

Managed Care Organizations

The MCOs help clients manage risks around healthcare spending.

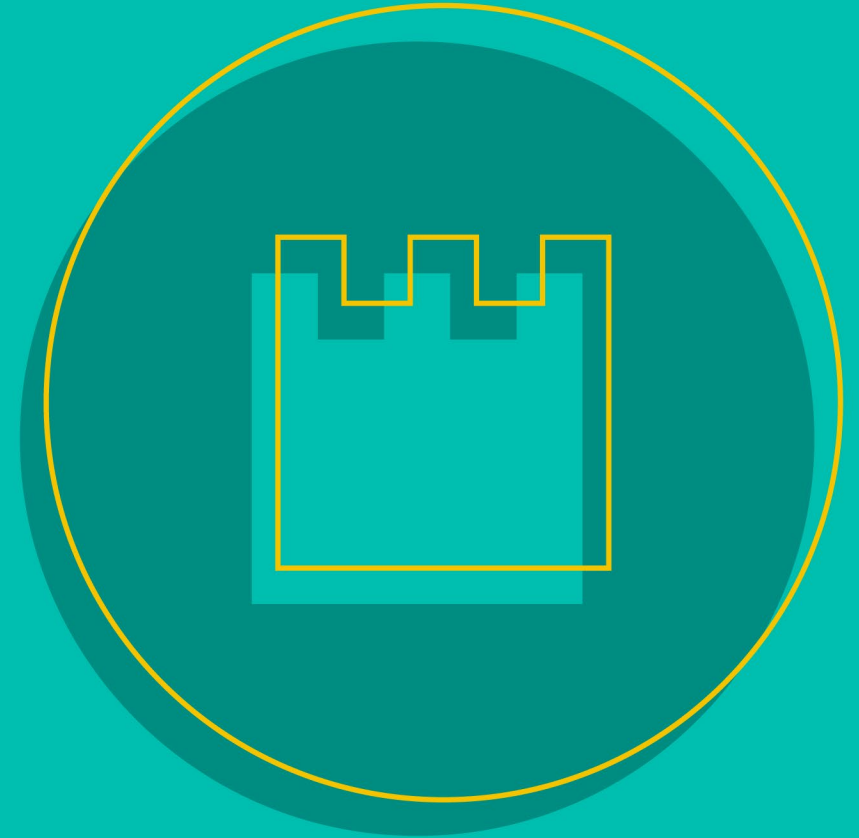


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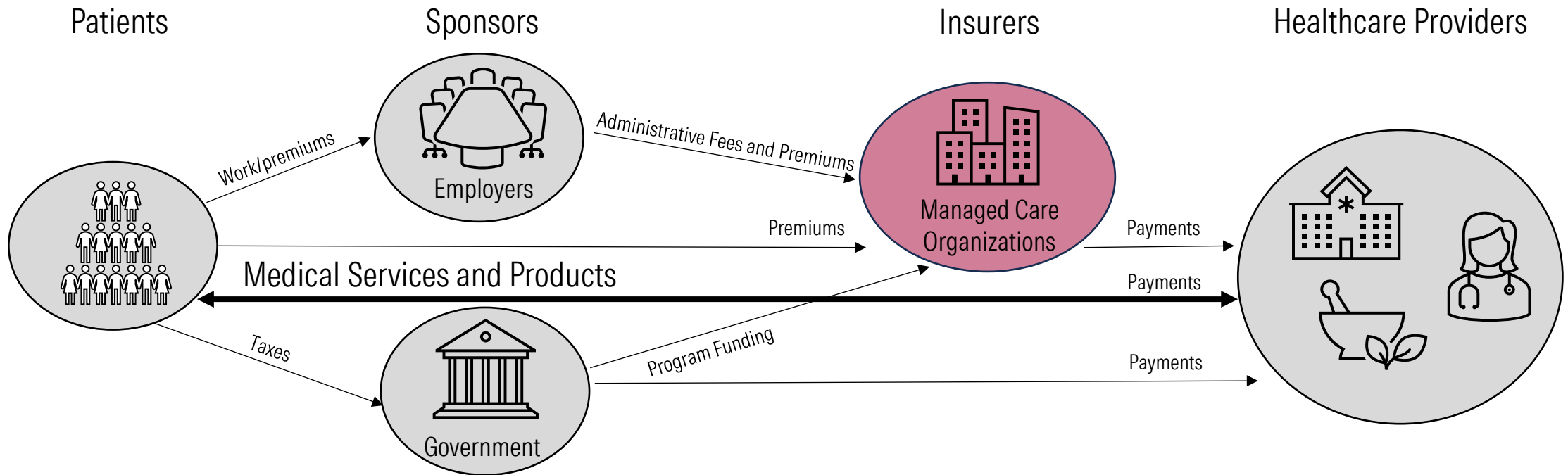
Executive Summary

The MCOs primarily offer medical and pharmaceutical benefit plans.

Industry Map

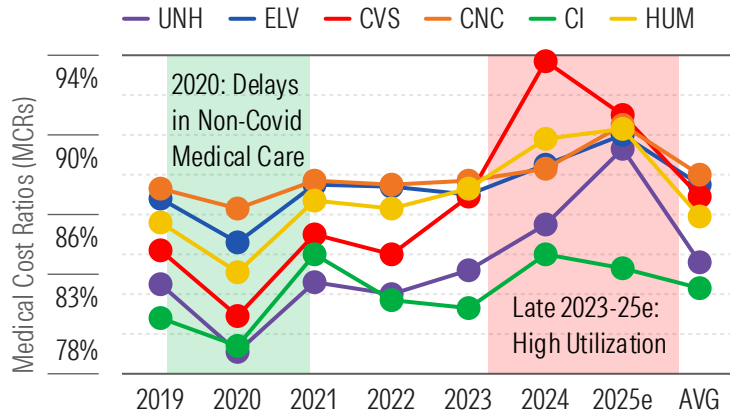
Managed care organizations, or MCOs, primarily help patients pay for medical services and pharmaceuticals within the multipayer US healthcare system. For example, MCOs help manage health insurance plans offered directly to individuals and through sponsors like employers and the government. Some MCOs have also expanded into healthcare provider offerings, too, including caregiving and pharmacy services.

The US Uses a Multipayer System for Medical Services and Products



Key Industry Themes

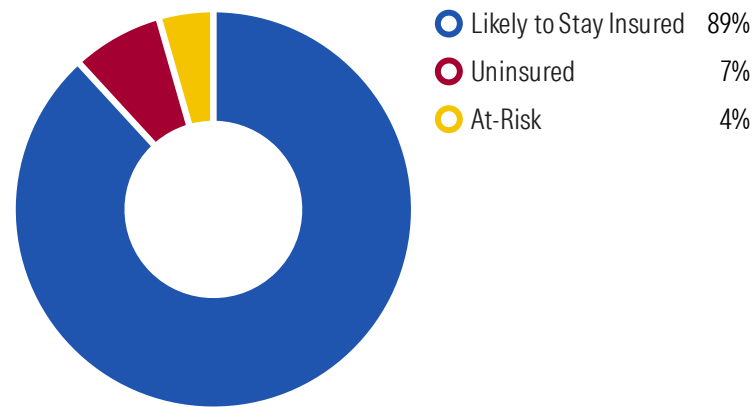
Mismatched Rates/Utilization Pressuring MCO Profits



To boost deflated profits, managed care organizations need to balance mismatched rates and utilization that are currently inflating medical cost ratios, or MCRs.

- On average, the MCOs expect to turn in MCRs that are over 300 basis points higher in 2025 than the prior five years, which is pressuring industry profits.
- Medicare Advantage, or MA, started this trend of mismatched rates and utilization in late 2023 and remains a problem area.
- Medicaid, individual, and employer plans are feeling a mismatch in rates and utilization currently, too.

One Big Beautiful Bill Act Could Reduce Insured Rate

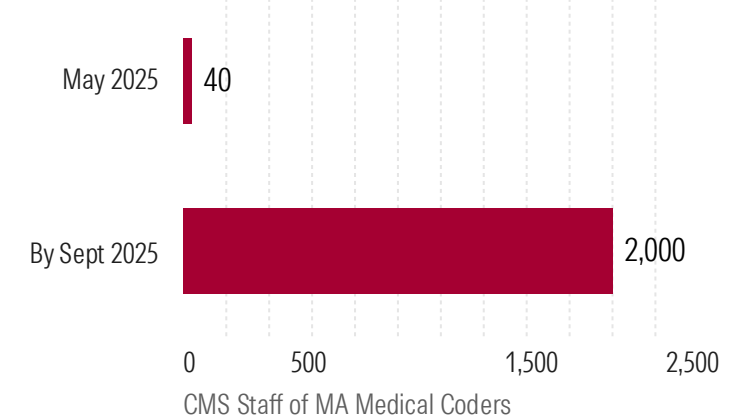


The US insured rate may decline by about 400 basis points from recent peaks (93% in 2023) due to Republican party policies that could reduce coverage by about 15 million people according to the Congressional Budget Office:

- In Medicaid, about 10 million people appear at risk from added work requirements, administrative hurdles, etc. expected in 2027.
- On the individual exchanges, about 5 million people may lose coverage as subsidies expire in 2026.

Centene, the leading Medicaid and individual exchange insurer, looks most at risk due to these pending changes.

Regulatory Scrutiny Rising on Medicare and PBMs



Two other major MCO markets could face more regulatory pressures going forward:

- Medicare Advantage insurers may face further margin pressure and potential clawbacks of previous payments, as regulators step up audit capabilities as shown above. MA leaders UnitedHealth and Humana look most at-risk due to these potential changes.
- Pharmacy benefit managers—like Cigna and CVS—face potential challenges around transparency, medical dispensing operations, and the federal government taking over drug price negotiations.

Industry Value Drivers

Simplified Financial Statement: Elevance Health 2024 Example

	2024	Relevant Ratio
Premiums	\$144,166	81% of Total Revenue
Product Revenue	\$22,630	13% of Total Revenue
Administrative Fees and Other	\$8,408	5% of Total Revenue
Operating Revenue	\$175,204	99% of Total Revenue
Investment Income, Net	\$1,807	1% of Total Revenue
Total Revenue ¹	\$177,011	100% of Total Revenue
Benefit Expense ²	\$127,567	88% of Premiums
Cost of Products Sold ³	\$19,750	87% of Product Revenue
Gross Profit	\$29,694	17% of Total Revenue
Selling, General, and Administrative Expense ⁴	\$20,025	11% of Total Revenue
Other	\$1,765	1% of Total Revenue
Income Taxes ⁵	\$1,933	24% Effective Tax Rate
Net Income	\$5,971	3% of Total Revenue
Adjustments to Net Income	\$1,556	1% of Total Revenue
Changes in Working Capital	-\$1,719	-1% of Total Revenue
Operating Cash Flow	\$5,808	3% of Total Revenue
Capital Expenditures	\$1,256	1% of Total Revenue
Free Cash Flow	\$4,552	3% of Total Revenue

Key Financial Statement Metrics

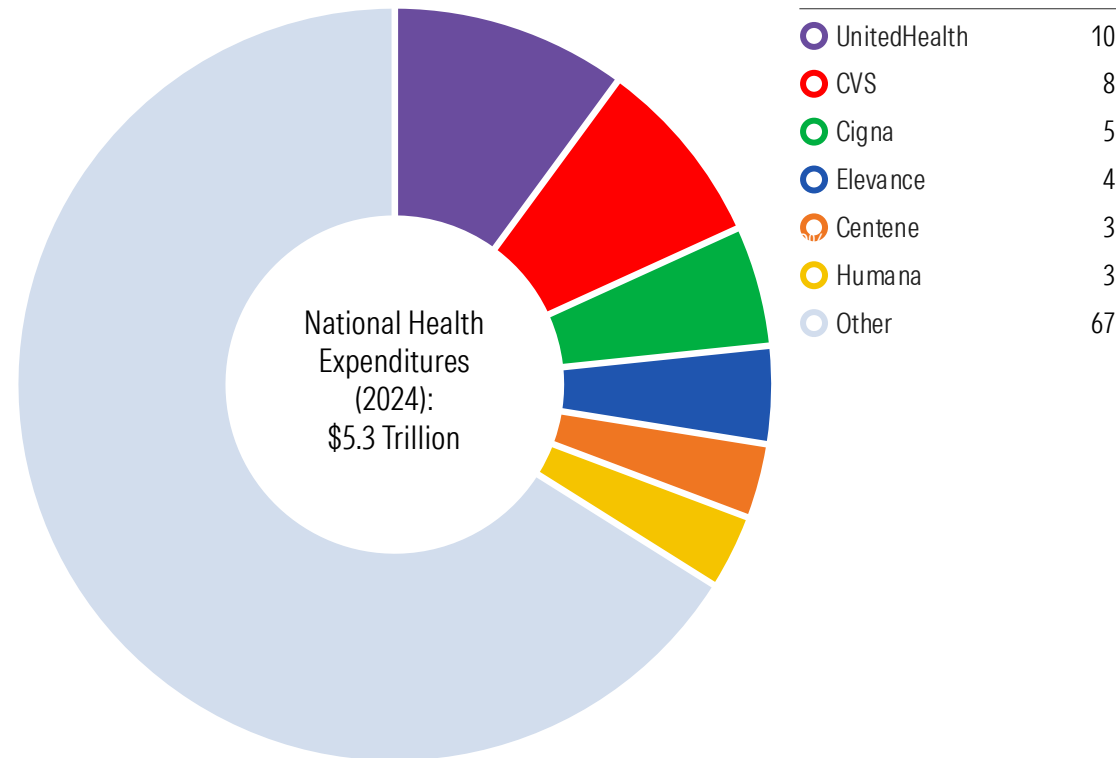
- Total revenue:** Managed care organizations get paid in several ways. They earn premiums when they fully manage a client's medical risks. Clients pay fees when they just use an MCO for administrative functions. Product revenue can come from a variety of goods, such as the drugs sold through pharmacy benefit managers. Investment portfolio income can flow through revenue, too.
- Benefit expenses:** Medical costs from at-risk client relationships are recognized as a benefit expense, and the medical cost ratio, or benefit expense per premiums, can show how well an MCO manages risk and how medical utilization is trending. Under the Affordable Care Act, gross profitability in medical insurance was capped by regulating benefit expenses at a minimum percentage of premiums by client size, including 85% for large groups and 80% for individuals/small groups.
- Cost of products sold:** When an MCO operates a nonmedical insurance business, other costs may be recognized through this line item. For example, this MCO runs a pharmacy benefit manager in which drug costs are related to product revenue.
- SG&A expenses:** Various corporate expenses plus costs associated with administrative fee relationships are recognized in this line item.
- Income Taxes:** Since the MCOs are primarily US-focused organizations, effective tax rates typically are close to the US corporate tax rate, which is currently 21%.

