

Humana and the 2025 Medicare Advantage bid

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Humana had weeks to finalize its 2025 Medicare Advantage (MA) bids. The national payment announcement showed an average increase, yet Humana's leaders warned that benefits and plan choice could still come under pressure. The strategic question was which plans and benefits to protect, redesign, or leave as the company balanced affordability, member growth, and margin recovery.

This case is a historical decision exercise. You are advising a hypothetical Humana MA portfolio committee on April 24, 2024. Humana's 2025 bids are due on the first Monday in June. The committee must choose a portfolio posture while key county-level costs, payments, and competitor bids remain uncertain.

A national increase, a company-level warning

On April 1, CMS announced that average government payments to Medicare Advantage plans were expected to rise 3.70% in 2025 compared with 2024, or more than \$16 billion across the industry. The final estimate incorporated newer fee-for-service data, policy and technical adjustments, Star Ratings, and the industry's average risk-score trend. CMS said it expected stable premiums, benefits, and plan options overall.

Humana's leaders saw a different implication for their own portfolio. In prepared remarks accompanying first-quarter results, management said the final rate notice was insufficient for the current medical-cost environment and expected benefit levels, plan stability, and choice for seniors to be negatively affected. It cited policy and technical rule changes, the Inflation Reduction Act, and limits on year-over-year Total Beneficiary Cost changes. Management said the company was evaluating plan-level pricing, consumer needs and benefit preferences, expected profitability, and membership growth. It expected to use some combination of targeted plan or county exits and varying benefit reductions. These were management's views and plans in progress, not completed bids or public county-level economics.

Growth and cost signals

Humana's individual MA enrollment stood at 5.55 million on March 31, up from 5.15 million a year earlier. Management raised its 2024 individual MA net-growth outlook to approximately 150,000, attributing the increase primarily to higher-than-expected non-Dual Eligible Special Needs Plan sales. Enrollment growth was an opportunity, but it did not reveal the profitability of any 2025 plan or the effect of a benefit change on retention.

Humana reported a first-quarter 2024 GAAP Insurance-segment benefit ratio of 89.3%, compared with 86.1% in the first quarter of 2023. The adjusted non-GAAP ratio was 89.4%, compared with 86.4%. Humana attributed the increase primarily to higher MA medical-cost trends, partly offset by pricing and benefit design. It also said that a shift in business mix toward MA and state-based contracts contributed. The reported ratio covered the broader Insurance segment, not individual MA alone.

The company described its early cost view as incomplete. Inpatient admissions per thousand were in line with expectations overall; January and February had run somewhat higher, offset by March. Humana said it had limited visibility into non-inpatient trends and inpatient unit costs until claims arrived. The Change Healthcare disruption affected claim submissions, and Humana said it used more conservative quarter-end reserves as a result. Q1 figures therefore did not settle the 2025 trend question.

The bid choice

The decision is not how to allocate a flat 3.70% increase to Humana. It is how to set county- and plan-level bids when the national average does not reveal Humana's local benchmarks, risk-adjusted payments, costs, or competitor offerings. Medicare Advantage plans bid against county benchmarks; payments and any rebate depend on factors that include the county, enrollee risk, bid, and quality rating. Plan-level decisions may therefore differ even within one national portfolio.

Consider three postures:

1. **Preserve plans and benefits where possible.** Emphasize continuity, member value, and growth while accepting that margins may recover more slowly in some markets.
2. **Make targeted changes and exits.** Focus benefit reductions or withdrawals on plans or counties whose expected economics do not support the existing offer, while preserving stronger products.
3. **Take a broader margin-first posture.** Redesign more of the portfolio to prioritize profitability and consistency, accepting greater risk of near-term benefit disruption or membership loss.

Each posture has a different risk. A broad pullback may sacrifice growth and member value; preserving benefits may leave weak offers exposed to trend or payment pressure; targeted action depends on forecasts that may be wrong and can create uneven disruption across markets. Public materials do not disclose the plan-level data needed to calculate these trade-offs.

Research lens: payment changes do not map one-for-one to benefits

Two studies of Medicare Advantage provide context, not a Humana forecast. Chernew, Miller, Petrin, and Town's analysis of CMS data from 2012-19 found modest average associations between higher benchmarks and selected premiums, cost sharing, and supplemental-benefit availability. Cabral, Geruso, and Mahoney's study of the 2000 BIPA payment-floor change found that plans passed through some, but not all, additional payments through lower premiums and benefits; premium pass-through differed across market-competition measures. Both studies cover earlier policy and market settings. Their estimates should not be applied as Humana's 2025 response.

Questions for the committee

1. Which portfolio posture would you recommend, and what evidence would make you change it?
2. What county- and plan-level measures should govern benefit preservation, redesign, or exit? How would you weigh expected margin against continuity, member value, and growth?
3. How should the committee handle incomplete medical-cost visibility and the risk that claims timing or reserves distort early signals?
4. Which local competitive facts matter, and how would you avoid treating the national 3.70% estimate as a Humana-specific rate?
5. What should Humana communicate to members, brokers, and regulators once decisions are made?

Selected sources

1. Humana, [Q1 2024 detailed earnings release](#), Apr. 24, 2024: Insurance-segment results and explanation, lines 234-262; membership, lines 795-843; revenue, lines 851-870.
2. Humana, [Q1 2024 prepared management remarks](#), Apr. 24, 2024: early indicators and cost visibility, lines 66-81; 2025 bid process and outlook, lines 120-125.
3. CMS, [2025 Medicare Advantage and Part D Rate Announcement fact sheet](#), Apr. 1, 2024: average payment change and methodology, lines 42, 66-67, 101-131; expected premiums and benefits, lines 142-148.
4. Chernew et al. (2023), [“Reducing Medicare Advantage Benchmarks Will Decrease Plan Generosity, But Those Effects Will Likely Be Modest”](#), *Health Affairs* 42(4):479-487: methods, pp. 480-482; results, Exhibits 3-4.
5. Cabral, Geruso, and Mahoney (2018), [“Do Larger Health Insurance Subsidies Benefit Patients or Producers? Evidence from Medicare Advantage”](#), *American Economic Review* 108(8):2048-2087. [BFI author working-paper PDF](#): full 95-page PDF accessed; design, pass-through, selection, and market-power sections read closely; appendices not comprehensively reviewed, and the final typeset text was not read. Locators: PDF pp. 1-3, 12-18, 27-34 (Tables 4-5; Figures 6 and 10).