

Centene - Where to Compete in Medicare Advantage?

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Decision scope: CY2025 Medicare Advantage portfolio and quality priorities

Case convention: This is an author-created strategic decision exercise. The executive committee setting and alternatives are hypothetical; company disclosures and regulatory requirements are historical. No private deliberations are represented.

The decision

Centene Corporation had built a national managed-care business around Medicaid, then extended into Medicare and the Health Insurance Marketplace. Its principal Medicare Advantage brand was Wellcare. On April 26, 2024, Centene filed its first-quarter results. Management said Medicare Advantage membership had declined year over year, consistent with its strategic positioning and bid strategy. It also reported lower Medicare Advantage revenue associated with Star quality ratings and continued elevated utilization. A \$300 million premium deficiency reserve related to the 2024 Medicare Advantage contract year reflected the company's estimate of expected premiums and costs; its filing said the increase from \$250 million at year-end was consistent with seasonality. [S2], Q1 2024 Form 10-Q, pp. 10, 20, 22, 24.

Assume Centene's executive committee meets on April 29 to set final guardrails for the company's 2025 Medicare Advantage bids. This meeting is fictional. Leaders must decide how much of the portfolio to retain, where to prioritize quality work and whether to direct more effort toward dual-eligible products that could align with Centene Medicaid plans. The bid deadline is June 3. [S6]

Assignment: Recommend one of three approaches: maintain broad Medicare Advantage reach with targeted fixes; concentrate more sharply on qualifying Medicaid-aligned dual-eligible special needs plans (D-SNPs); or apply a selective market-by-market test with explicit retention and exit criteria. Explain how your choice balances bid economics, quality, member access, provider networks, state contracts and the regulatory timetable. Identify what internal evidence Centene should require before finalizing individual bids. Use only information available on April 26, 2024.

Centene's starting position

At year-end 2023, Centene reported 27.5 million members and \$154.0 billion in revenue. Medicaid represented 66% of external revenue, Medicare 14%, Marketplace and other commercial coverage 16%, and Other 4%. "Medicare" is a broad segment that includes Medicare Advantage, Medicare Supplement, D-SNP and prescription drug plans; it is not a measure of Medicare Advantage alone. [S1], 2023 Form 10-K, Item 1, pp. 1-3.

Centene reported 1.3 million Medicare Advantage members across 36 states at December 31, 2023, primarily under Wellcare. It described its Medicare population as having a higher concentration of lower-income and complex members than competitors. The company also said its local leadership and Medicaid experience could inform Medicare product, distribution, network and pricing decisions. Those statements describe Centene's position and its own view of its capabilities; they do not establish that Medicaid scale produces superior Medicare economics in every county. [S1], Item 1, pp. 3, 5.

The company's Medicaid business is governed by state-specific contracts and capitation rates. Some Medicaid contracts require Centene to maintain D-SNPs. Contract requirements, covered populations and payment rates differ by state. Centene reported Medicaid operations in 30 states and more than 14 million Medicaid recipients at the end of 2023. [S1], Item 1, pp. 2, 13.

Competition is similarly local. Centene said plan choice depends on quality, access, provider participation, supplemental benefits, price and reputation. Providers consider member volume, reimbursement, value-based arrangements, provider experience and administrative service. The company stated that the importance of these factors and the identity of competitors vary by market and product. It did not provide a public county-by-county comparison of Wellcare's bid economics or network strength. [S1], Item 1, "Competition," p. 10.

Pressure on the Medicare Advantage portfolio

Centene reported that 87% of its members were associated with Medicare Advantage contracts rated at least 3.0 stars as of October 2023. Its stated goal was to move 85% of members into contracts rated at least 3.5 stars for rating year 2026, expected to be published in October 2025. The company disclosed termination notices for two Medicare Advantage contracts for 2025. It also said that other contracts below 3.0 stars for two consecutive years could be terminated for 2026 if their ratings did not improve. [S1], Item 1A, pp. 20-21.