MCO Share of National Health Expenditures

In the highly fragmented US healthcare system—that includes insurance, caregiving, and pharmaceuticals—the six managed care organizations we cover generated gross revenue worth about one-third of the 2024 national health expenditures, or NHEs, shown below left, and about two-thirds of the roughly half of NHEs that private insurers manage cumulatively, shown below right. UnitedHealth leads the MCOs with 10% share of NHEs, followed by CVS (8%), Cigna (5%), Elevance (4%), Centene (3%), and Humana (3%).

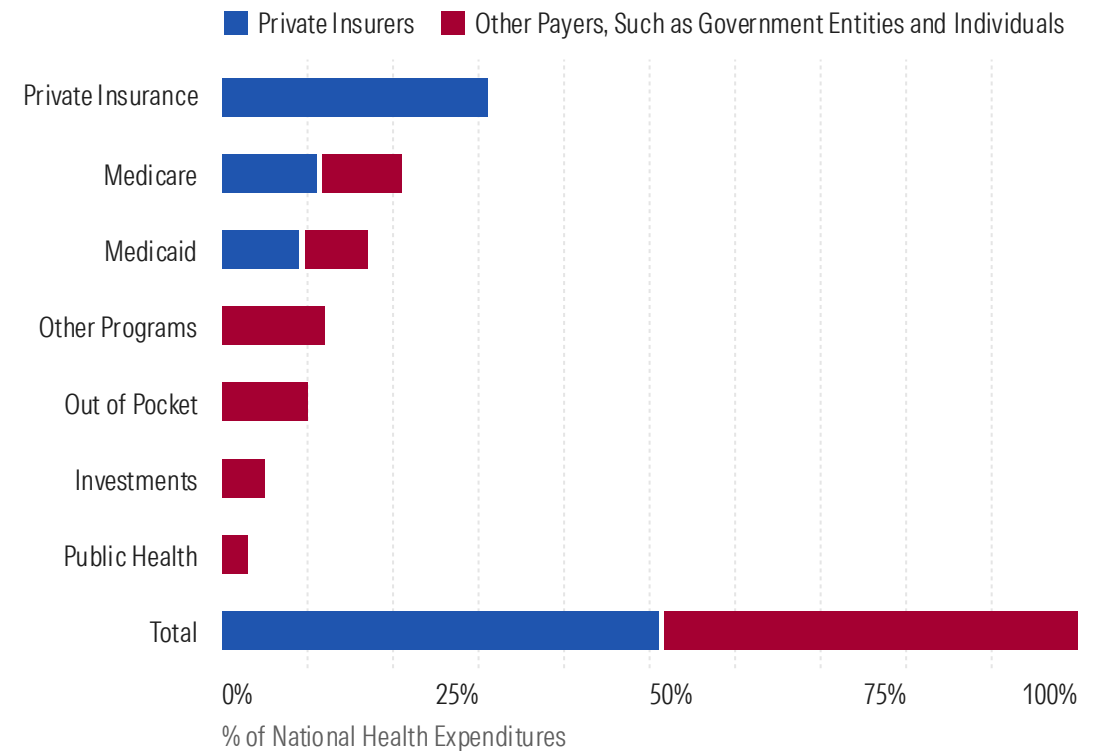
Key Managed Care Organization Share of US National Health Expenditures

Gross revenue as a percentage of \$5.3 trillion national health expenditure in 2024.



Public-Private Partnerships Permeate the US Healthcare System

About half of national health expenditures were managed by private insurers in 2024.



Coverage List and Ratings

Covered MCOs Look Undervalued, Trading Below Fair Value and at Reasonable P/E Multiples on Deflated Earnings From Mismatched Rates and Utilization

Company	Ticker	Market Cap \$ in Billions	Moat Rating	Capital Allocation	Uncertainty Rating	Star Rating	Market Price	Fair Value	Price/Fair Value	Price/2025e Earnings	Adjusted EPS CAGR 2024-2029e	PEG Ratio	Dividend Yield	US Members (12/31/24)	Typical Operating Profit %		
														Med Ins	PBM	Other	
UnitedHealth	UNH	\$290	Narrow	Standard	High	★★★★	\$320	\$400	0.80	20x	5%	4.0x	2.8%	49	51%	16%	33%
CVS Health	CVS	\$89	None	Standard	High	★★★★	\$70	\$92	0.76	11x	10%	1.1x	3.6%	27	30%	35%	36%
Cigna	CI	\$80	Narrow	Standard	High	★★★★	\$301	\$357	0.84	10x	10%	1.0x	2.0%	18	40%	60%	0%
Elevance Health	ELV	\$70	Narrow	Standard	High	★★★★	\$308	\$507	0.61	10x	8%	1.3x	2.2%	46	72%	21%	7%
Humana	HUM	\$36	Narrow	Standard	Very High	★★★	\$310	\$353	0.88	18x	14%	1.3x	1.2%	14	65%	14%	21%
Centene	CNC	\$14	None	Standard	Very High	★★★★★	\$29	\$70	0.41	17x	4%	4.2x	0.0%	22	100%	0%	0%
Average									0.72	14x	9%	1.7x	2.0%	29	60%	24%	16%

Economic Moat

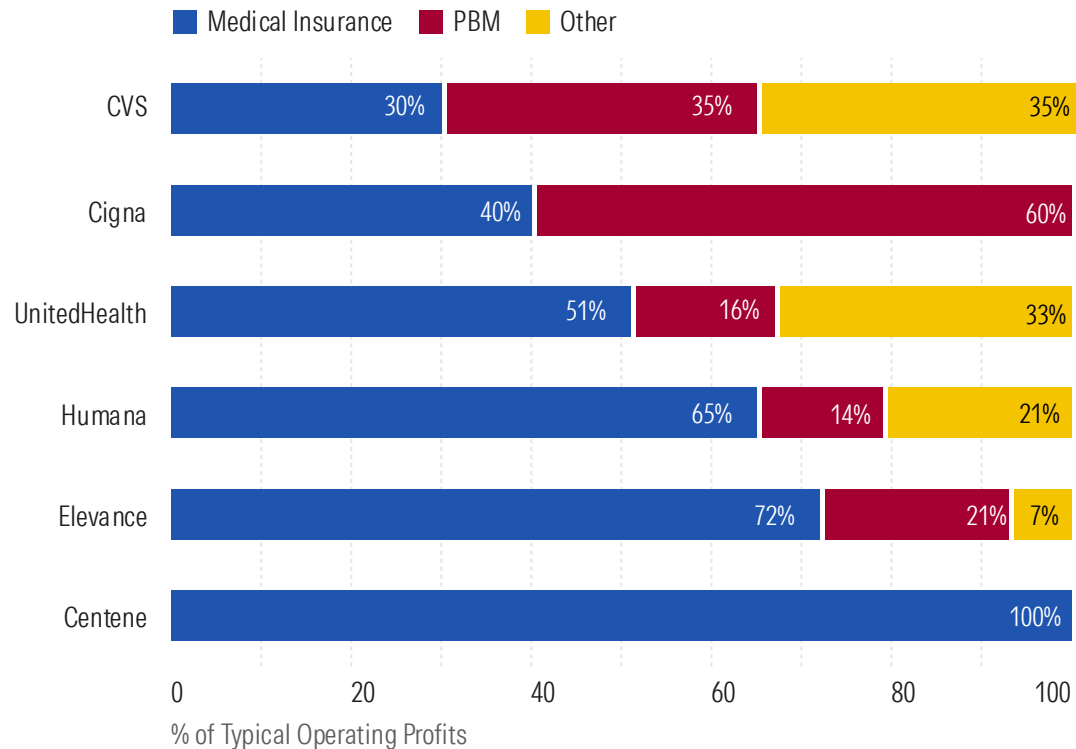
Due to regulatory risks, MCO moat ratings appear capped at narrow.

Business Mix Helps Determine MCO Moat Ratings and Sources

While all provide medical insurance, covered MCOs typically provide other offerings, too, such as pharmacy benefit management, caregiving services, and retail pharmacies. Below on the left, operating profit mix is sorted by medical insurance exposure, while medical insurance focus is sorted by concentration in employer-sponsored plans on the right. Different dynamics drive these end markets, creating the potential for different moat ratings and sources at the MCOs we cover, which are explored further on the next slide.

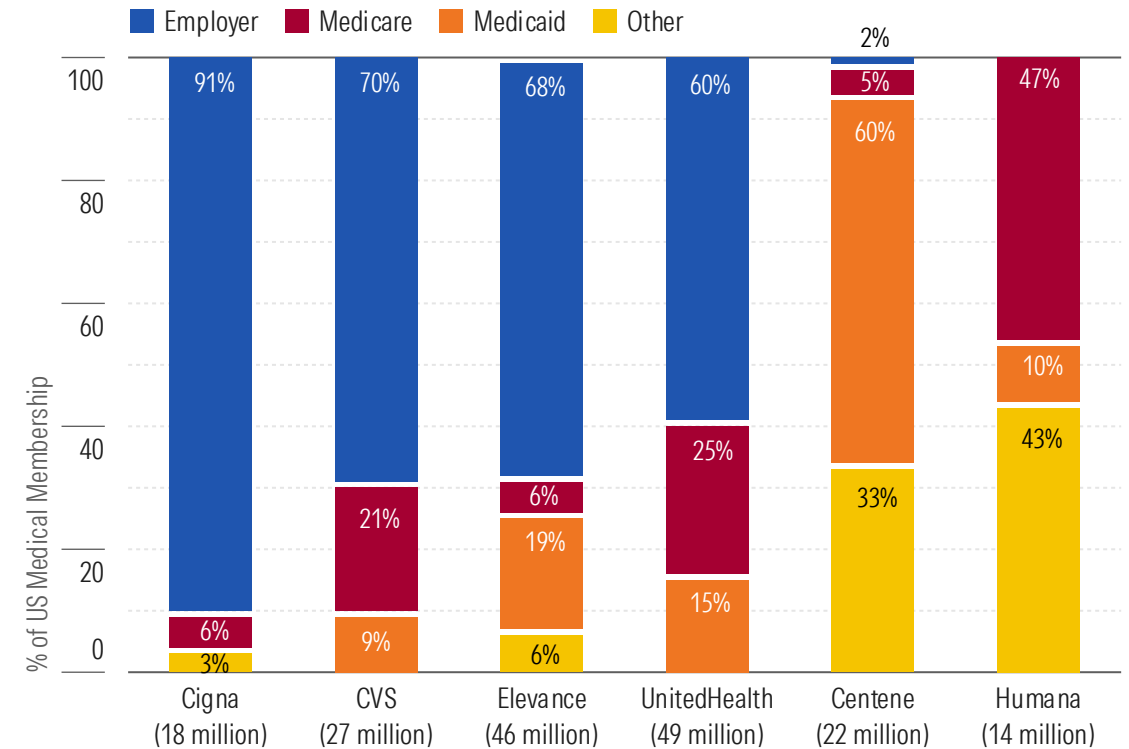
MCO Concentration From Least to Most Exposure to Medical Insurance

Typical operating profit mix (estimated, if not reported by company).



Medical Insurance Concentration, Sorted by Employer Plan Concentration

Medical membership mix as of December 2024.



