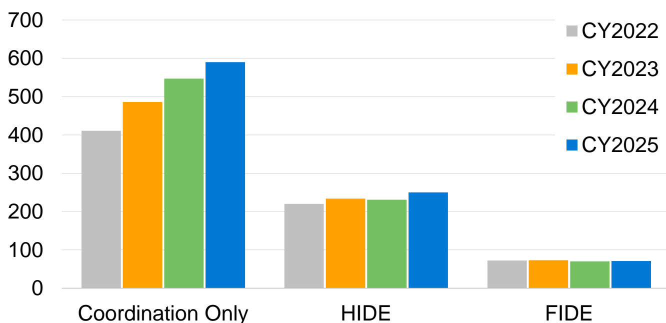


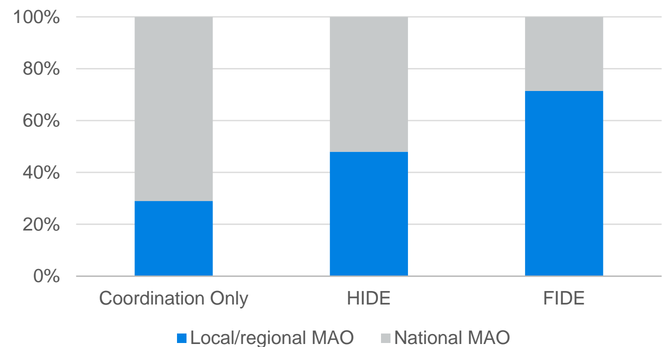
Figure 8 shows the growth in each type of D-SNP plan from CY 2022 to CY 2025. For the first time since 2021, the percent growth in coordination-only plans (7.9%) was smaller than the growth in HIDE SNPs (8.2%). FIDE SNP offerings remain relatively flat. Coordination-only plans represent approximately 65% of D-SNPs, while HIDE and FIDE plans represent approximately 27% and 8% of D-SNPs, respectively.

FIGURE 8: NUMBER OF D-SNPS BY INTEGRATION STATUS (CY 2022–CY 2025)



The composition of MAOs offering D-SNPs varies considerably by D-SNP integration status. Figure 9 shows the proportion of D-SNPs offered by national MAOs (UnitedHealthcare, Humana, Aetna, Centene, Cigna, Anthem, and Molina) and by local/regional MAOs (all other MAOs). The proportion of D-SNPs offered by local or regional MAOs increases with the level of integration. Local and regional MAOs offer less than one-third of coordination-only D-SNPs, almost one-half of HIDE SNPs, and over two-thirds of FIDE SNPs.

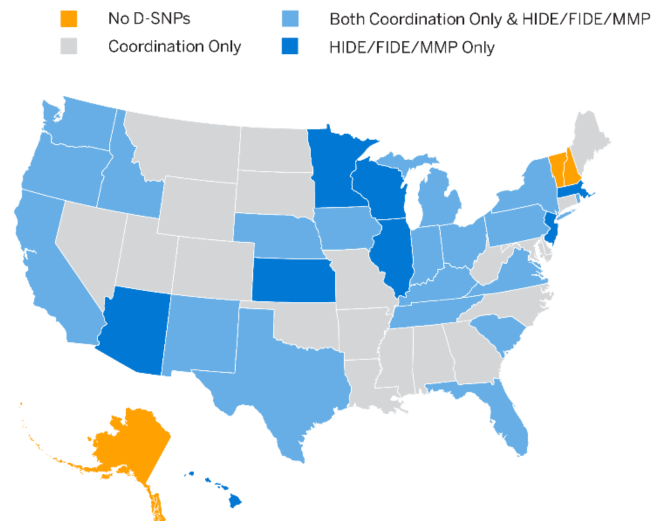
FIGURE 9: MAO TYPE BY D-SNP INTEGRATION STATUS (CY 2025)



D-SNP offerings in nine states (including Puerto Rico) are limited to HIDE SNP, FIDE SNP, or MMP plans. Figure 10 illustrates whether each state offers coordination-only plans, only integrated plans, or a combination of both in CY 2025. New Mexico was previously a HIDE SNP only state, but UnitedHealthcare is offering a coordination-only D-SNP in 2025. In Indiana and Iowa, HIDE SNPs have been added to previously coordination-only offerings. In Wisconsin, there are no longer any coordination-only plans.

Figure 10 also shows that in 2025, D-SNPs or MMPs will be available in every state except New Hampshire, Vermont, and Alaska. New Hampshire is currently exploring the feasibility of supporting D-SNPs in the future.[10] In 2024, four states did not offer D-SNPs or MMPs, but North Dakota will have its first D-SNP in 2025.