In the first quarter of 2024, Centene attributed pressure in its Medicare business partly to lower Medicare Advantage revenue associated with Star ratings and elevated utilization. Medicare segment gross margin fell by \$322 million year over year, while total Medicare revenue increased 1%, driven by 44% growth in stand-alone prescription drug plan membership. The filing does not isolate the effect of each factor or disclose contract-level margins. [S2], Q1 2024 Form 10-Q, pp. 20, 24.

Exhibit 1. Selected Medicare signals

Measure	Disclosed position at the cutoff
Medicare Advantage footprint	1.3 million members; 36 states at 31 Dec 2023, primarily Wellcare
Members in contracts rated at least 3.0 stars	Approximately 87% as of Oct 2023
Company quality goal	85% of members in contracts rated at least 3.5 stars for rating year 2026; rating publication anticipated Oct 2025
2025 contract status	Two MA contracts received termination notices
Q1 2024 Medicare segment gross margin	Down \$322 million year over year; company cited lower MA revenue from Star ratings and elevated utilization
Q1 2024 PDP membership	Up 44% year over year
Medicare Advantage premium deficiency reserve	\$250 million at 31 Dec 2023; \$300 million at 31 Mar 2024, with the change attributed to intra-year seasonality

Sources: [S1], Centene 2023 Form 10-K, pp. 3, 20-21; [S2], Q1 2024 Form 10-Q, pp. 10, 20, 24. The reserve is an estimate, not a realized full-year loss. The Medicare segment is broader than Medicare Advantage.

Alignment opportunity, with conditions

Dual-eligible members qualify for both Medicare and Medicaid. D-SNPs are Medicare Advantage plans designed for dual-eligible populations; the degree of Medicaid integration varies. Some manage Medicaid services through the affiliated organization, while others coordinate benefits with a separate Medicaid plan. Centene said finalized CMS rules could require aligned enrollment in certain integrated D-SNPs beginning in 2027 and might restrict offerings in some geographies. It asserted that its Medicaid overlap puts it in a strong position. [S2], Q1 2024 Form 10-Q, p. 18.

The CY2025 final rule is narrower and phased. Beginning in CY2027, when an MA organization or common parent also contracts as a Medicaid managed-care organization enrolling full-benefit duals in the same service area—even when geographic overlap is partial—the affiliated organization generally may offer only one D-SNP for full-benefit duals in that area, subject to exceptions, and must limit new enrollment to people enrolled in or in the process of enrolling in the affiliated Medicaid MCO. The continued-enrollment alignment phase begins in CY2030, also with exceptions. This rule does not require every dual-eligible person to enroll in Centene or apply to every market where the company has both Medicare and Medicaid operations. [S5], 89 FR 30675-30681, 30695, and §422.514(h), p. 30825.

For 2025, CMS projected an average 3.70% increase in Medicare Advantage payments across the industry and phased in the updated risk-adjustment model at 67%, with 33% under the prior model. Those figures do not determine Centene's rate or profitability in any particular market. The plans' bid submission deadline was June 3, 2024. [S4], [S6]

Exhibit 2. Rule and bid calendar

Timing	Publicly known requirement
2025 bid cycle	Bid submission deadline: 3 June 2024
CY2027	In qualifying affiliated MCO/service-area cases: generally one full-benefit D-SNP offering, subject to exceptions; new enrollment must be aligned with the affiliated Medicaid MCO
CY2030	Continued D-SNP enrollment must be aligned with the affiliated Medicaid MCO, subject to exceptions

Source: [S5], 89 FR 30675-30681, 30695, §422.514(h); [S6], CY2025 MA Bid Pricing Tool Instructions. Rule implementation is specific to the relevant affiliation, service area and product conditions.

What can integration deliver?

Academic studies do not answer whether Centene should shrink or expand its MA portfolio. They do help define what leaders should measure if they pursue D-SNP alignment.