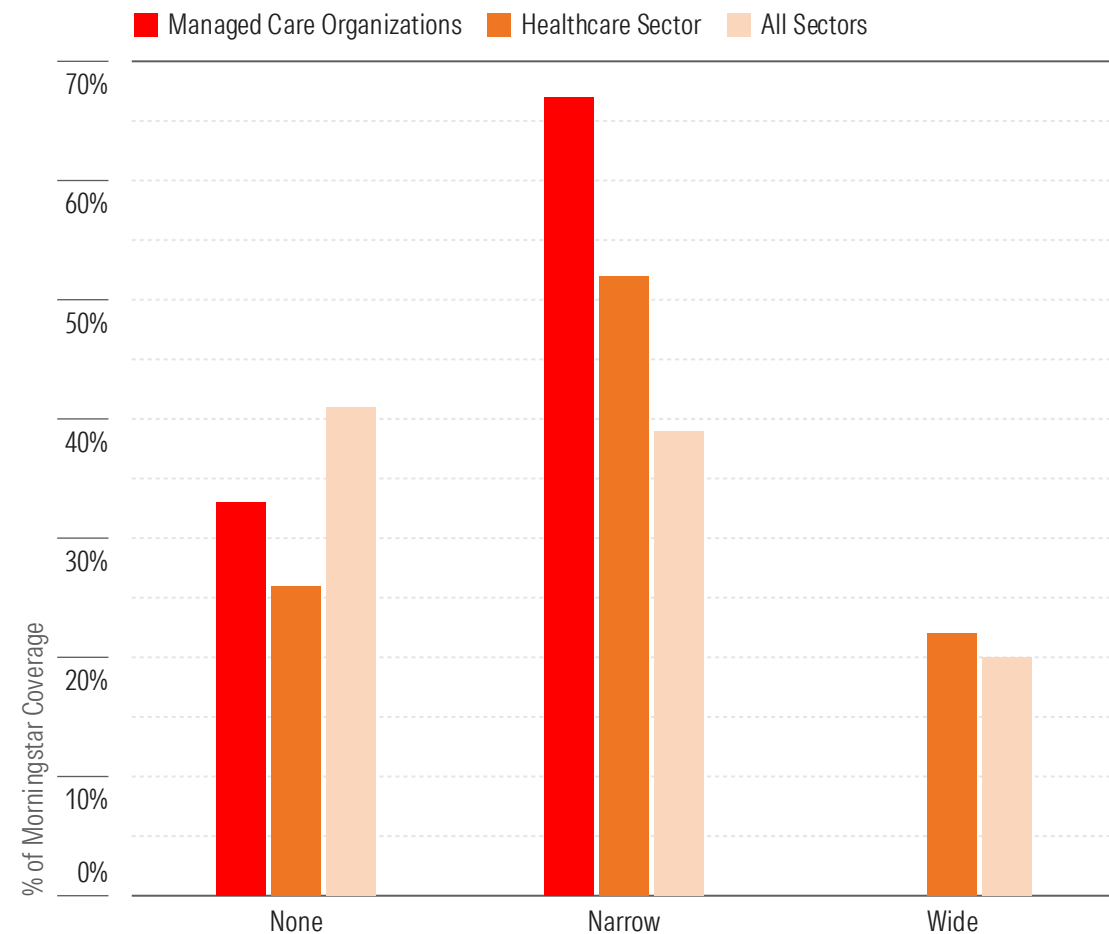
Source: Morningstar analysis of company reports as of September 2025.

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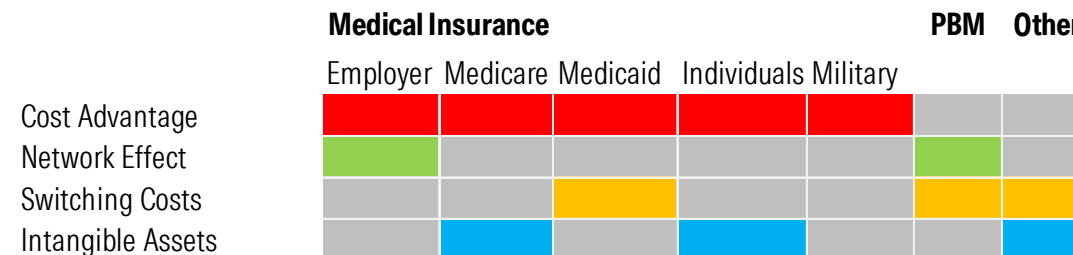
MCO Moat Ratings Are Capped at Narrow by Regulatory Risks, and Potential Moat Sources Vary by End Market

Narrow Is the Highest Moat Rating Possible for an MCO Due to Regulatory Risks

Four of the six covered MCOs have narrow moats while Centene and CVS have none.



Potential Moat Sources Vary by MCO End Market



Cost Advantage and Network Effect Are the Most Common MCO Moat Sources

Company	Moat Rating	ROIC 2029e	WACC	Potential Moat Sources by Key End Market										
				Cost Advantage				Network Effect		Switching Costs		Intangibles		
				Emp	M-Care	M-Caid	Military	Emp	PBM	M-Caid	PBM	Other	M-Care	Other
UnitedHealth	Narrow	17%	8%	X	Red	Red	Gray	Green	Green	Yellow	Yellow	Yellow	Blue	Blue
Humana	Narrow	16%	8%	Gray	X	Red	Red	Gray	Gray	Yellow	Gray	Gray	Blue	Gray
Elevance	Narrow	14%	8%	X	Red	Red	Gray	Green	Green	Yellow	Gray	Gray	Gray	Gray
Cigna	Narrow	12%	8%	Red	Gray	Gray	Gray	Green	X	Gray	X	Gray	Gray	Gray
Centene	None	9%	8%	Gray	Gray	Gray	Gray	Gray	Gray	Gray	Gray	Gray	Gray	Gray
CVS	None	8%	8%	Gray	Gray	Gray	Gray	Gray	Gray	Gray	Gray	Gray	Gray	Gray

Source: Morningstar analysis as of September 2025. In charts on the right, x = companywide moat source; bold color = moat source is possible or present; faded moat source color = moat source is present but not a companywide moat source; gray = moat source is not possible or present.

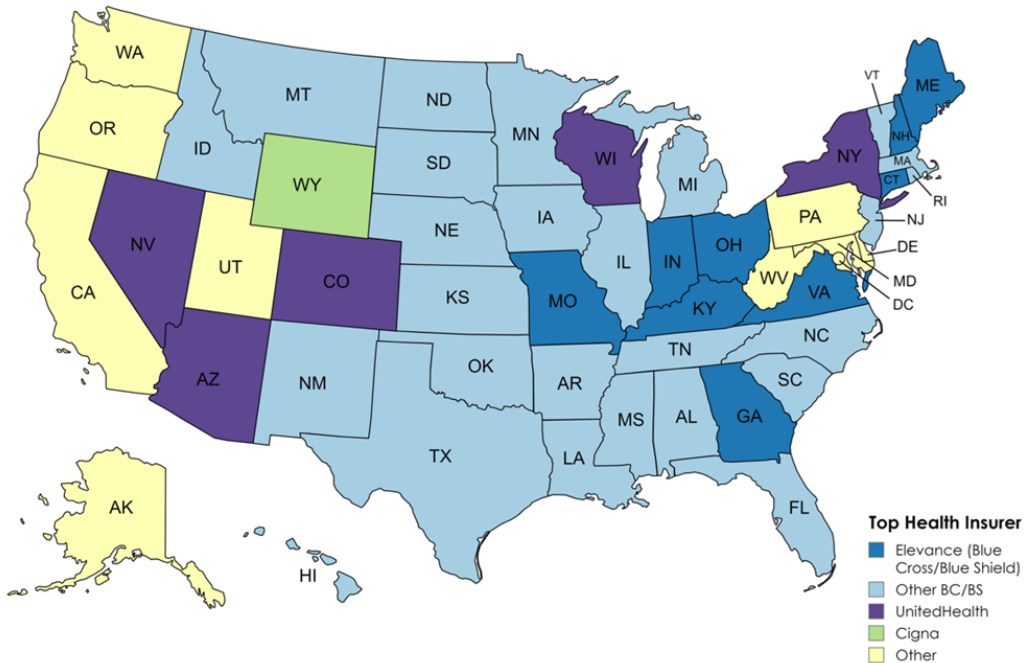
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Local Market Share Matters Most for Negotiating Power in the Industry's Employer Stronghold

An MCO's negotiating power with providers relates to its local market share, which helps it offer advantageous prices, provider networks, and benefits. The Blue Cross/Blue Shield licensees dominate local markets across the US, and Elevance (dark blue below), is the largest Blue Cross/Blue Shield licensee (14 states), which helps give it pricing-related competitive advantages over local competitors. However, even its local power can vary by geographic area, such as in Ohio where it leads overall but lags in some cities, like Akron.

Blue Cross/Blue Shield Licensees Lead Health Insurers on Local Market Share

Market leaders, according to AMA's competition in health insurance (2024 update).



Created with mapchart.net

Negotiating Power Dynamics Can Vary by Metropolitan Statistical Area

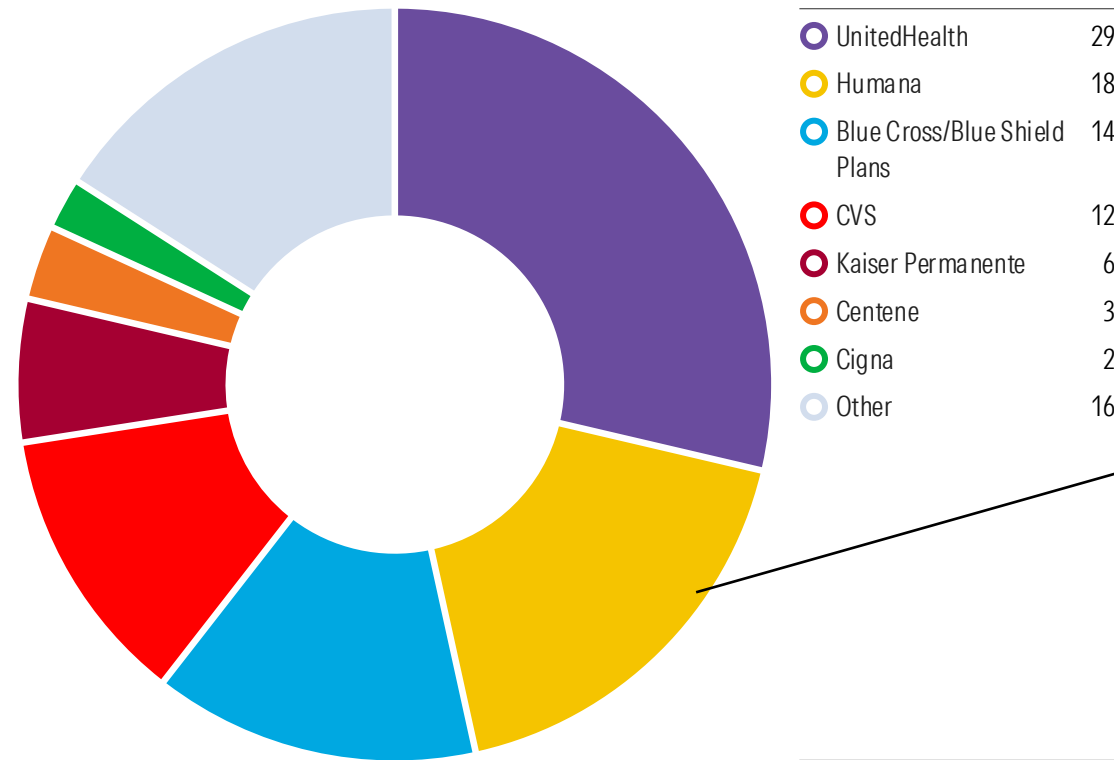
Ohio example.

Metropolitan Area	Insurer 1	Market Share	Insurer 2	Market Share
Akron	Cigna	31%	Medical Mutual	23%
Canton-Massillon	Cigna	31%	Medical Mutual	23%
Cincinnati	Elevance	52%	UnitedHealth	22%
Cleveland-Elyria	Cigna	33%	Medical Mutual	24%
Columbus	Elevance	28%	UnitedHealth	25%
Dayton-Kettering	Elevance	49%	UnitedHealth	20%
Lima	Elevance	36%	Cigna	25%
Mansfield	Cigna	30%	Elevance	30%
Springfield	Elevance	48%	UnitedHealth	18%
Toledo	Cigna	25%	Elevance	23%
Weirton-Steubenville	Highmark	28%	Elevance	20%
Youngstown-Warren-Boardman	Elevance	28%	Cigna	20%
Total Ohio	Elevance	31%	Cigna	22%

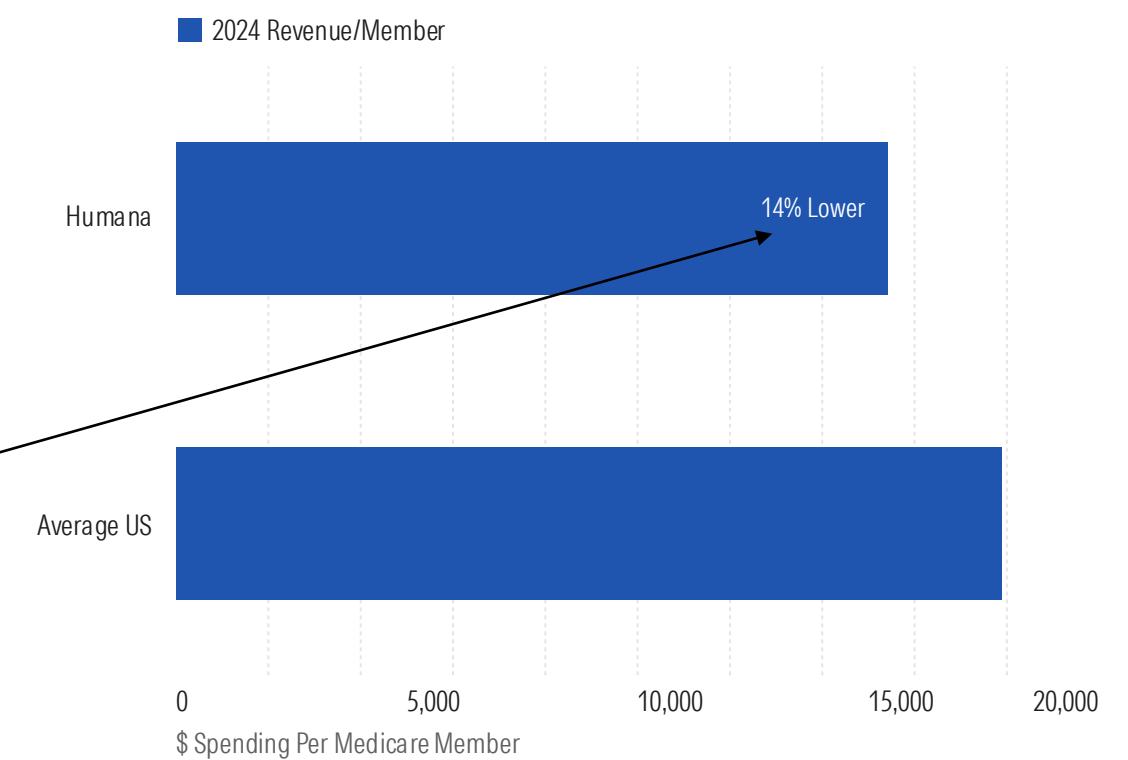
Scale-Related Cost Advantages Can Help MCOs in Other End Markets, Too

Revenue per member represents what users or plan sponsors pay for coverage and points to the MCO's cost structure in each target market, given the regulations on medical loss ratios (85% minimum for large clients; 80% minimum for small clients and individuals.) For example, in Medicare Advantage, or MA, Humana enjoys deep local market share and insures about one out of every three MA members in the states it operates in, helping it provide more benefits and charge significantly less than the average MA plan, as shown on the right.

