

Elevance Health: Renew, rebuild, or retreat in Medicaid?

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This is a constructed teaching decision. Elevance Health has not been reported to have held this meeting or adopted the options below. The setting uses information public by the cutoff; it does not include later results or outcomes.

A portfolio decision with local consequences

On August 3, Elevance Health's strategy team is preparing a recommendation for a hypothetical leadership review of its Medicaid business. The question is not whether public health insurance matters to Elevance: the company serves millions of Medicaid members, and state contracts connect its health plans with a broad provider and community network. The question is what the company should do when membership changes faster than contract economics and local delivery capabilities can be reset.

Elevance's latest report shows both pressure and choice. At June 30, Medicaid membership was 8.358 million, down 375,000, or 4.3%, from a year earlier. Elevance attributed the decline primarily to eligibility redeterminations. Federal redeterminations were required to conclude by December 31, 2025, but the company warned that state reverifications and recent policy changes may continue to affect enrollment, member acuity, utilization and rate-setting.

[Elevance Q2 2026 Form 10-Q](#), pp. 39-40.

The decline does not reveal which members left, whether the remaining members have different care needs, or how profitability varies by contract. Nor does it establish that state rates are inadequate. Medicaid is a state-by-state business: state payment terms, benefits, procurement cycles, provider networks and enrollment dynamics differ. The 10-Q gives company-wide and segment results, not a Medicaid profit-and-loss statement by state or contract.

Meanwhile, Elevance has described a stronger role for Carelon, its healthcare-services businesses. In its July 15 release, the company raised its 2026 adjusted diluted earnings-per-share guidance to at least \$27 and said it was accelerating targeted investment in medical-cost management, member and provider experience, operating efficiency, and Carelon's integrated solutions. These are management priorities and forecasts, not completed outcomes. [Q2 2026 earnings release](#).

An integrated-services promise that still needs proof

Carelon Services describes its work as bringing together physical, behavioral, pharmacy and social services through Carelon Health and Carelon Insights, for affiliated and external customers. That portfolio could help a Medicaid plan coordinate care for members with complex needs and sustain provider relationships. It could also become a service platform with customers beyond Elevance's own plans.

But scale and integration do not prove savings or better care. Elevance's Q2 results show different directions across businesses. Health Benefits operating gain was \$896 million, compared with \$1.560 billion a year earlier; CarelonRx operating gain was \$582 million, versus \$536 million; and Carelon Services operating gain was \$366 million, versus \$400 million. Carelon Services revenue grew 7.2% to \$7.975 billion, even as operating gain declined. These segment totals cover different customers and services and do not show Carelon's incremental effect on a particular Medicaid contract. [Q2 2026 Form 10-Q](#), pp. 44-46.

The member trend is not uniform across government programs. Medicare Advantage membership was 1.897 million, down 15.9% year over year. Elevance described deliberate repositioning in MA. The company reported that about 59% of its MA members were in plans rated at least four stars for 2026 ratings, compared with about 40% under the 2025 ratings used for 2026 payments. Medicaid's 4.3% decline and MA's 15.9% decline should not be combined into one trend: the products, payment systems, contract structures and company explanations differ. [Q2 2026 Form 10-Q](#), pp. 39-45.

Policy also creates different kinds of uncertainty. CMS's April 2026 announcement projected a 2.48% average increase in MA payments nationally for 2027, combining several rate and risk-adjustment components. That is not an Elevance-specific estimate, and it says nothing about Medicaid rates. A separate CMS final rule changes the MA Star Ratings system: among other changes, it removes 11 measures and adds a depression-screening measure beginning with the 2027 measurement year and 2029 ratings. Neither announcement provides a Medicaid contract forecast. [CMS CY2027 MA rate announcement](#); [CMS CY2027 final-rule fact sheet](#).

