



# Q2 2025 Earnings Call Consolidated Report

Strategic Intelligence Brief • Competitive Landscape Analysis

August 18, 2025 • Prepared by HealthWorksAI

### □ Index

Why This Report	2
Summary	3
What Does This Mean to Competitors?	3
Impact on the MA Industry	4
Implications for Other Health Plans	4
Q2 2025 Payer Care-Cost Ratios: Fast Read	5
Strategic Positioning	6
Graphical Comparison	7
Key Takeaways	7
Summary Table	8
Medicare Advantage	8
Medicaid	9
ACA Marketplace	10
• Stars	11
Financial Analysis	12
CMS Rebate Reallocation	13

### Why This Report

As Medicare Advantage competition intensifies, staying informed isn't optional, it's a strategic advantage. That's why HealthworksAl is curating rapid-turn summaries of earnings calls from key MA players, started with Humana. In a matter of minutes, you'll get the key themes and what it all means for your 2026 plan design, provider alignment, and market positioning.

This is part of our CI (Competitive Intelligence) Beta Series—insightful, fast, and focused on helping MA leaders to strategize.





### Executive Summary

The market, spanning Medicare Advantage (MA), Medicaid, and ACA is increasingly shaped by scale, integration, and disciplined cost control. UnitedHealth Group leads in both size and efficiency, leveraging Optum and technologydriven care to sustain profitability. Humana remains a major MA player but faces elevated MLRs and regulatory risks from its concentrated senior focus. CVS Health (Aetna) benefits from a balanced portfolio and vertical integration, creating opportunities in digital and retail-aligned care. Elevance Health dominates Medicaid, delivers efficient MA operations, and is expanding in ACA with whole-health strategies. Molina Healthcare is a disciplined Medicaid and ACA operator with growth from new contracts despite mild cost pressures. Alignment Health, a niche MA disruptor, targets underserved seniors with tech-enabled care but faces sustainability challenges from high MLRs and limited scale. Centene plans to pursue higher Medicaid reimbursements to regain margin stability. Their Medicare strategy emphasizes PDP growth and stabilization. The growth was fueled by higher premiums and increased membership in PDP (Prescription Drug Plans) and Marketplace segments.

Across the market, success hinges on leveraging integration for margin gains, navigating MA regulatory headwinds, executing well in Medicaid, capturing ACA growth while managing margins, and embedding whole-person, techenabled care models.

### What Does This Mean to Competitors?

- Margin Pressures Intensify: Humana's elevated MLRs, especially in Medicare Advantage, signal persistent cost pressures. Competitors are likely facing similar challenges, particularly as CMS policy changes tighten reimbursement and incentive structures. Plans with less scale or diversified portfolios risk margin compression and may need to exit unprofitable markets.
- Strategic Exits and Realignment: Humana's move to strategically exit the ACA market highlights a broader industry trend—withdrawal from low-margin segments in favor of areas where scale or expertise offers competitive advantage. Other payers will need to evaluate their own portfolios and could follow suit.



### Impact on the MA Industry

- Sector-Wide Cost Containment: The high and rising MLRs across MA plans point to an industry-wide imperative to control medical costs, improve care quality, and manage risk adjustment more aggressively. Expect more plan design innovation, tighter network arrangements, and increased investment in tech-enabled care delivery to offset trend pressures.
- CMS Policy Sensitivity: MA's dependence on government rates and Star ratings will make policy changes (e.g., risk adjustment, rebate allocations, Star methodology tweaks) increasingly consequential. All MA carriers must adapt quickly to maintain profitability and avoid dramatic shifts in market positions.

### Implications for Other Health Plans

- Cross-Segment Volatility: Medicaid and ACA marketplace plans are seeing similar cost and margin pressures, as illustrated by Molina and CVS (Aetna). Payers active across products will need tailored strategies for each: for instance, tighter cost control in Medicaid, repricing ACA plans, and selective MA expansion.
- Rising Need for Diversification: Plans that diversify across product segments and invest in value-based care delivery models (like UnitedHealth and Elevance) are better cushioned against line-specific shocks. Others, especially niche or regional players, remain exposed and must pursue partnerships or operational overhauls.

### 22 2025 Payer Care-Cost Ratios: Fast Read

**United Healthcare**: Consolidated MCR 89.4%, up 430 bps YoY; driven by medical cost trends outpacing pricing (unit costs, service intensity) and ongoing Medicare funding reductions.

Humana: Insurance segment benefit ratio (MLR) 89.9%, in line with ~90% guidance.