Humana Enjoys a Top-Tier Position in Medicare Advantage (2024)



Humana Looks Like a Cost-Leader in Medicare Advantage



Source: Morningstar analysis of company reports, KFF data, and Centers for Medicare and Medicaid Services data as of September 2025.

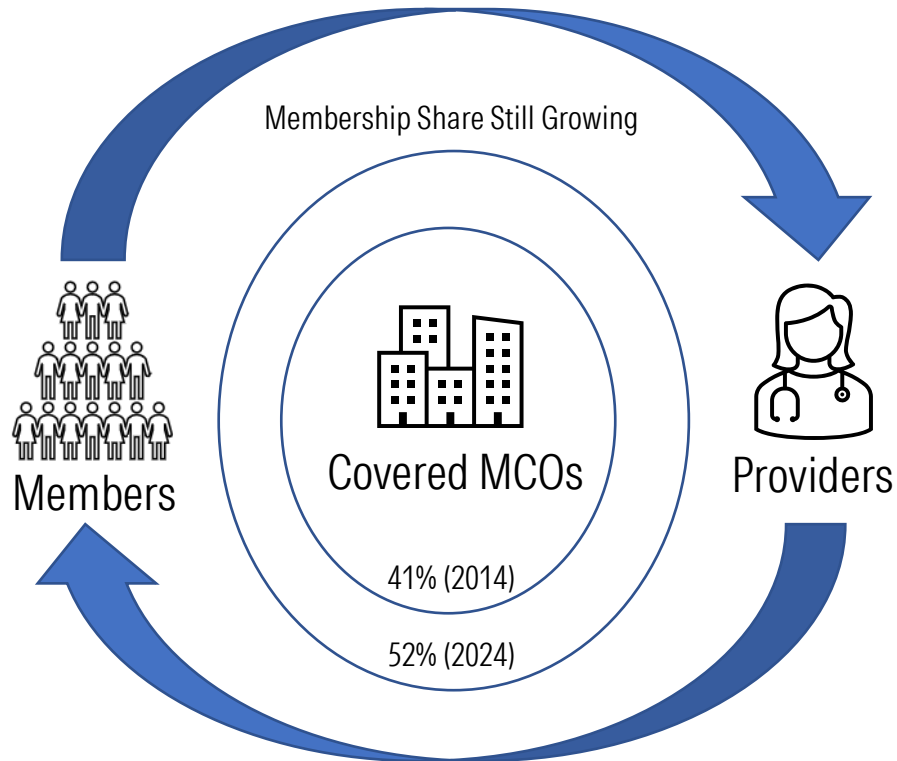
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Network Effects Continue to Help the Big Get Bigger in Medical Insurance and Pharmacy Benefit Management

As an MCO's membership or PBM claim base grows, typically, they can more effectively negotiate with providers on prices for medical services and products and then pass those discounts on to members in the form of even lower prices or better benefits. This two-sided marketplace feeds into each other, creating a virtuous cycle, as members typically want to belong to an MCO with the best provider network at the lowest prices, while providers typically want access to the most potential patients to maximize their income prospects.

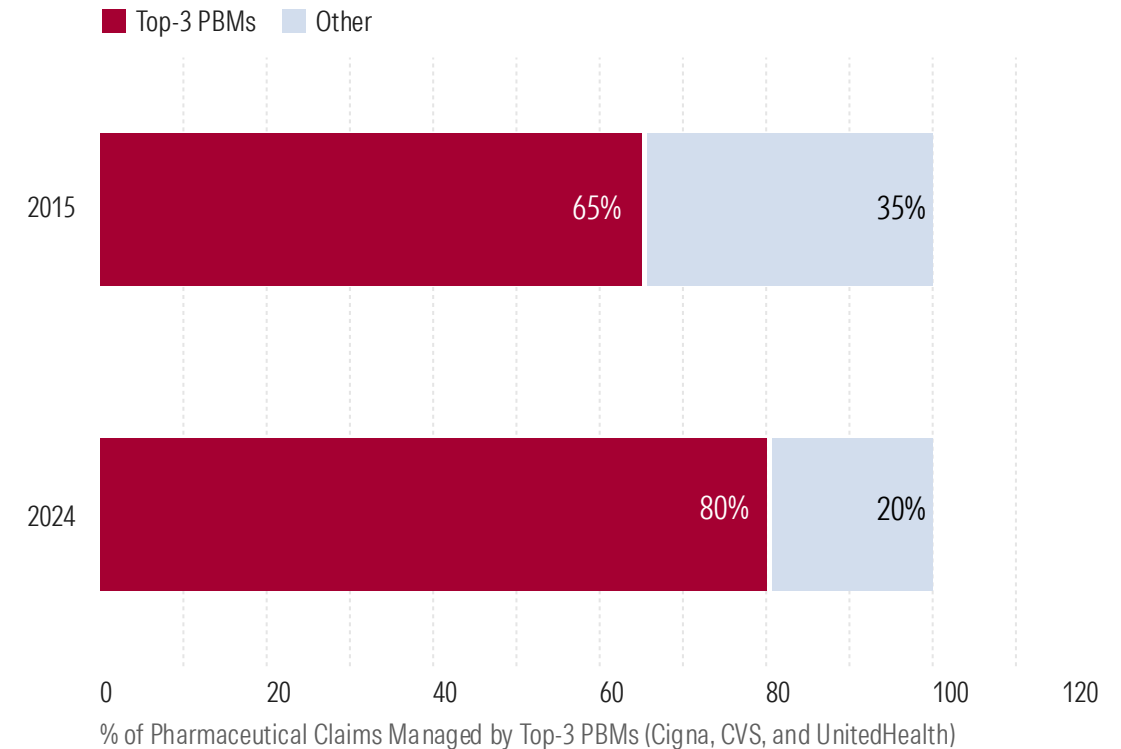
Top Medical Insurers Continue to Gain Membership Share

Medical membership at covered MCOs rose to 52% of the US in 2024 from 41% in 2014.



The Top-3 PBMs Have Been Gaining Claim Share, Too

Pharmaceutical claim share of the Top-3 PBMs grew to 80% in 2024 from 65% in 2015.



Industry Basics

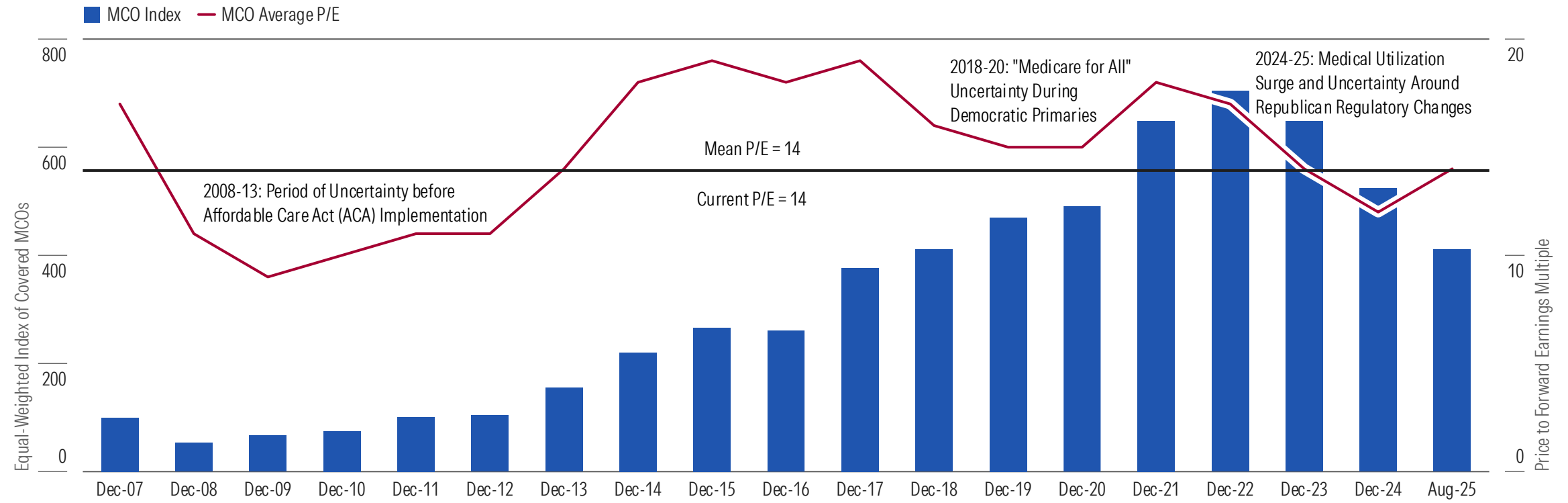
MCOs are expanding by insurance plan type and by related services.

MCO Shares Have Retreated in Recent Years, as Industry Profits Declined and Regulatory Scrutiny Rose

Since the end of 2007, shares of the six MCOs we cover collectively returned 8% on 9% EPS growth compounded annually, but it was a bumpy ride for investors, especially during election cycles when healthcare policy changes were in focus, like they are now. P/E multiples often weaken during major election cycles because of new regulatory scrutiny. Additionally, the current election cycle appears unique because of the industrywide mismatch in rates and medical utilization that has also significantly deflated MCO earnings.

Over the Long Term, the MCOs Produced Solid Shareholder Returns, but Shares Have Declined Since 2022 on Deflated Profits and Elevated Regulatory Scrutiny

An equal-weighted index of covered MCOs returned 8% on adjusted EPS growth of 9%, compounded annually from December 2007 through August 2025.



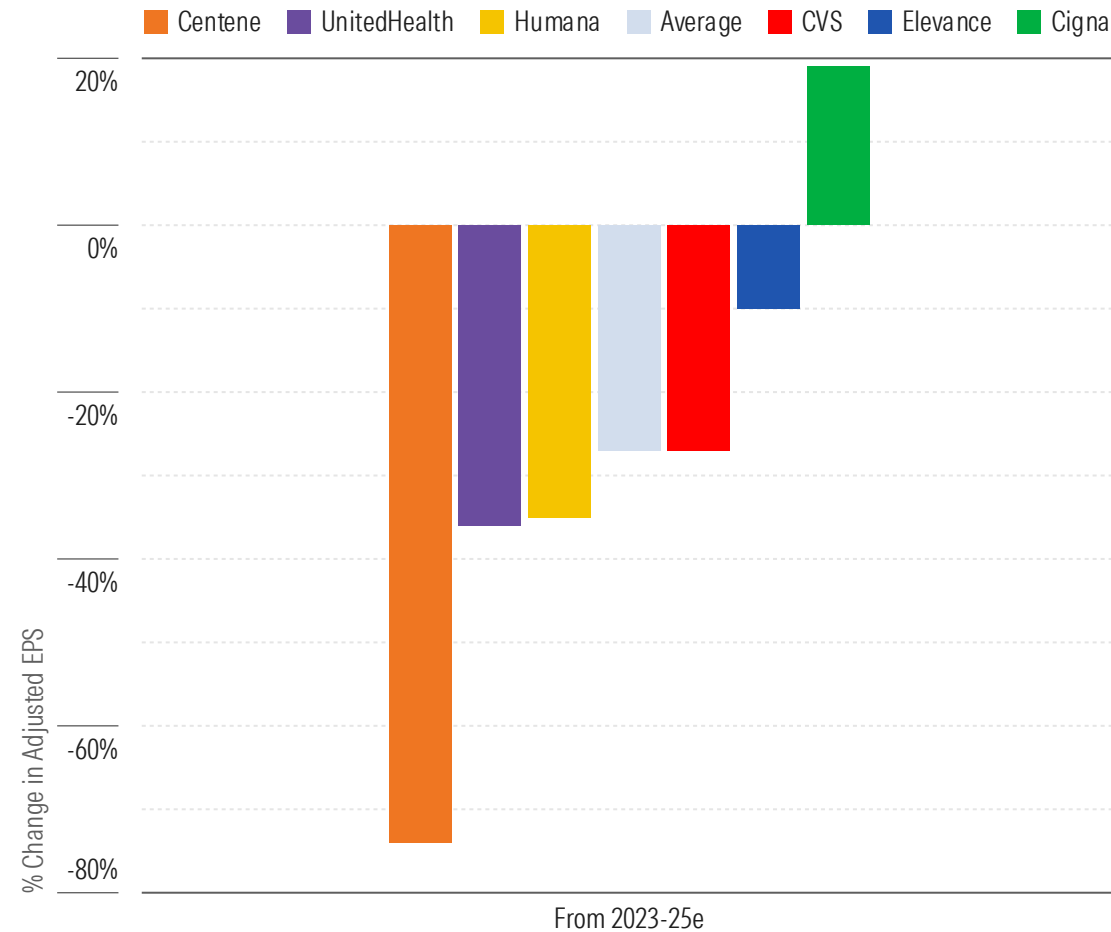
Source: Morningstar analysis and PitchBook. Data as of Aug. 31, 2025.