What leaving a market might mean

Research offers no automatic answer. One study of Medicaid managed-care plans from 2006 to 2014 found that plans that exited had lower prior scores in several quality and patient-experience measures, while the remaining market's average quality did not significantly change in the following year. Another study of involuntary plan switching found lower primary-care and prescription use and more hospital admissions after affected members were moved. Research on a provider leaving a plan's network found disruptions to primary-care visits, especially among chronically ill members. A study of forced plan and provider transitions for children with persistent asthma, however, found fewer outpatient visits without consistent changes in asthma quality or emergency use. [Selected studies: Ndumele et al.; Politzer; Staiger; Piwnica-Worms et al.](#)

These studies examine different markets, populations and types of disruption. They do not predict what would happen to Elevance members in a specific state. They do suggest that any exit plan should consider both portfolio performance and how affected members would maintain care.

The choice

The hypothetical strategy team has been asked to recommend a Medicaid portfolio posture for the next planning cycle. Three paths are on the table:

1. **Renew and reprice selectively.** Continue bidding in strategically important states where contract terms can be aligned with expected costs and member needs. Set explicit renewal conditions and be prepared to decline contracts whose terms do not support a credible operating plan.
2. **Invest in continuity and integrated care.** Prioritize selected markets for Carelon-enabled care coordination, behavioral-health access, provider connectivity and transition support. Define the member and quality outcomes the investment should achieve; determine whether the value accrues to members, state partners, Elevance plans, Carelon, or all four.
3. **Reduce exposure and exit selectively.** Narrow participation where the company cannot develop a sustainable offer. Plan the transition with states and providers, and account for how to protect continuity for affected members and what capabilities or scale the company may lose.

These options can be combined by state; none is a company-wide instruction. The recommendation must explain how Elevance would distinguish one market from another and what it would do when local evidence is incomplete.

Exhibits

Exhibit 1. Selected membership at June 30

Product / metric	2026	2025	Change
Medicaid	8.358m	8.733m	–375k / –4.3%
Medicare Advantage	1.897m	2.255m	–358k / –15.9%
Total medical membership	44.949m	45.621m	–672k / –1.5%

Source: Elevance Q2 2026 Form 10-Q, p. 40. Company-reported, unaudited point-in-time membership; some counts are estimates. Medicaid and MA are separate products with different business conditions.

Exhibit 2. Selected Q2 segment results

Segment	Q2 2026 revenue	Q2 2025 revenue	Q2 2026 operating gain	Q2 2025 operating gain
Health Benefits	\$42.720bn	\$41.582bn	\$896m	\$1,560m
CarelonRx	\$11.250bn	\$10.643bn	\$582m	\$536m
Carelon Services	\$7.975bn	\$7.441bn	\$366m	\$400m

Source: Elevance Q2 2026 Form 10-Q, pp. 44-46. Dollar figures as reported. Segment totals include varied business and customer mix; they do not reveal Medicaid-only or state-contract economics. Revenue is not profit, and operating gain does not identify Carelon's incremental contribution to a Health Benefits contract.

Exhibit 3. Known policy context by August 3, 2026

Program	Public information available by cutoff	What it does not establish
Medicaid	Federal redeterminations were required to conclude by Dec. 31, 2025; state reverifications and policy changes remain potential drivers of enrollment, acuity, utilization and rate-setting.	Future enrollment or state-by-state rate adequacy.
Medicare Advantage	CMS projected a 2.48% average national payment increase for CY2027. Star Ratings changes were finalized separately.	Elevance's MA revenue or profit change; any Medicaid payment effect.

Sources: Elevance Q2 2026 Form 10-Q, p. 39; CMS CY2027 Rate Announcement and final-rule fact sheet.

Assignment

Prepare a recommendation for the hypothetical leadership review. Identify which markets should be renewed and repriced, which merit targeted continuity/Carelon investment, and which should be considered for reduced exposure or exit. State the evidence you would require before making each decision, the indicators that would trigger a change in course, and how members and state partners would be affected. Distinguish facts from assumptions and do not infer contract-level profitability from company segment results.

Discussion questions

1. What is the strategic role of Medicaid within Elevance's portfolio, and how does the evidence support or challenge that role?
2. How should management separate temporary membership/rate timing effects from structural contract economics?
3. What would make Carelon integration valuable to Medicaid members and plans? How should Elevance test whether value is incremental?
4. What decision gates should trigger renewal, repricing, investment, or exit at the state level?
5. How should Elevance preserve continuity for members if it reduces participation, and what evidence would show that the transition is working?