**CVS Health/Aetna:** Medical benefit ratio of 89.9%, increased from 89.6% in the prior year, driven by a \$471 million premium deficiency reserve.

Elevance Health: Benefit expense ratio 88.9%, up 260 bps YoY on elevated medical cost trends.

**Molina Healthcare**: Consolidated MCR 90.4% (from 88.6% GAAP); by product: Medicaid 91.3%, Medicare 90.0%, Marketplace 85.4%. (Link) / MCR 90.4%—up from 88.6% the prior year.

Alignment Healthcare: MLR 86.7% (Q2, based on adjusted gross profit).

**Centene:** Overall HBR 93.0% (up from 87.5% between quarters); Medicaid HBR 94.9%, called "an unanticipated and unacceptable."



### Strategic Positioning

#### **United Healthcare**

Industry scale leader with dominance across MA, Medicaid, and ACA; unmatched integration of Optum's care delivery, pharmacy, and analytics capabilities; benchmark in profitability and risk management; continued investment in technology-enabled, value-based care; diversification reduces exposure to singleline volatility.

#### Humana

Highly concentrated in Medicare Advantage with deep expertise in senior-focused care; strong clinical programs and Stars performance critical to competitiveness; vulnerable to CMS reimbursement changes and Star rating shifts; ongoing investments in primary care expansion, home health, and cost containment initiatives.

#### CVS Health/Aetna

Fully vertically integrated model spanning insurance, retail pharmacy, PBM (Caremark), and clinics (MinuteClinic/HealthHUB); balanced portfolio across MA, Medicaid, and ACA; leveraging omnichannel member engagement; targeting growth through digital health, chronic care management, and tighter pharmacy-benefits alignment.

#### **Elevance Health**

Medicaid powerhouse with leading state contract portfolio; expanding ACA presence with improved exchange positioning; efficient MA operations with low MLR; strong emphasis on whole-person health, behavioral health integration, and SDoH programs; leveraging Carelon services to drive value-based care and cost efficiency.

#### Molina Healthcare

Focused operator in government-sponsored programs, especially Medicaid and ACA; disciplined cost containment through narrow networks and lean operations; winning new state contracts to drive growth; expanding MA cautiously to diversify revenue; resilient in managing regulatory and reimbursement changes.

#### Alignment Healthcare

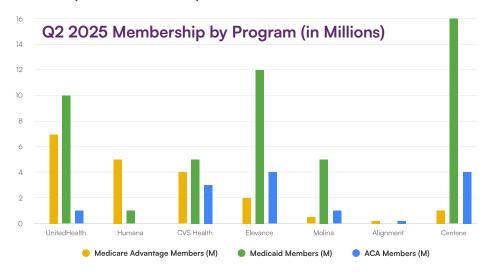
Medicare Advantage-focused disruptor targeting high-acuity, underserved seniors; tech-enabled, hightouch care model aimed at improving outcomes; elevated MLRs reflect care intensity and acuity; requires membership scale, geographic expansion, and operational leverage to sustain long-term competitiveness in a consolidating market.

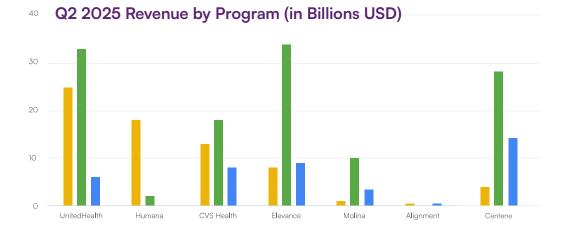
#### Centene

Seeking higher reimbursement; cost containment focus, Leverage stable Medicare performance for margin support, Repricing for 2026; operational restructuring, high HBR and guidance cut spotlight systemic pressure on Medicaid and ACA sectors — influencing peers like Molina, Elevance, and UnitedHealth.



### Graphical Comparison





Medicaid Revenue (B)

# 

MA Revenue (B)

MA remains a growth engine for most—especially UnitedHealth, Alignment, Humana, and Elevance.

ACA Revenue (B)

Medicaid and ACA segments are pressure points, with high medical cost ratios and enrollment volatility (much due to eligibility redeterminations). Molina and Centene continue to be Medicaid-heavy, though both also have meaningful ACA revenue. Centene dominates Medicaid, reflecting its strong government program focus.

**CVS Health stands out**, with effective cost management in MA and government insurance boosting margins, while also strategically exiting ACA amid cost uncertainty.