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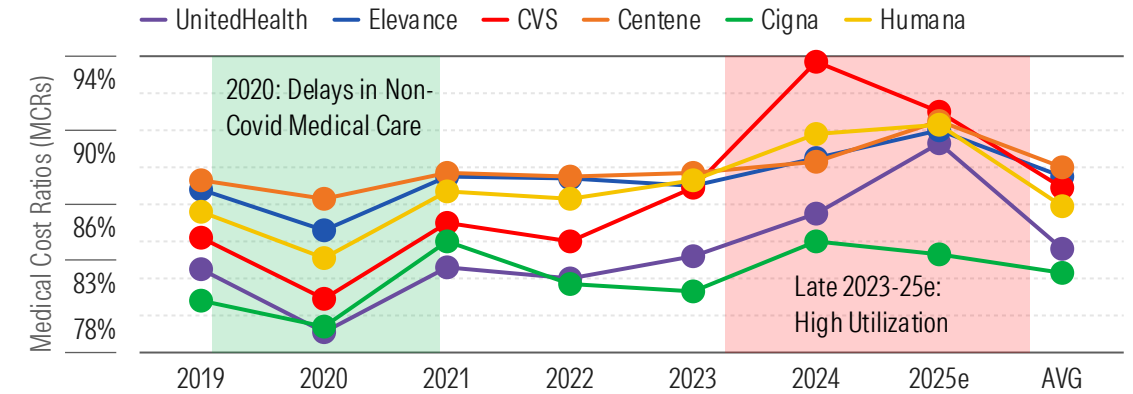
MCO Profits Declined in Recent Years Because of a Big Mismatch in Rates and Medical Utilization

MCO Profits Have Declined 27% on Average Since 2023, With Only Cigna Growing

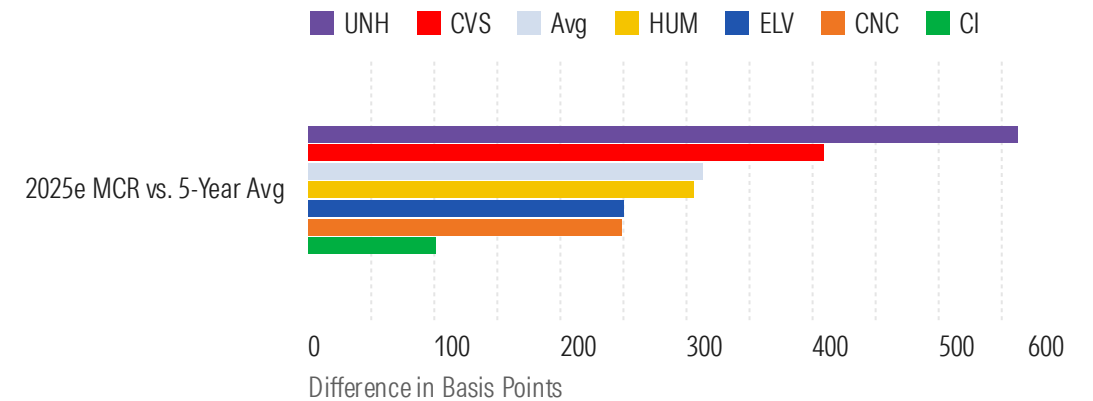
Total change in adjusted EPS from 2023-25e.



Medical Cost Ratios (MCRs) Have Risen on Surging Medical Utilization



Average MCR Expected To Be >300 Basis Points Higher in 2025 Than in Past 5 Years

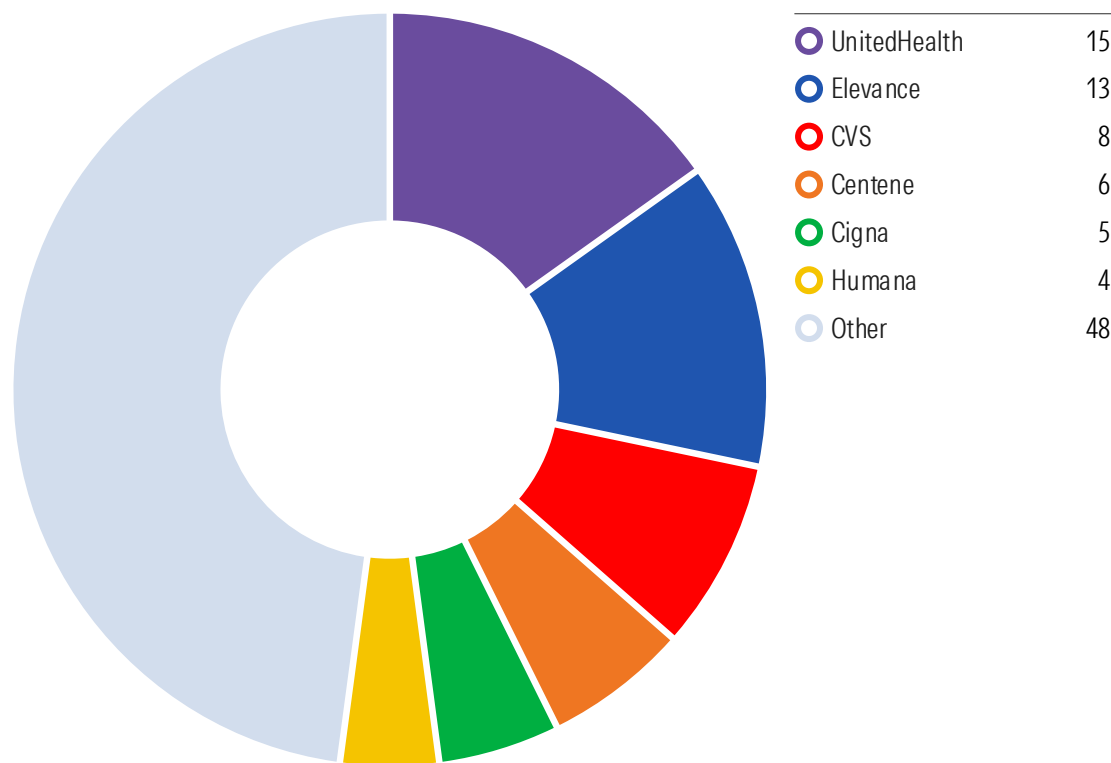


Medical Insurance Market Share and Membership Concentration Varies by MCO

At the end of 2024, the six MCOs we cover insured 52% of the US population. UnitedHealth and Elevance both covered a midteens percentage of the population, followed by CVS, Centene, Cigna, and Humana. Sorted by the overall membership size in the right exhibit, UnitedHealth, Elevance, CVS, and Cigna operate with more exposure to employer plans while Centene (mostly Medicaid) and Humana (mostly Medicare) operate with more government plan exposure, although all MCOs serve multiple end markets.

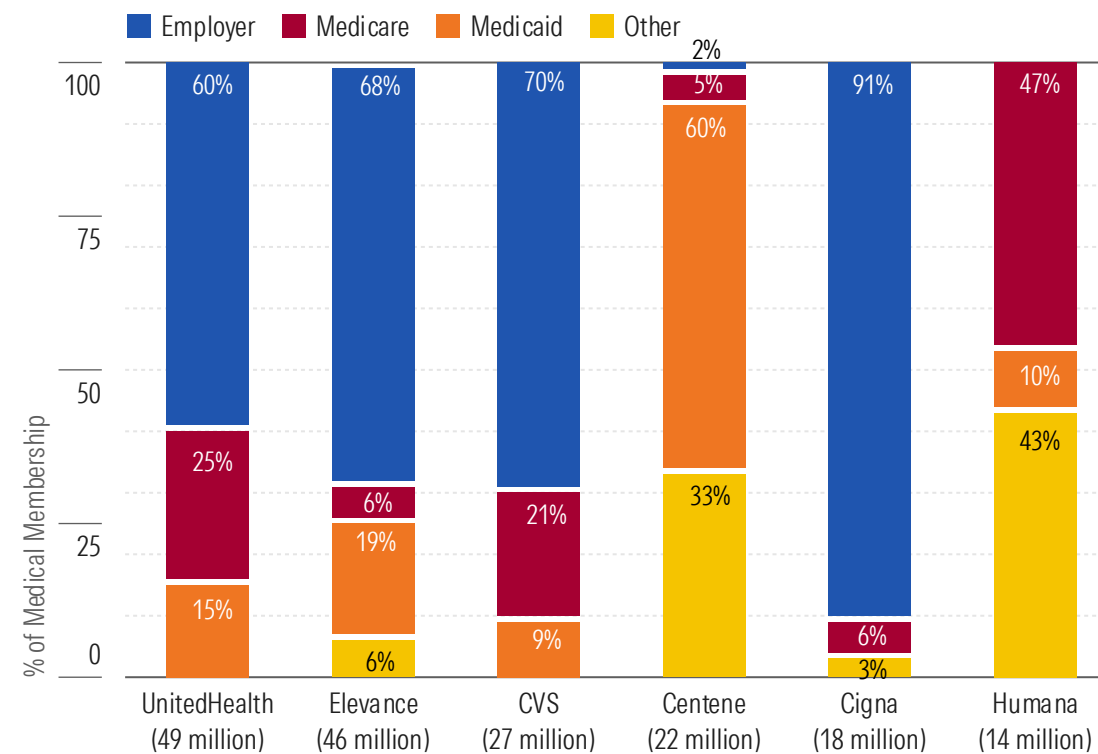
Covered MCOs Insure Over Half of the US Population

As a percentage of US population.



Medical Membership Concentration of MCO Leaders

Sorted by membership size.



Source: Morningstar analysis of company report and US Census Bureau data as of December 2024.

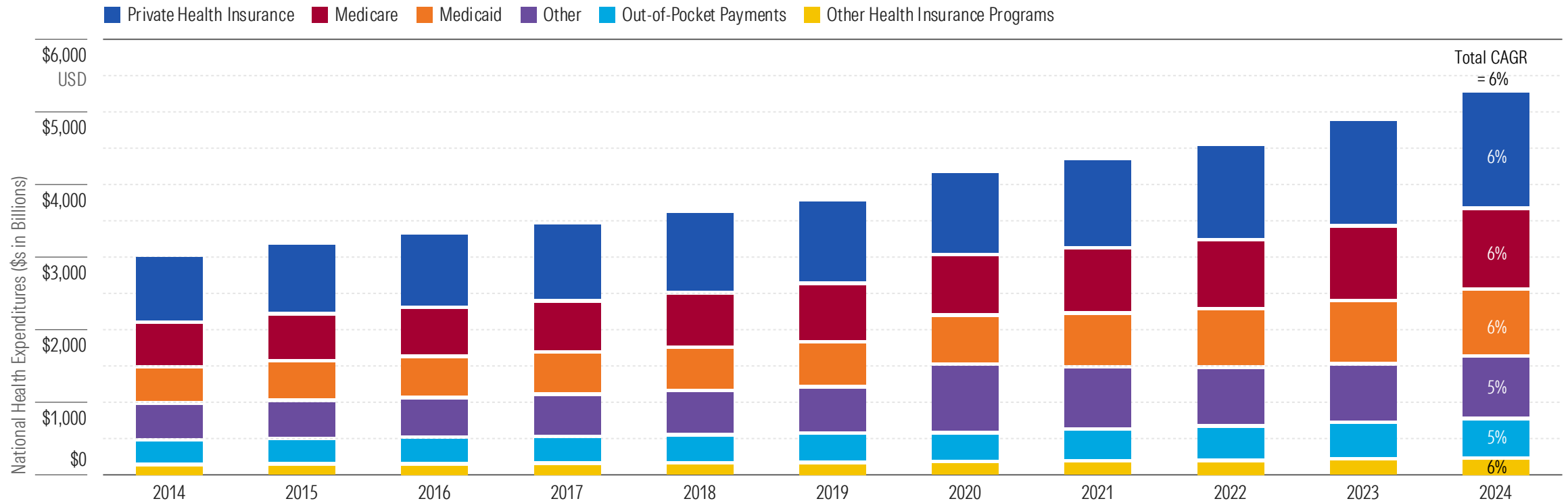
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US Healthcare Spending Grew 6% Compounded Annually Over the Past Decade

After the Affordable Care Act's, or ACA's, implementation in 2014, US healthcare spending grew 6% compounded annually through 2024. This growth was roughly balanced by plan type, as shown below. Also, despite initial uncertainty around the ACA, additional coverage through Medicaid (managed mostly by the MCOs) and the individual exchanges (fully managed by MCOs) helped the industry grow.

