UNITEDHEALTH GROUP®

Earnings Conference Call
Third Quarter 2024 Remarks
October 15, 2024

Moderator:

Good morning, and welcome to the UnitedHealth Group Third Quarter 2024 Earnings Conference Call. A question-and-answer session will follow UnitedHealth Group's prepared remarks. As a reminder, this call is being recorded.

Here is some important introductory information. This call contains "forward-looking" statements under U.S. federal securities laws. These statements are subject to risks and uncertainties that could cause actual results to differ materially from historical experience or present expectations. A description of some of the risks and uncertainties can be found in the reports that we file with the Securities and Exchange Commission, including the cautionary statements included in our current and periodic filings.

This call will also reference non-GAAP amounts. A reconciliation of the non-GAAP to GAAP amounts is available on the "Financial & Earnings Reports" section of the Company's Investor Relations page at www.unitedhealthgroup.com.

Information presented on this call is contained in the Earnings Release we issued this morning and in our Form 8-K dated October 15, 2024, which may be accessed from the Investor Relations page of the Company's website. I will now turn the conference over to the chief executive officer of UnitedHealth Group, Andrew Witty.

Andrew Witty

Good morning and thank you for joining us.

As you saw in our release, the people of UnitedHealth Group continue to deliver on our growth pillars. Our teams are providing more people with more high-quality health care services and benefits, and restlessly looking for ways to simplify the health system and deliver more value for patients, employers and providers alike.

By the end of this year, we will have grown to:

- Serve more than 2 million new consumers with commercial offerings.
- Fulfill more than 1.6 billion prescriptions through Optum Rx.
- And care for 4.7 million people in value-based arrangements.

Our people will have done all this and more in a challenging period, navigating:

- The first year of the CMS Medicare rate cuts and its impact on member mix.
- The effects of the state-driven Medicaid member redeterminations.
- Certain novel care patterns.
- And the Change Healthcare cyberattack.

While many of those factors could not have been anticipated, thanks to our people's efforts, we can affirm a full year 2024 earnings outlook still within the range we first offered back in November 2023. It is a distinctive part of the culture of UnitedHealth Group that we continue to strive to deliver on our financial commitments to you through changing environments and unforeseen challenges.

As we look to 2025, and I will address this shortly, we remain in a dynamic period for the health care sector. Amid this, it's important that we continue to invest in the durable value-creating capabilities of this company that support our 13 to 16% long term growth objective.

We will balance our commitments to investing in the promising future before us with managing the known and potential challenges. We remain highly optimistic for the future, even as we are respectful of the pressures the sector faces again next year.

Even within this environment, we are well-positioned to continue our growth in the years ahead.

I want to highlight two important reasons for this optimism.

First is our relentless focus on execution, quality and innovation.

In particular, we continue to work tirelessly to improve people's experiences with the health system. To that end, this month we launched a first of its kind national Gold Card program, which will reduce the number of prior authorizations by 500,000 every year for qualified in-network providers. This can help improve both the quality and the affordability of care, while reducing friction in the system.

Artificial Intelligence is starting to be an important tool in improving our work. Our advanced practice clinicians use AI to summarize lengthy patient histories, freeing up

hundreds of hours that can better be spent caring for people. Our nurses use generative AI to review documentation more efficiently, saving time and improving patient service.

AI is helping our consumer advocates, powering tens of millions of consumer interactions and provider searches. This allows our advocates to spend more time with people on more complex inquiries, driving better efficiency while also improving the consumer experience as reflected in higher NPS scores.

And finally, using AI to help build software is enabling technology engineering teams to enhance the speed and quality necessary to help drive our technology modernization.

Our focus on execution and quality is also evident in the Medicare Advantage plans we are offering for 2025. Once again, we focused on consumer value and, as much as possible, on benefit stability – even as we navigated the adverse Medicare funding environment. With annual enrollment beginning today, we believe we will continue to be a top choice for consumers.

A second element underpinning our growth is delivery on our commitment to the transition of the health system to value-based care.

For over 20 years, there has been a bipartisan consensus among health care experts and policymakers that value-based care — that is, integrated, patient-centered and outcome-focused care — is superior to the often fragmented and unnecessarily expensive fee-for-service system.

Across four presidential administrations, CMS has called for private-public innovation in the development of value-based care models in Medicare and Medicaid. It provides better outcomes for patients. It saves money for the customers and taxpayers who fund care. And it empowers clinicians to focus on providing the most beneficial care.