Exhibit 3. Selected studies of D-SNP integration

Study	Design and setting	Selected finding
Meyers et al. (2023)	Cross-sectional analysis of MA-CAHPS responses from 181,806 dual-eligible members (2015-2018)	FIDE-SNP respondents rated some plan and service domains more highly than non-D-SNP MA respondents, but rated care coordination and needed drugs lower. Findings against coordination-only D-SNPs were mixed.
Roberts et al. (2023)	Difference-in-differences study of a Pennsylvania FIDE-SNP associated with a 2018 state reform; 7,967 integration cohort and 3,832 comparison members	Integration was associated with 0.61 additional HCBS days per member-month by year three; the study found no differential change in several other outcomes, including hospitalizations and care coordination.
Keohane et al. (2022)	Tennessee county-level analysis of aligned D-SNP participation, 2011-2017	Among beneficiaries aged 65+, a 10-percentage-point increase in aligned participation was associated with 0.3 fewer inpatient admissions and 13.9 fewer prescription drugs per month per 100 dual-eligible beneficiaries; other findings were mixed or marginal.

Sources: [S7]-[S9]. These studies use older or state-specific settings and observational designs; none estimates Centene's expected quality, costs, margins or member experience. Study definitions and limitations are in the research dossier.

Choose the scope and the proof

Centene's public disclosures establish a national footprint, a quality-improvement objective, current Medicare Advantage pressure and the future requirements for certain aligned D-SNPs. They do not reveal the market-level information needed to rank each county: projected bid margin, member-level acuity, provider capacity, likely Star trajectory, eligible dual population, competing bids or the investment required to improve service.

The decision is therefore not simply whether integration is good or bad. It is whether Centene should preserve broad reach while repairing performance, focus faster on markets where alignment is feasible, or use explicit market gates to decide which products merit continued investment. Each path puts different weight on near-term bid discipline, future operating capabilities, state partnerships, member access and the option to serve a broader population.

Discussion questions

1. What does Centene's Medicaid position make possible in Medicare Advantage, and what evidence would show that the advantage exists market by market?
2. Which of the three portfolio approaches would you recommend before the June 3 bid deadline? What is the strongest case against it?
3. How should Centene interpret the Star-rating and reserve signals? Which comparisons are not valid from the public data?
4. What member, provider, quality and economic measures should determine whether an aligned D-SNP strategy is working? How should the measures differ before 2027 and before 2030?
5. What additional information should management require before finalizing bids? What result would cause you to change your recommendation?

Sources and cutoff

The case uses information available by 26 April 2024. The sources cited above are:

- **[S1]** Centene Corporation, 2023 Form 10-K, filed 20 February 2024. [SEC filing](#)
- **[S2]** Centene Corporation, Q1 2024 Form 10-Q, filed 26 April 2024. [SEC filing](#)
- **[S3]** Centene Corporation, Q4 and FY2023 results, 6 February 2024. [Investor release](#)
- **[S4]** Centers for Medicare & Medicaid Services, “2025 Medicare Advantage and Part D Rate Announcement,” 1 April 2024. [CMS announcement](#)
- **[S5]** Centers for Medicare & Medicaid Services, CY2025 Medicare Advantage and Part D final rule, 89 FR 30448, FR Doc. 2024-07105, published 23 April 2024. [Official Federal Register PDF via GovInfo](#)
- **[S6]** Centers for Medicare & Medicaid Services, CY2025 Medicare Advantage Bid Pricing Tool Instructions, 5 April 2024. [CMS instructions](#)
- **[S7]** Meyers DJ, Offiaeli K, Trivedi AN, Roberts ET. “Medicare and Medicaid Dual-Eligible Special Needs Plan Enrollment and Beneficiary-Reported Experiences With Care.” *JAMA Health Forum*. 2023;4(9):e232957. [Full article](#)
- **[S8]** Roberts ET, Xue L, Lovelace J, et al. “Changes in Care Associated With Integrating Medicare and Medicaid for Dual-Eligible Individuals.” *JAMA Health Forum*. 2023;4(12):e234583. [Full article](#)
- **[S9]** Keohane LM, Zhou Z, Stevenson DG. “Aligning Medicaid and Medicare Advantage Managed Care Plans for Dual-Eligible Beneficiaries.” *Medical Care Research and Review*. 2022;79(2):207-217. [Full text](#)

Page locators and reading-depth notes are available in the research source register; detailed facts and limitations are in the evidence extraction.

The April 29 executive committee setting and three alternatives are hypothetical teaching constructs. No later bids, enrollment, market exits, financial results or other outcomes are included.