US Healthcare Spending Has Grown 6% Compounded Annually Since the Affordable Care Act's Implementation in 2014

\$s in billions.

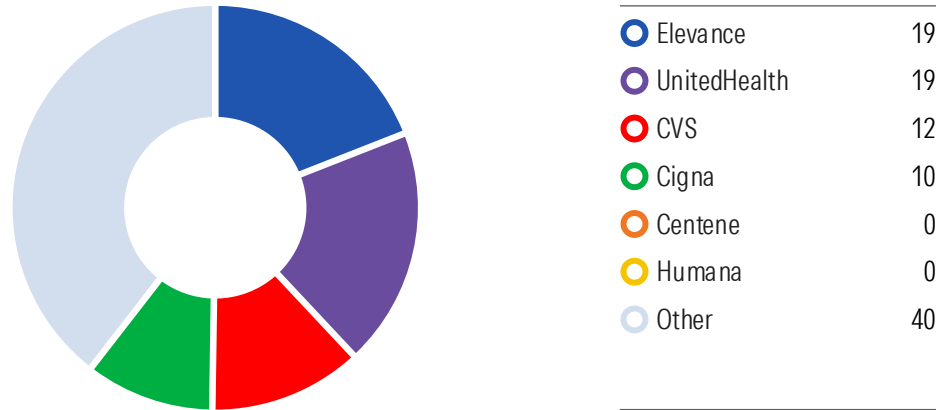


Source: Morningstar analysis of Centers for Medicare & Medicaid Services, Office of the Actuary data as of September 2025.
CAGR = Compound Annual Growth Rate.

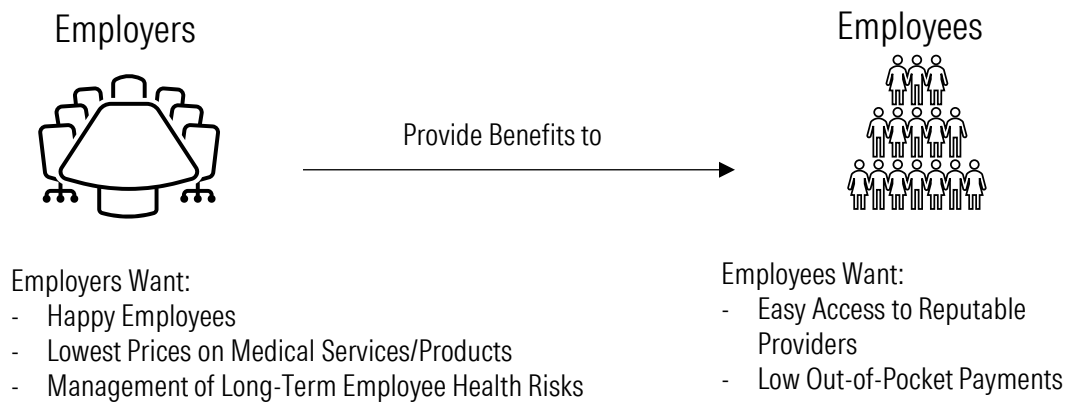
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Employers Cover the Most Americans by Medical Insurance Plan Type but Appear Largely Tapped Out

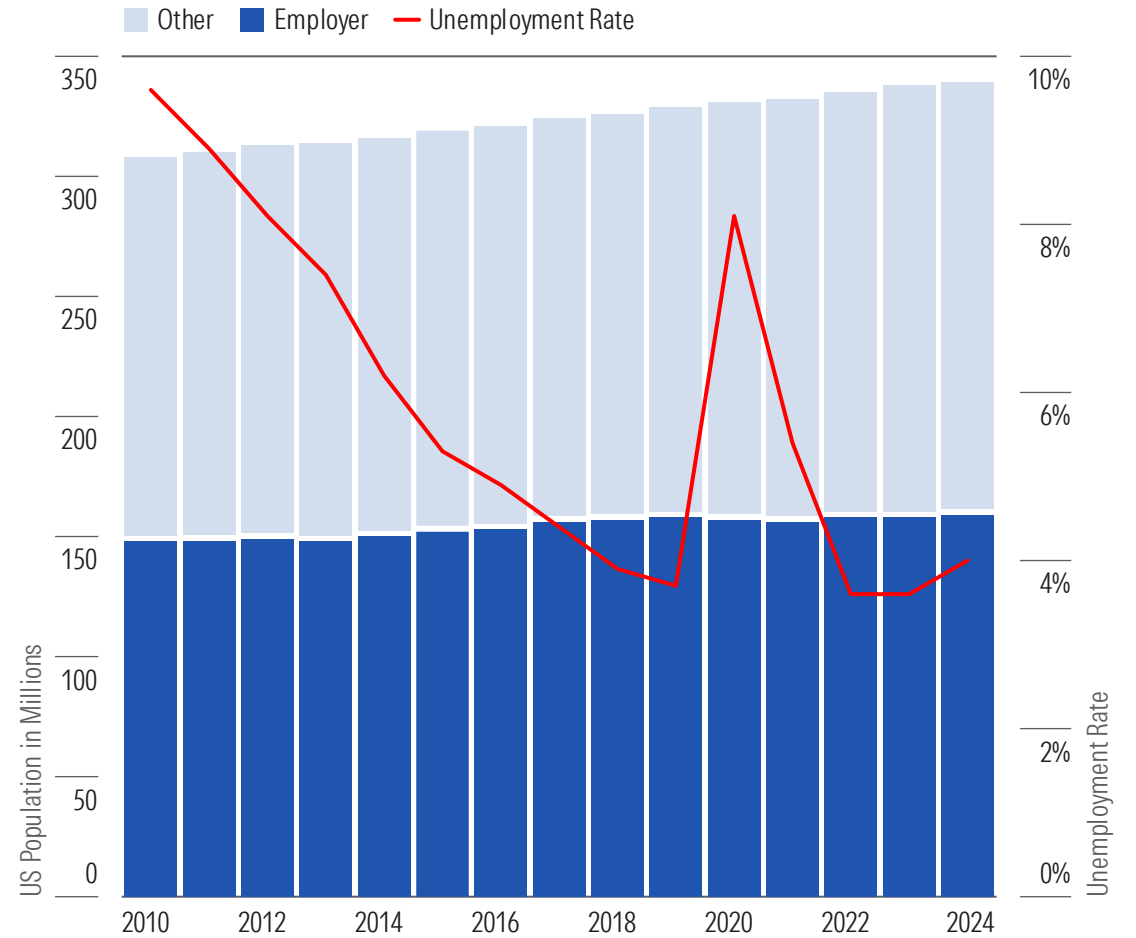
Elevance Leads Employer Plans Due to Scale Advantages in Its 14 BC/BS States



Lowest Cost Typically Wins in the Price-Sensitive Employer Market



Employer Plans Plateau, Even as Unemployment Rates Stay Near Historic Lows



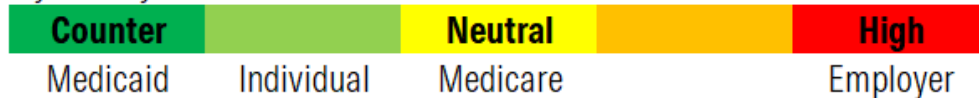
Medical Insurer's Mild Cyclicity Continues to Decline, as Membership Shifts Away From Employer Plans

The Global Financial Crisis Only Mildly Pressured Insurer Membership and Profits

		Recession			
% Growth	2007	2008	2009	2010	2011
U.S. GDP	2%	0%	-3%	3%	2%
Big-Six MCO Cumulative Growth:					
Medical Members	4%	5%	-1%	1%	3%
Gross Revenue	27%	8%	8%	2%	12%
Operating Profit	29%	-12%	13%	6%	5%

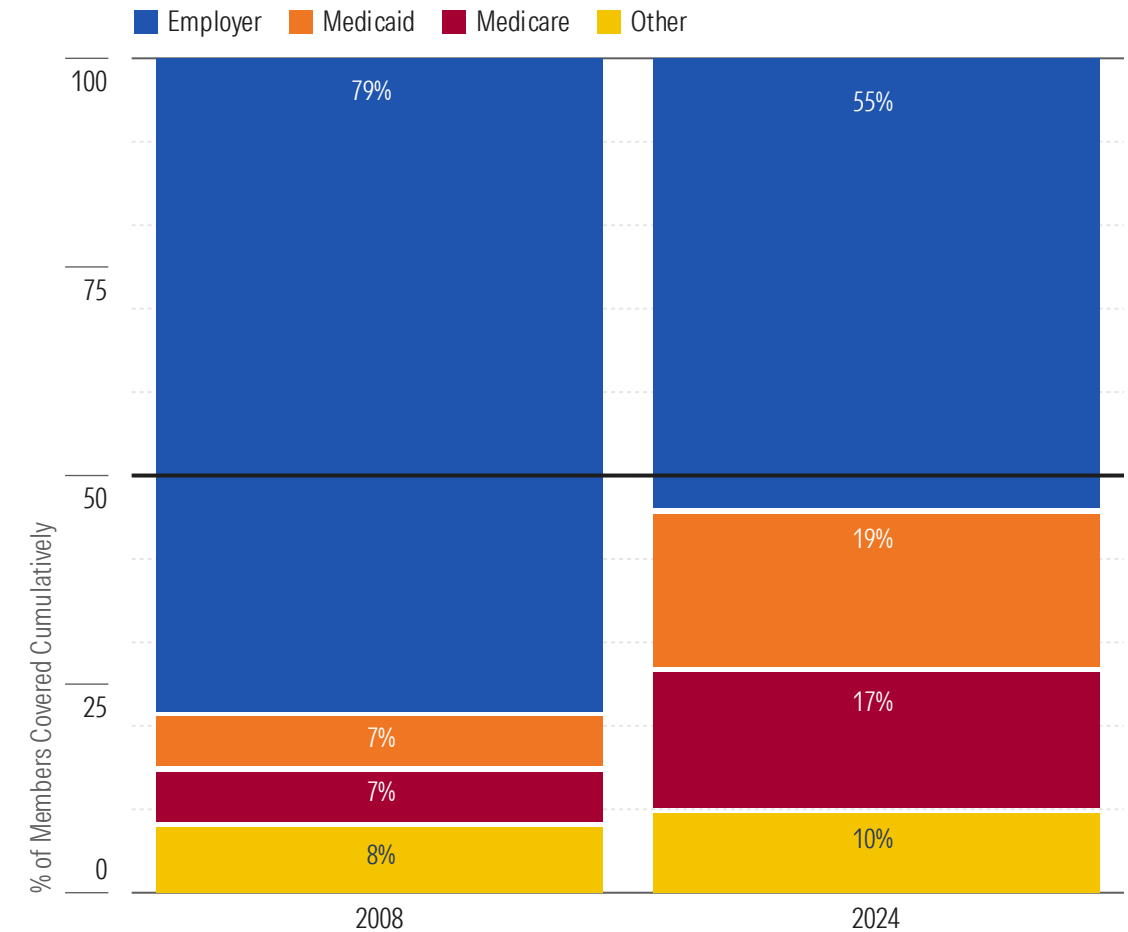
Employer Plans Experience More Cyclicity Than Government-Sponsored Plans

Cyclicity of Insurance Plans



Exposure to Cyclical Employer Plans Has Also Declined Substantially Since 2008

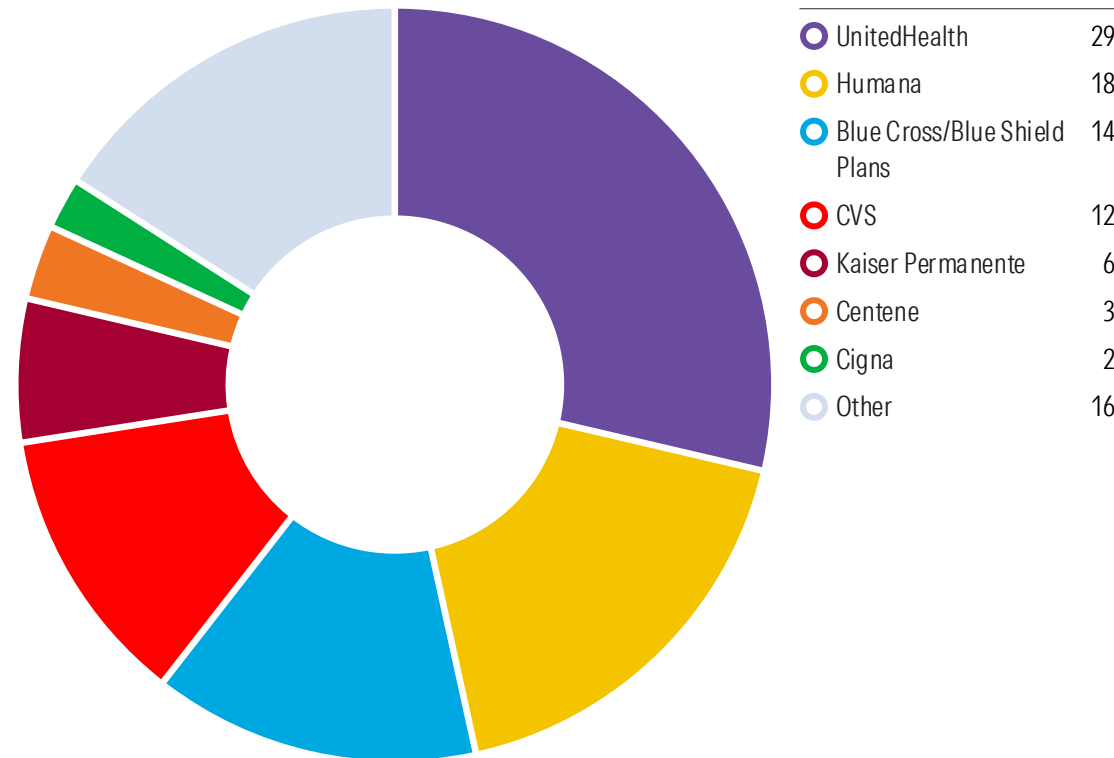
Cumulative medical membership concentration at covered MCOs.