The rationale for this decades-long effort to develop value-based care is both simple and sound:

- It moves from incentives based solely on volume to incentives based on a patient’s health outcomes and experience.

- And it helps ensure patient care is delivered not at the highest cost sites of service … but rather those that combine the highest quality and value.

The effectiveness of value-based care for patients is proven and powerful … and it's good for the system.

At UnitedHealth Group, we are purposefully organized to support the transition to value-based care.

It requires deep engagement with patients, setting the foundation to move to more coordinated care:

- Connecting patients to primary care earlier.
- Driving clinically accurate diagnoses.
- More effectively recognizing and managing chronic conditions.
- And slowing disease progression.

We are seeing the benefits of this work come to fruition. People served by Optum Health's value-based care models are *more* likely to receive cancer screenings and be in better control of their diabetes and hypertension than people in fee-for-service Medicare … and 10% *less* likely to visit the emergency room or be re-admitted to a hospital.

One example of the impact of better care coordination is our Emergency Room Safe Discharge program, which helps patients who may be at risk for unnecessary and expensive ER use and readmissions. We have learned that the specific ways in which a discharge is managed can have a substantial impact on readmissions, which are a problem for both patients and facilities.

Our nurse care managers proactively engage the emergency teams to provide them relevant information from the outpatient medical record, and to facilitate a safe discharge. This approach, currently in eight markets, is already helping to avoid hundreds of inpatient stays each month. It preserves emergency resources for those who truly need them, saves money and is a better experience for patients.

Our many care offerings now serve people in value-based care arrangements in dozens of service areas, integrating primary, surgical, behavioral and home care. These patients come from many diverse payers and employers – a clear sign of confidence from the market that we are on the right track.

This is the value proposition of UnitedHealth Group: committed to serving patients, providers, payers and customers with quality, integrity and innovation; and joining with federal and state governments in the effort to help build a better health system that meets the needs of all stakeholders now and into the future.

Fundamentally, we continue to grow because more people and organizations are purchasing more of the products and services we offer. It's a simple statement to make, yet a hard thing to do year in and year out. But it's the enduring reason for our optimism about the long-term growth and future of this enterprise.

Now, I'll turn it over to John Rex, our president and chief financial officer.

John Rex

Thank you, Andrew.

Strong growth across the company sets us up well to deliver upon our commitments to you. Amid all the puts and takes of this unusual year, we are seeing what we always look for:

- New products and innovations taking root among customers.
- More people being served through our services.
- And continued improvement in the experience people have.

These are key to our long-term success.

I'll start today by offering some observations on care activity patterns, as we know that is most likely top of mind for many of you.

Certain care patterns persisted at higher levels than we expected in the period for three specific, and we believe, primarily transitory reasons … two of which we noted last quarter.

First, the still pronounced upshift in coding intensity by hospitals, which we flagged last quarter. In some cases, the coding actions are extreme. Certain entities have been notably and persistently aggressive, having upshifted their coding intensity factors by more than 20%. We are actively addressing this unnecessary additional cost burden to the health system.

The second item, also noted last quarter, is the continued timing mismatch between the current health status of Medicaid members and state rate updates. States often use care activity data that is well over a year old in setting their rates. That typically has minimal impact when member mix levels are relatively stable. Eligibility redeterminations significantly shifted both the number and average acuity of people covered has changed. As a result of the lagging care activity data, as well as the annual rate cycle timing, updates remain well short of current care activity ... a factor that for us was more pronounced through the period than anticipated.

A third item that emerged more substantially in the period was a rather rapid acceleration in the prescribing of certain high-cost specialty medications, primarily those used to treat cardiovascular disease, auto-immune disorders and cancer. We believe a contributing factor to the acceleration was the Inflation Reduction Act, which eliminated the individual coinsurance requirement during the catastrophic coverage phase. As many of you know, more people enter this phase in the second half of the year.

While we anticipated this would become a more meaningful factor in 2025 … drug manufacturer campaigns pulled some of this activity into this year more sharply than anticipated.

With that, let’s turn to our third quarter results.

Revenues of $101 billion grew more than 9% over the prior year, with strong growth again at both Optum and UnitedHealthcare.

Optum Health revenues grew by over $2 billion and are approaching $26 billion. This was driven by an increase in both the number and type of care services we offer and the patients we serve, especially in the home and among those with complex needs.

Optum Rx revenues grew by over $5 billion to more than $34 billion, driven by strength in our pharmacy care offerings, as well as growth in pharmacy benefits management from new customers, and expanding specialty services.