FIGURE 10: CY 2025 D-SNP PLAN OFFERINGS BY STATE



6. Regulatory changes will continue to shape the D-SNP market

CMS and states continue to shape the D-SNP market through targeted rulemaking and policy decisions. Recent federal policymaking has focused on promoting FIDE SNPs as a preferred vehicle for improving Medicare-Medicaid integration, preventing MAOs from shifting costs to Medicaid, limiting the ability of MAOs to enroll dual eligible members in plans without a D-SNP model of care, and reducing choice overload in the D-SNP market. Many states, including those who have participated in the managed care Financial Alignment Initiative (FAI), are taking their own steps to further pursue integration to promote higher-quality care, enhance member experience for dual eligible beneficiaries, and potentially consider cost savings. Some of these efforts are discussed below.

FEDERAL REGULATORY CHANGES

CY 2023 Medicare Advantage Final Rule

In the 2023 MA Final Rule, CMS implemented additional requirements for HIDE SNPs and FIDE SNPs starting in 2025, including a requirement that FIDE SNPs have exclusively aligned enrollment (i.e., enrollment is limited to dual eligible beneficiaries who are also enrolled in the MAO's associated Medicaid plan) and cover nearly all Medicaid-covered services through a capitated Medicaid contract.[11]

D-SNP look-alikes

In CY 2023, CMS began non-renewing D-SNP look-alike plans in states with existing D-SNPs or MMPs. CMS originally identified D-SNP look-alike plans as general enrollment plans whose membership is comprised of over 80% dual eligible beneficiaries.[12] As finalized in the CY 2025 MA Final Rule, CMS is lowering this threshold to 70% in 2025 and 60% in 2026.[13]

CY 2025 Medicare Advantage Final Rule

In the CY 2025 MA Final Rule, CMS also finalized several changes to increase aligned enrollment, reduce "choice overload" of D-SNP options, and reduce out-of-network (OON) cost sharing for D-SNP enrollees. The changes include:

- Changing the special enrollment period (SEP) from quarterly to monthly for low-income subsidy (LIS) and dual eligible beneficiaries starting in 2025 and limiting SEP MA enrollment to integrated D-SNPs, i.e., FIDE, HIDE, or applicable integrated plan (AIP).
- Limiting new enrollment of full benefit duals into D-SNPs that also contract with a state as a Medicaid managed care organization (MCO) to dual eligible beneficiaries enrolled in the D-SNP's affiliated MCO, beginning in 2027. In 2030, all membership for these plans will be required to be aligned between the D-SNP and Medicaid MCO.

  MAOs that serve dual eligible beneficiaries through Medicaid may need to consider Medicaid and D-SNP plan design, marketing strategy, care management, and operations more holistically.
- Limiting certain MAOs to a single D-SNP Plan Benefit Package (PBP) within a given service area. Starting in 2027, each parent organization (including all related organizations) will only be permitted to offer a single D-SNP PBP enrolling full benefit duals within a given service area when the MAO (or any related organization) has an affiliated Medicaid MCO enrolling dual eligible beneficiaries. Exceptions include when a state requires multiple D-SNPs for distinct beneficiary types (e.g., over/under 65) or separate D-SNPs for full and partial duals.

  MAOs that serve dual eligible beneficiaries through Medicaid and offer multiple D-SNP plans within a service area may need to consider how to combine D-SNPs, cross-walk members to a single D-SNP, and/or create plans for distinct beneficiary types that satisfy both federal and state requirements.
- Limiting the OON cost sharing for D-SNP PPOs to the in-network cost-sharing limits for professional services. This is intended to reduce cost shifting to Medicaid. Note that this follows the CY 2023 MA Final Rule, which required member cost sharing that is either paid by the state or not paid due to the state's lesser of coordination of benefit policies, to be counted toward the member's maximum out-of-pocket (MOOP) expense beginning in CY 2023.

CY 2026 Medicare Advantage Proposed Rule

In the CY 2026 MA Proposed Rule, CMS signaled the 2024 administration's continued focus on dual eligible beneficiaries and proposed the following changes:

- Establish requirements for D-SNPs that are AIPs to have integrated member identification (ID) cards that serve as the ID cards for both of the enrollee's Medicare and Medicaid plans and to conduct an integrated health risk assessment for Medicare and Medicaid rather than separate Health Risk Assessments (HRAs) for each program.
- Amend the requirements related to HRAs and individualized care plans (ICPs) for all SNPs to codify timeframes for SNPs to conduct HRAs and develop ICPs, and prioritize the involvement of the beneficiary in this development.
- Clarify the definition of HIDE SNPs to account for certain ownership arrangements of Medicaid managed care organizations that did not previously meet the explicit definition.