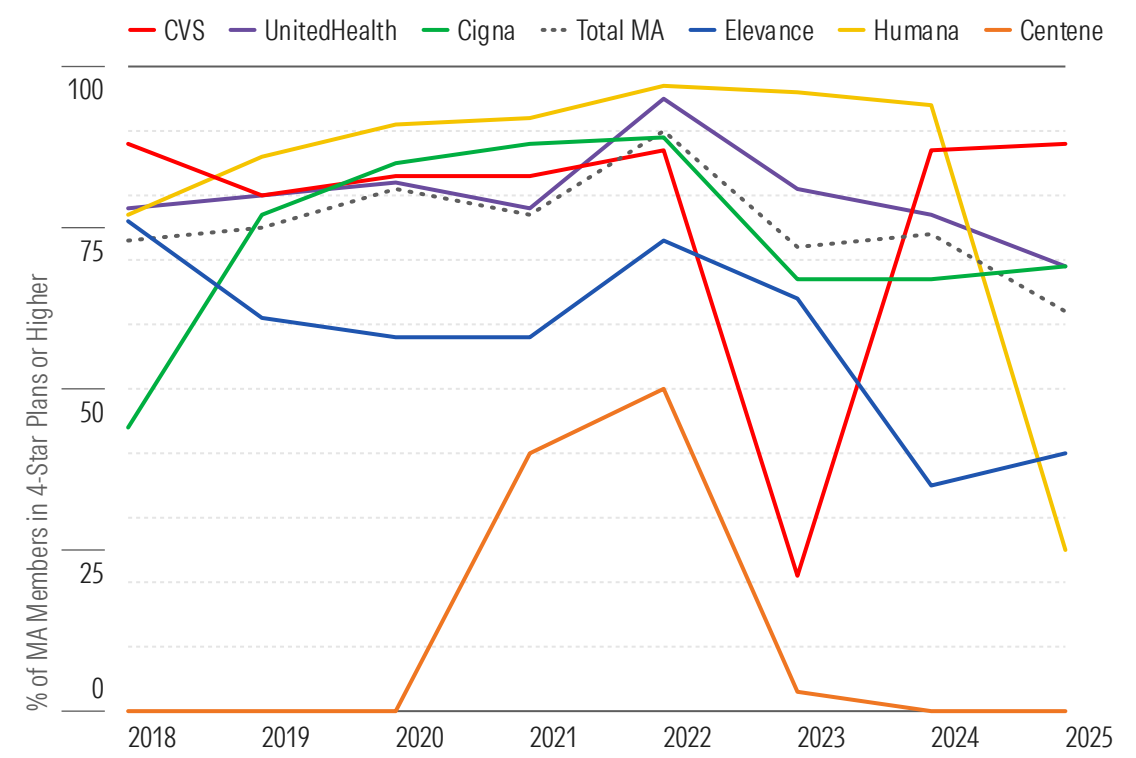
Medicare Advantage's Leaders Typically Shine in Star Ratings, Although CVS and Humana's Have Been Volatile

For senior citizens, private insurers offer Medicare Advantage, or MA, plans and supportive plans for traditional Medicare, although the latter is much less important to insurer profits than MA. End users directly choose their Medicare plans each year, and UnitedHealth, Humana, and CVS stand out as MA leaders. This leadership relates to their high-quality plans that are typically recognized by regulators with above-average MA star ratings (below right), although ratings at Humana and CVS have been especially volatile in recent years.

Medicare Advantage Market Led by UnitedHealth and Humana



MA Plan Quality Highlighted in Star Ratings

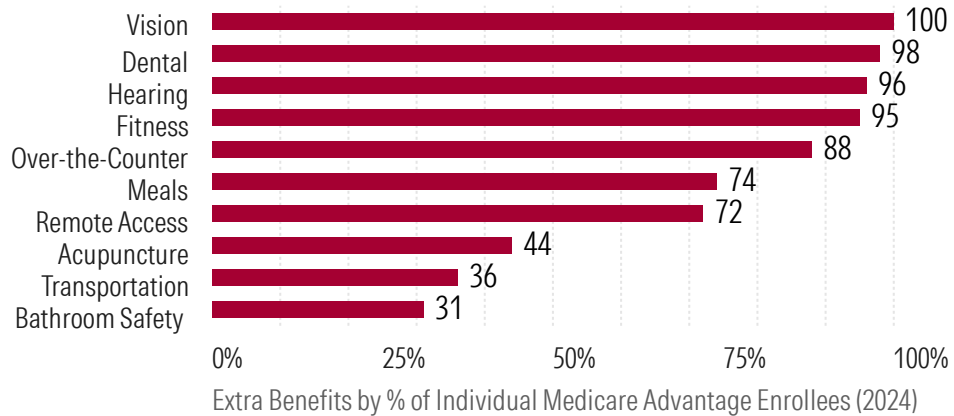


Source: Morningstar analysis of company report, CMS and KFF data as of September 2025.

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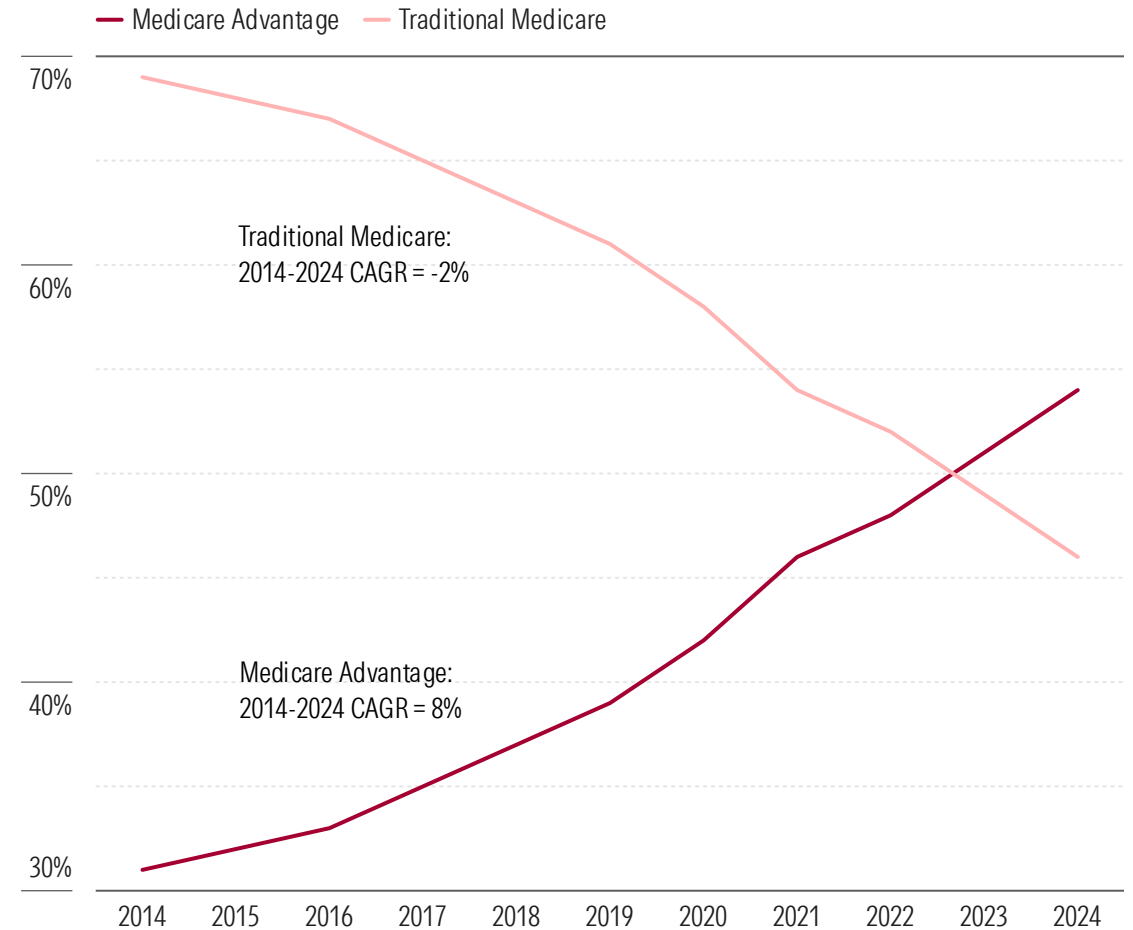
Medicare Advantage's Extra Benefits Have Contributed to Its Increasing Popularity Over Traditional Medicare

Medicare Advantage Plans Offer Seniors Extra Benefits Worth Around \$2,150/Year



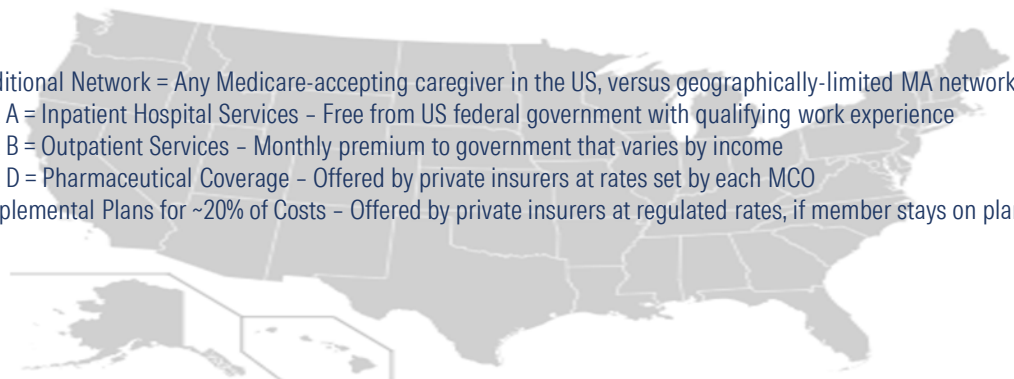
US Seniors Have Increasingly Chosen MA for Extra Benefits and Lower Initial Costs

% of Medicare population.



Traditional Medicare: MCOs Offer Pharma and Supplemental Coverage, Too

Traditional Network = Any Medicare-accepting caregiver in the US, versus geographically-limited MA networks
 Part A = Inpatient Hospital Services - Free from US federal government with qualifying work experience
 Part B = Outpatient Services - Monthly premium to government that varies by income
 Part D = Pharmaceutical Coverage - Offered by private insurers at rates set by each MCO
 Supplemental Plans for ~20% of Costs - Offered by private insurers at regulated rates, if member stays on plan



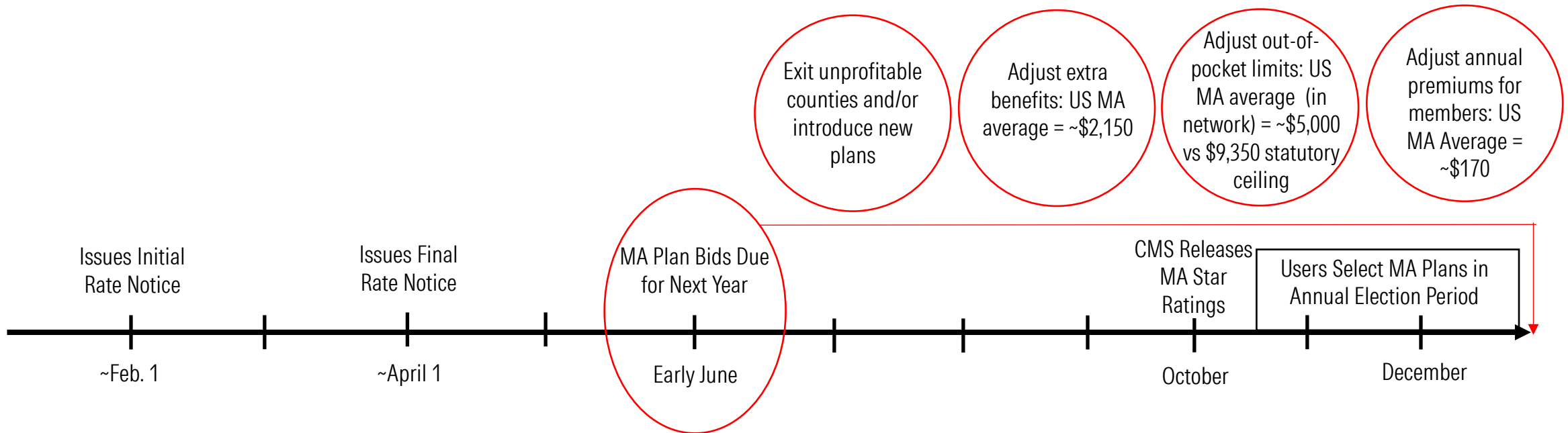
Medicare Advantage Fortunes Can Rise and Fall as the Annual MA Event Calendar Unfolds

Every year, the prospects of Medicare Advantage insurers can change through a series of events—from MA reimbursement rate notices early in the year to the release of MA star ratings that measure quality in the fall, and to the annual election period late in the year, in which most seniors select their plans. One of the most important events in the MA calendar is the June bidding process, in which MA insurers can change a variety of plan features such as those circled in red below, greatly influencing MA plan profitability for the next year.