### Summary Table: Medicare Advantage

#### **United Healthcare**

- Medical cost trends in Medicare Advantage ran around 7.5% in 2025.
- Improvement is expected through benefit reductions, pricing adjustments, and trend mitigation efforts.
- UnitedHealthcare is exiting select Medicare Advantage markets, especially where provider networks are broader and cost/rate dynamics are unfavorable.

#### Humana

- Part D performance is tracking as forecasted, with drug trends high but as expected.
- Prioritize profitable lines and pricing discipline.
- Decline in Individual Medicare Advantage membership—partly due to exiting unprofitable plans and geographic markets.
- How proactive benefit reductions and plan exits in 2024—25 strengthened pricing alignment.

#### CVS Health/Aetna

- Strong performance in individual Medicare, including Part D and supplemental products.
- Group MA business continues to be a drag due to elevated medical trends and underperforming contracts.
- CVS simplified its Part D offering to a single standard plan, which yielded strong performance.
- Individual MA improved with better Star ratings; Group MA pressured, prompting premium reserve booking.

#### **Elevance Health**

- Membership growth contributed positively to revenue, underscoring strength in MA uptake.
- Solid MA performance, citing resilience and earnings contributions from this portfolio despite broader cost pressures.
- Strong membership and revenue growth. Continue leveraging MA portfolio.

#### Molina Healthcare

- Higher costs from duals and high-cost drugs.
- Notable expansion in higher-margin D-SNP.
- CMS Part D "rebate reallocation" poses tight timing/response demands for plan bids potentially affecting benefits, premiums, and Star performance.

#### **Alignment Healthcare**

- SG&A rate of 8.8%, calling it a benchmark-setting performance for an MA plan.
- Part D outperformance in H1 as driven by conservative forecasting rather than structural shifts.
- We were outperforming based on low bar that we had set in terms of whwat we were forecasting.

#### Centene

- Medicare revenue grew 58% to \$9.45 billion, reflecting expanded PDP and other Medicare-related lines.
- Medicare Prescription Drug Plan membership reached 7.8 million.
- Medicare's HBR stood at 90.9%, better than overall company metrics.





### Summary Table: Medicaid

#### **United Healthcare**

- 2026 could see negative margins (-1% to -1.7%) due to redetermination effects.
- Q2 Community & State (Medicaid) revenue climbed ~20% YoY.
- UnitedHealth cited contracting Medicaid and Exchange markets as headwinds, contributing to performance challenges.

#### Humana

- Medicaid performance is stable and aligned with internal expectations.
- Continued investment in Medicaid and dual-eligible markets.
- Humana expanded its Medicaid footprint by launching a dual-eligible S-D-SNP contract in Virginia during Q2.
- Humana's advantage in Medicaid due to its LTSS-focused product mix, favorable state footprint, and value-based network structure.

#### **CVS Health/Aetna**

- CVS remarks noted rate advocacy for Medicaid was tracking as expected for 2025, indicating controlled utilization.
- Continue managing utilization and state negotiations.

#### **Elevance Health**

- Membership declined (with fewer members QoQ), reflecting a weaker Medicaid book.
- Enrolment decline; cost trend pressure; margin slack.
- Elevated medical cost trends and "slower-than-expected Medicaid rate alignment" were highlighted as significant headwinds.

#### Molina Healthcare

- Expectation to improve margins with rate adjustments in 2026.
- States granting pricing flexibility due to acuity shifts.
- Q2 Medicaid MCR: 91.3%, exceeding target ranges, driven by high utilization in behavioral health, specialty pharmacy, and complex care.

#### Centene

- Medicaid HBR climbed to 94.9%, driven by higher usage in behavioral health, home health, and specialty drug claims.
- Medicaid enrollment fell by ~2.4% YoY to ~12.8 million, attributed to post-pandemic eligibility redeterminations.
- Centene plans to pursue higher Medicaid reimbursements to regain margin stability.





### Summary Table: ACA Marketplace

#### **United Healthcare**

- The company flagged under-pricing in ACA (individual exchange) plans as well, leading to losses.
- UnitedHealth plans to stay in most ACA markets, but could exit some unprofitable ones if rates don't support.

#### **CVS Health/Aetna**

- CVS has announced an exit from ACA marketplaces by January 2026.
- Performance in ACA was bolstered by favorable changes to risk adjustment estimates.
- Divest from unprofitable markets.