Finally, CMS solicited comments on a consideration for making state Medicaid agency contracts (SMACs) public, as some states have already done.

In addition to D-SNP specific policy actions, the federal government continues to propose legislation impacting the overall MA program that will also shape the D-SNP market. This includes refinements to the risk score model, the IRA, supplemental benefit requirements, and changes to star ratings. Continued changes to these elements of the MA program will influence the D-SNP market moving forward.

CY 2026 VBID model termination

In December 2024, CMS announced that the VBID model that allowed many D-SNPs to provide Part D coverage with $0 cost sharing will terminate after CY 2025.[14] In 2025, about 90% of D-SNP members will have this benefit, according to the white paper mentioned above.

STATE POLICY CHANGES

MMP transitions

Ten states have participated in the CMS FAI capitated model, which allows states to test models to integrate care for dual eligible beneficiaries through MMPs that provide both Medicare and Medicaid benefits through a single managed care plan. Per the CY 2023 MA Final Rule, CMS will require states to sunset their MMPs by the end of CY 2025.[15] Some states have already done this (i.e., California and Virginia). Many states are expected to transition existing MMPs into integrated D-SNPs and place a greater emphasis on D-SNPs.

State-specific policies

State Medicaid policy carried out through contracting requirements, facilitated enrollment into D-SNPs, and state-specific D-SNP requirements has also influenced local D-SNP markets. Levers that states may use to shape the D-SNP market include but are not limited to:

- **Limiting the ability of certain MAOs to offer D-SNPs in the state**: To operate in a state, D-SNPs must have a contract with the state and CMS, but states do not have to offer contracts to any interested D-SNPs. An increasing number of states have leveraged these contracts to limit the number of MAOs offering D-SNPs to MAOs with affiliated Medicaid managed care plans for dual eligible beneficiaries. By 2024, nine states required D-SNPs to offer affiliated managed care plans.[16] In 2025 and 2026, this trend is expected to continue as states such as Nevada, Ohio, and Illinois have issued competitive procurement for their D-SNP contracts.
- **Aligning enrollment for Medicaid enrollees in D-SNPs and Medicaid managed care plans operated by the same parent company**: In 2021, four states (Idaho, Massachusetts, Minnesota, and New Hampshire) used exclusively aligned enrollment for their D-SNPs. Given changes to federal policy, all FIDE SNPs are required to use exclusively aligned enrollment as of 2025. However, some states, such as California, have signaled their intent to require exclusively aligned enrollment for other types of D-SNPs as well.
- **Requiring D-SNP only MA contracts**: States may also choose to require D-SNPs to have their own MA contract (i.e., separate from general enrollment plans or other SNP types), impacting star ratings and other aspects of Medicare for the D-SNP. In 2024, four states (California, Idaho, Massachusetts, and Minnesota) required D-SNP only contracts. By 2026, 12 states are expected to require D-SNP only contracts.[17]
- **Requiring alignment of D-SNP and Medicaid managed care provider networks**: States may choose to require aligned provider networks for services. Indiana's 2025 SMAC includes a requirement that D-SNPs have a minimum 80% overlap with the companion Medicaid managed care network for select provider types.[18]
- **Requiring coverage of certain benefits through the SMAC**: States may require coverage of certain benefits as supplemental benefits in the SMAC. For example, New York began requiring its D-SNPs cover Medicaid dental benefits as a Medicare supplemental benefit in CY 2025.[19]
- **Requiring coverage of certain care management through the SMAC:** California is leveraging its SMAC to require D-SNPs include enhanced care management (ECM) in their models of care (MOCs).[20] This is intended to allow beneficiaries to receive any ECM-like services they may need through the D-SNP. Similarly, Washington state requires D-SNPs include the Medicaid Health Home model within the D-SNP MOCs.[21]

Conclusion

The D-SNP market is continually evolving due to recent growth, ongoing D-SNP policy changes, and significant changes in the overall MA market. MAOs, states, and other stakeholders will need to understand the financial and competitive implications of market dynamics to effectively serve the dual eligible beneficiaries enrolling in these plans.

Limitations

The opinions stated in this article are those of the authors and do not represent the viewpoint of Milliman.

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This information is intended to provide an overview of the CY 2025 Medicare Advantage D-SNP market. The list of considerations outlined in this article is not exhaustive. This information may not be appropriate, and should not be used, for other purposes.

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milliman.com

CONTACT

Nick Johnson
nick.johnson@milliman.com

Annie Hallum
annie.hallum@milliman.com

Nick Gipe
nick.gipe@milliman.com

Logan Blank
logan.blank@milliman.com

ENDNOTES

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