Optum Insight revenues in the quarter were stable, approaching $5 billion, and the nearly $33 billion revenue backlog increased by more than $1 billion from last year.

Turning to UnitedHealthcare:

Our domestic commercial business has added more than 2.4 million people through the third quarter. Selling season indications are tracking favorably as we head into ’25, reflecting continued strong uptake of UnitedHealthcare’s innovative offerings.

Our Medicare Advantage plans on offer this fall balance providing as much benefit stability as possible for seniors, while contending with the CMS funding cuts, IRA changes and expected care patterns. The initial Stars ratings for plan year ’26 for consumers in 4 star or better rated plans is largely consistent with what we saw in our initial results last year. As has been the case in recent years, we expect these percentages to increase.

In Medicaid, our new state customer, expansion and retention performance remains strong, including recent awards in Massachusetts, Colorado, Rhode Island, Florida and Michigan. We hope to continue to support people and families in the post-redeterminations period and are advocating with states to ensure adequate funding and resources for these often underserved people.

Our capital capacities remain strong and continue to underpin our long-term growth objectives. In the quarter, cash flows from operations were $14 billion, or 2.2 times net income and year-to-date, were nearly $22 billion. So far this year, we have returned $9.6 billion to shareholders via dividends and share repurchase. Additionally, we have invested more than $11 billion in a wide range of strategic opportunities, including

updating and extending our longstanding and productive relationship with AARP, to better serve older Americans.

As highlighted last quarter, after the cyberattack we prioritized devoting resources to support care providers over some activities such as share repurchase. Payments and claims flows for most care providers have normalized and repayment of these capital advances is underway.

Regarding Change Healthcare, for full year ’24, we now estimate the business disruption costs will be about 75 cents per share, an increase of 10 cents from the former mid-point. As you may recall, business disruption largely encompasses the loss of revenues, combined with the costs of keeping these capabilities fully ready to serve. These effects are not excluded from adjusted earnings.

We continue to work with customers to bring transaction volumes back to pre-event levels and to win new business with our now more modern, secure and capable offerings. We expect to continue to build back the business to pre-attack levels over the course of ’25 and estimate next year’s full year impact will be roughly half of the ’24 level.

As we enter the final quarter of the year, we are narrowing our ’24 adjusted earnings outlook to a range of $27.50 to $27.75, to reflect business disruption impacts and the care patterns we discussed.

Our company’s ability to deliver within the range of the commitments established nearly a year ago – even in challenging circumstances – is another example of the discipline and innovation of the enterprise and the confidence we have in delivering diverse growth for the long-term.

Now I’ll turn it back to Andrew.

Andrew Witty

Thanks, John.

Before we turn to your questions, I want to provide some preliminary observations about next year, which we will review in more depth at our upcoming investor conference.

Perhaps the most important element is that our businesses are operating well and our growth potential remains strong. We see continued momentum in the selling season performance for UnitedHealthcare's commercial business and Optum Rx, which both offer best in class innovation and performance for customers.

The consumer value-proposition of Medicare Advantage continues to be highly compelling, and we see strong growth potential in this market for many years to come.

The Optum Health value-based care businesses that we have been building for well over a decade are beginning to approach the very early stages of their potential … and will be a key differentiating growth factor in the years ahead.

At the same time, and as we build for the future and contemplate our 2025 outlook, we are taking into account several unique dynamics:

- First: The concurrent timing of the second year of the CMS Medicare rate cuts and the most significant Inflation Reduction Act impacts into a single year … and the negative effects of that on the people we serve.

- Second: Within Medicaid, the timing mismatch of state customer rate actions, which do not yet reflect the higher acuity of remaining consumers.

- And third: A respectful view of the care activity that John noted. We are actively addressing and managing for these … and continuing to believe our 2025 planning assumptions appropriately capture these components, though we will be prudent in an initial early view.

The majority of those 2025 factors are expected to be most impactful to the UnitedHealthcare businesses.

As a result, we anticipate stepping out for 2025 more conservatively than is typical. At this distance we expect the upper end of the likely range we'll offer in December as being around $30 per share.

As always, we will seek to advance beyond this initial view as the year progresses, and we remain committed to and focused on our long-term, 13 to 16% earnings per share growth objective. We see 2025 as a year of opportunity in building to that commitment … so you will see us investing in our growth pillars…aggressively modernizing our company with AI and other technologies … and – always – exercising discipline in our operating performance.

We look forward to discussing this with you in much greater detail at our Investor Conference on December the 4th in New York.