#### **Elevance Health**

- ACA plans faced rising cost trends and adverse risk pool dynamics, with "elevated cost trends".
- Elevated cost and morbidity; pressure on risk pool.
- Active repricing efforts for 2026 ACA plans to mitigate risk and align with cost levels.

#### Molina Healthcare

- Worsening acuity (up ~8% YoY) leading to elevated cost expectations.
- Molina plans cautious growth in ACA markets, maintaining a smaller footprint (~10% of revenue) to protect margins.

#### Centene

- ACA/Marketplace faced higher medical spend and lower-than-expected risk adjustment revenue, triggering a \$1.8 billion shortfall.
- 2025 enrollment skewed toward higher-acuity members, pushing morbidity up by ~16—17%.
- Centene is refiling 2026 ACA plan rates across 17 states to realign pricing with costs and risk.



### Summary Table: Stars

#### **United Healthcare**

Not directly addressed, but external pressures include tightening scrutiny and incentive realignments.

#### Humana

Humana expects improved metric-level performance and remains confident in its direction.

#### CVS Health/Aetna

- Improved Medicare Advantage Star Ratings for the 2025 payment year.
- These enhanced ratings likely support better risk adjustment, member retention, and overall margin.
- Stronger MA Stars noted as a performance driver. Focus on plan quality and ratings-driven incentives.

#### **Elevance Health**

Not addressed in earnings, but remains pivotal due to earlier action.

#### Molina Healthcare

The impact of rebate reallocations, plan bid agility, and the emphasis on DSNP expansion suggest Stars remain a critical lens.

### **Alignment Healthcare**

- Alignment saw improved Stars ratings in key geographies, especially Arizona.
- This will allow positive bid adjustments for 2026.
- We're like five stars on pretty much everything except CAPS.

# Financial Analysis

Company	Medicare Advantage	Medicaid	ACA Marketplace
United Healthcare	\$42.6B revenue (+22%), +505K members	\$23.7B revenue (+20%), ~7.5M members	\$620M one-time loss
Molina Healthcare	~267K members (small base)	~4.8M members, MCR 91.3%	~690K enrollees, MCR 85.4%
CVS Health/ Aetna	Included in Health Care Benefits	Included in HCB (MCR ~89.9%)	Exiting ACA by 2026
Humana	Strong utilization and member retention	-	-
Alignment Healthcare	Core business (MA-only): \$1B rev, +49%; 223K members	-	-
Elevance Health	MA membership +12.4%; steady premium growth	Membership decline; cost pressure	Cost drag; repricing underway
Centene	Slower growth vs peers like Humana and UnitedHealth.	Largest share, with growth in expansion populations but higher utilization.	Continued strong enrollments (Centene remains one of the largest ACA players).



### © CMS Rebate Reallocation: What It Means for Medicare Advantage Plans

### From Subsidy Shift to Strategic Reallocation

The recent CMS adjustment to Part D direct subsidies while presented as a technical update has become a strategic trigger for plan executives. Internally referred to by many clients as rebate reallocation, this refers to late-cycle shifts in rebate values (e.g., a \$10—\$20 delta from projected benchmarks) that can significantly impact final plan bids.

Plans must now respond with agility tweaking premiums, adjusting givebacks, and fine-tuning benefit configurations, all under high time pressure.

#### Rapid Response Requires Predictive Readiness

The organizations best prepared are those who've already run scenario simulations and can act on final rebate figures within hours, not days.

### Where HealthworksAl's xAl-Powered Intelligence Delivers

This is where our Benefit Simulator, powered by HealthworksAl's xAl predictive analytics engine, creates true competitive advantage. With our platform, leading payers are able to:

- Pre-load likely subsidy ranges and simulate benefit trade-offs in advance.
- Quantify the enrollment and financial impact of each \$ rebate shift.
- Align decisions with Stars, market share, and benchmark positioning across counties.

#### Make It Annual. Make It Actionable.

As CMS continues to evolve its IRA-driven reimbursement strategy, plans must treat this as a recurring AEP ritual. HealthworksAl clients are operationalizing this now embedding it into their annual benefit design calendar. Those who simulate earlier, win earlier.



### Real-Time Intelligence. Strategic Advantage

It's earnings season — and while others wait for industry roundups, our clients already have the insights.



Key executive quotes flagged by theme (Stars, ACA, Medicaid, MLR, Compliance)



Market movements decoded by enrollment, benefit shifts & margin levers



Used by top MA teams to inform 2026 bid strategy & pricing



Deep-dive earnings call analysis within 24—48 hours

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