

Aetna and the 2025 Medicare Advantage bid

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The decision

It is 1 April 2024. CMS has just released its final payment announcement for the 2025 Medicare Advantage (MA) year. Aetna is preparing its 2025 plans, and its leadership team must decide how to balance medical-cost pressure, member value and competitive position as it sets bids and benefits.

For this classroom exercise, assume you are an outside strategy adviser asked to recommend a bid and benefit posture. This is a hypothetical role; CVS has not disclosed such an assignment, an internal meeting, or a final decision. Your recommendation should explain where Aetna should preserve its current value proposition, where it should make selective changes, and what evidence would justify those choices. Do not calculate a county-level bid: the public information below does not support one.

What changed in 2023?

CVS reported that its Health Care Benefits (HCB) segment's adjusted operating income fell from \$6.338 billion in 2022 to \$5.577 billion in 2023, a decline of \$761 million, or 12%. Its reported HCB medical benefit ratio (MBR) rose from 83.8% to 86.2% over the same period. These measures have different scopes: adjusted operating income is for the whole HCB segment; CVS defines MBR for its insured HCB products. Neither figure is an Aetna MA-only result. HCB contains several businesses, including Commercial and Medicaid, as well as Medicare. [1]

CVS attributed much of the MBR increase to higher MA utilization, including outpatient and supplemental benefits, compared with pandemic-influenced utilization in 2022. It also cited Commercial and Medicaid trends returning to more normal levels. This is management's explanation, not an independently established cause or a breakdown of Aetna's MA costs by county or service. [1]

The company said that after completing its fourth-quarter medical-cost analysis it lowered its 2024 adjusted earnings-per-share outlook from at least \$8.50 to at least \$8.30, and operating cash flow guidance from at least \$12.5 billion to at least \$12.0 billion. The revised outlook was company-wide. [1]

CVS reported 3.460 million Aetna MA members at 31 December 2023, compared with 3.270 million a year earlier. The public release does not show which counties or plan designs drove that change, or the profitability of that membership. [2]

A payment headline, and a quality counterweight

CMS estimates that government payments to MA plans will rise by an average of 3.70%-more than \$16 billion in total-from 2024 to 2025. The figure includes several components, including growth rates, quality bonuses, risk-model changes and the estimated industry risk-score trend. CMS cautions that plan-specific impacts vary. The headline is not an Aetna rate guarantee, a county benchmark change or an estimate of medical-cost inflation. [3]

CVS also disclosed a potential quality-payment tailwind. CMS released its **2024 Star ratings** in October 2023; these ratings affect 2025 payment. CVS forecast that 87% of Aetna MA members, measured by enrollment and contract affiliation at 31 December 2023, would be in plans rated at least four stars for 2025 payment, compared with an unmitigated 21% under the 2023 ratings. CVS expected the higher ratings to recover most of an approximately \$800 million-\$1.0 billion 2024 revenue headwind and said it planned to reinvest a portion of the net improvement. These were management expectations, not realized results or a county-by-county allocation. [4]

The 3.70% national payment estimate and CVS's Star-rating expectation are not additive estimates of Aetna's revenue. Neither tells Aetna's leaders what each local plan will receive, how much a benefit costs in that market, or how competitors will bid.

A competitor's response

Humana management described higher MA medical costs as an industrywide development in its January 2024 prepared remarks. It cited inpatient, physician, outpatient surgery and supplemental-benefit costs, and said its 2024 outlook assumed elevated costs would persist. Humana also said it expected benefit reductions to partially offset utilization and reimbursement headwinds. This is a competitor's management view and stated plan, not independent proof that Aetna faced the same cost pattern or should copy Humana's actions. [5]

Three paths for Aetna

The alternatives below are hypothetical strategy choices for analysis; CVS has not disclosed them as its intended actions.

1. **Protect a broad member-value proposition.** Preserve a wide benefit offer and growth posture, relying on quality-payment improvement and the long-run appeal of MA while monitoring costs closely.
2. **Reprice and narrow selectively.** Change premiums, cost sharing or benefits-and reconsider participation where appropriate-in markets where plan-level projections do not support the offer.
3. **Differentiate selectively and manage care.** Protect benefits with a clear member-value rationale, redesign others where warranted, and pair the offer with targeted service or care-management actions where evidence supports them.

Each path has risks. Preserving more benefits may leave a plan exposed if cost pressure persists. Pulling back may weaken member value or competitive position, especially where alternatives are limited. A targeted approach depends on having reliable local data and the ability to execute changes without undermining care or service.

Questions for discussion

1. What does the 2023 evidence tell you about Aetna MA, and what does it not tell you?
2. How much decision weight should you place on the reported utilization trend, the 3.70% national payment estimate, and the 2024 Star-rating forecast? What would you keep separate?
3. Which of the three paths would you recommend, and what conditions would change your recommendation?
4. What plan-, service- and market-level information would you request before bids are finalized? How would you distinguish utilization from mix, acuity, unit price and claims timing?
5. What safeguards should the recommendation include for member value, service quality and financial sustainability?

Selected sources

1. CVS Health, “CVS Health Reports Fourth Quarter and Full-Year 2023 Results,” 7 Feb 2024: [official release](#), HCB table and narrative, HTML lines 116-164; 2024 guidance, lines 44-49. The adjusted operating income is whole-segment; the MBR definition is in endnote 3.
2. CVS Health, same release, supplemental “Health Care Benefits Segment Medical Membership” table, HTML lines 1383-1430 (units: thousands; year-end counts).
3. Centers for Medicare & Medicaid Services, “2025 Medicare Advantage and Part D Rate Announcement,” 1 Apr 2024: [fact sheet](#), overview and FAQ Q1, lines 42 and 101-104; all-in estimate and risk-score explanation, lines 124-131.
4. CVS Health, Form 10-K for year ended 31 Dec 2023, filed 7 Feb 2024: [SEC filing](#), HCB Star Ratings discussion, printed pp.85-86 (official report PDF viewer pp.97-98): 2024 ratings and 87%/21% comparison on p.85; 2024 revenue headwind and expected 2025 recovery on p.86.
5. Humana, “Fourth Quarter 2023 Prepared Management Remarks,” 25 Jan 2024, Exhibit 99.3: [SEC exhibit](#), printed pp.1-3 and 7-9; SEC HTML lines 31-64 and 82-125.