Major Events That Can Affect Medicare Advantage Insurer Profits Each Year

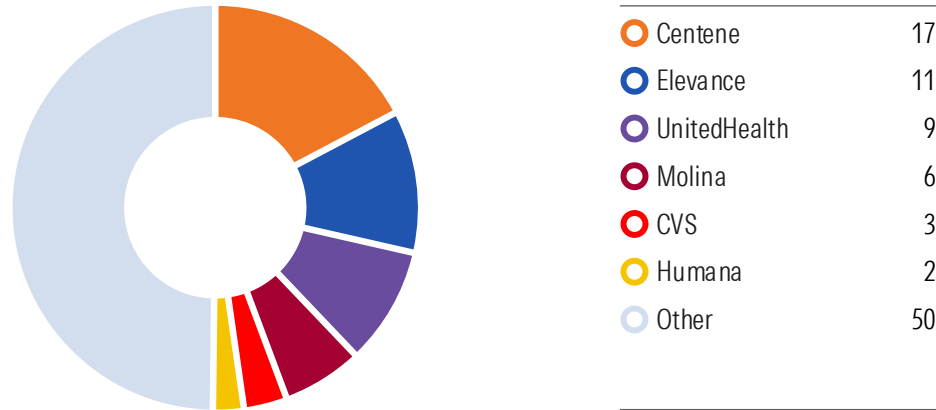
MCO Levers to Adjust MA Plan Design and Profits

Cost threshold, or increases to members, is typically limited to about 3%/year.

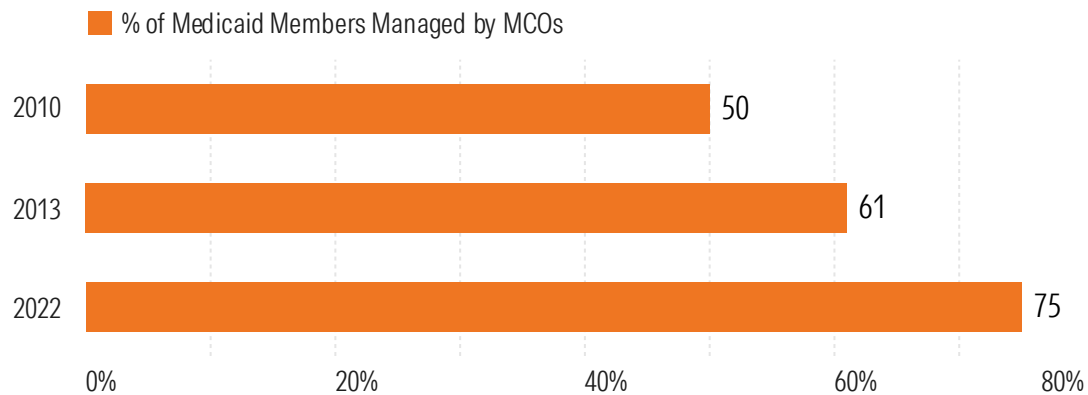


Medicaid States Outsource Risks to MCOs to Save Money and Limit Intra-Year Budget Fluctuations

Centene Leads the Medicaid Market by Membership Share in 2024



States Continue to Outsource More Medicaid Enrollees to MCOs



Long Contracts and Government Stakeholders Make Medicaid Market Unique

Federal Government:

- Sets basic Medicaid plan and funding standards, but it also issues waivers to states to deviate from those standards, if necessary.
- Funds 50%-83% of a state or territory's Medicaid expenditures, depending on its per capita income ranking.

End Users:

- Low-income individuals, including up to 138% of the federal poverty level in 41 Medicaid expansion states, including DC.
- Seek a plan with the best provider network, benefits, and reputation.

Medicaid Stakeholders

States/Territories:

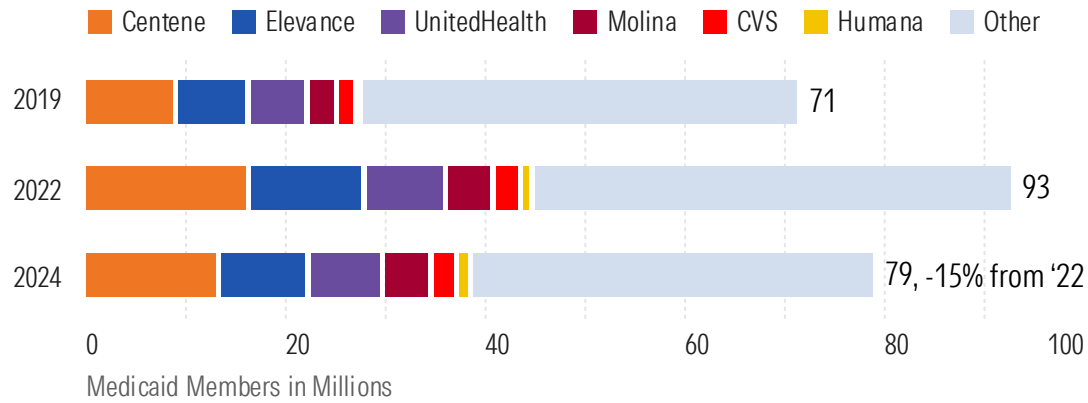
- Independently administer Medicaid programs, including setting up MCO contracts as desired.
- Seek MCOs with the best provider networks and programs to manage the costs in the Medicaid population.
- Fund 17%-50% balance of Medicaid budget that federal government does not provide.

MCOs:

- Manage risks of Medicaid populations to reduce magnitude and variability of annual budgeted costs for their state partners.
- Receive contracts with limited competition in each geographic region that typically last from three to five years initially, with the potential for renewals and new contract wins to extend those relationships.

Eligibility Redeterminations Reduced Medicaid Enrollment, as Utilization Rose and Rates Struggled to Keep Pace

Eligibility Redeterminations Reduced Medicaid Population After the Pandemic



Public Health Emergency (March 2020-April 2023): To maximize health coverage during the pandemic, the federal government mandated that states would not receive federal funding for their respective Medicaid programs if they performed eligibility redeterminations. All states complied, and Medicaid membership ballooned, with existing enrollees enjoying this free healthcare coverage, whether or not they were eligible.

Resumed Eligibility Redeterminations (April 2023-December 2024): That federal mandate expired at the end of the public health emergency in April 2023. Since then, states resumed eligibility redeterminations to see if Medicaid members still qualify for this low-income program. With many members now ineligible, about 15% were pushed off Medicaid from the end of 2022 to the end of 2024, or toward prepandemic levels. However, with increased outsourcing by states to the MCOs and new contract wins, the highlighted MCOs gained Medicaid membership and market share from 2019 to 2024, despite recent redetermination activities.

Mismatched Rates and Utilization Are Constraining MCO Profits

Rising Medical Utilization

+ Lagging Rate Decisions
by State Partners

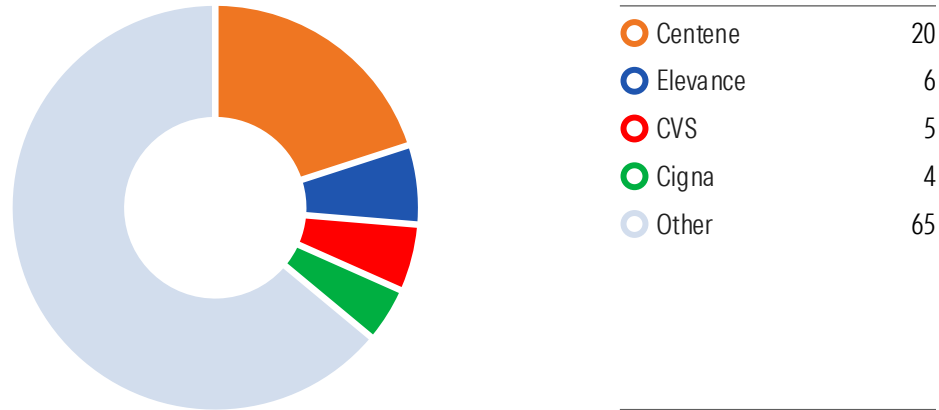
= Profit Pressures
on Medicaid MCOs

Started in 2024 → Through 2026?

Mismatched Rates/Utilization (Through 2026?): Also, Medicaid MCO margins have contracted since mid-2024, when medical utilization started to surge in the Medicaid population and rates received from state partners struggled to keep up with that inflation. This mismatch in rates and utilization has been hurting profits, and MCOs now expect this mismatch will bleed into 2026 or right before potential reductions in Medicaid membership in 2027 due to the One Big Beautiful Bill Act, or OBBBA.

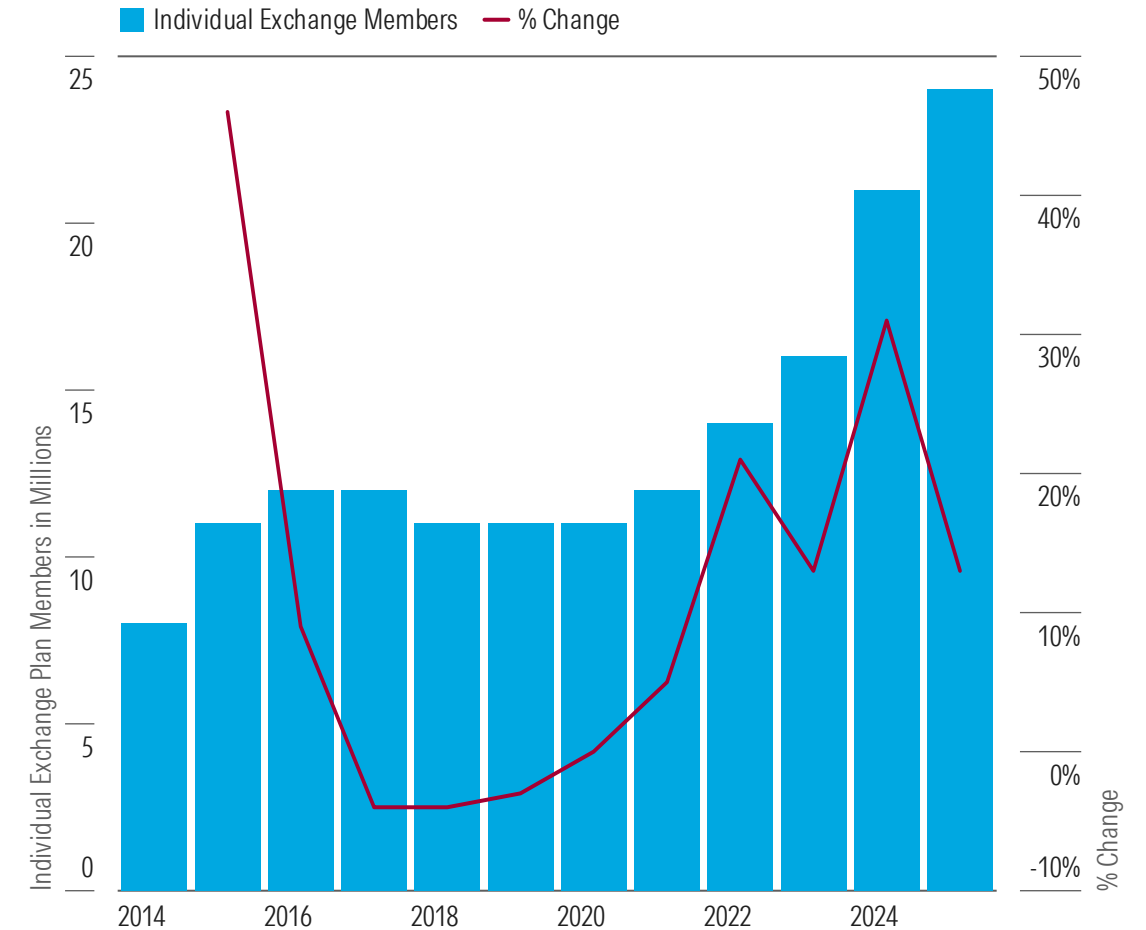
Individual Exchanges Provide Another Safety Net for Individuals, but a Subsidy Cliff Looms Beyond 2025

Individual Exchange Market Share by MCO as a % of Members (2024)



Recent Individual Plan Growth May Reverse if Affordability Initiatives Expire

Expiring subsidies after 2025 threaten ~5 million individual plan members (~20%).



The ACA Exchanges Provide a Safety Net for Individuals

Typical End Users:

- People who do not qualify for Medicare (>65) or Medicaid (low income)
- Seasonal workers when employed
- Employees of businesses that do not offer health benefits



Insurers Compete on:

- Price
- Provider network
- Benefits offered above and beyond essential requirements
- Plan reputation

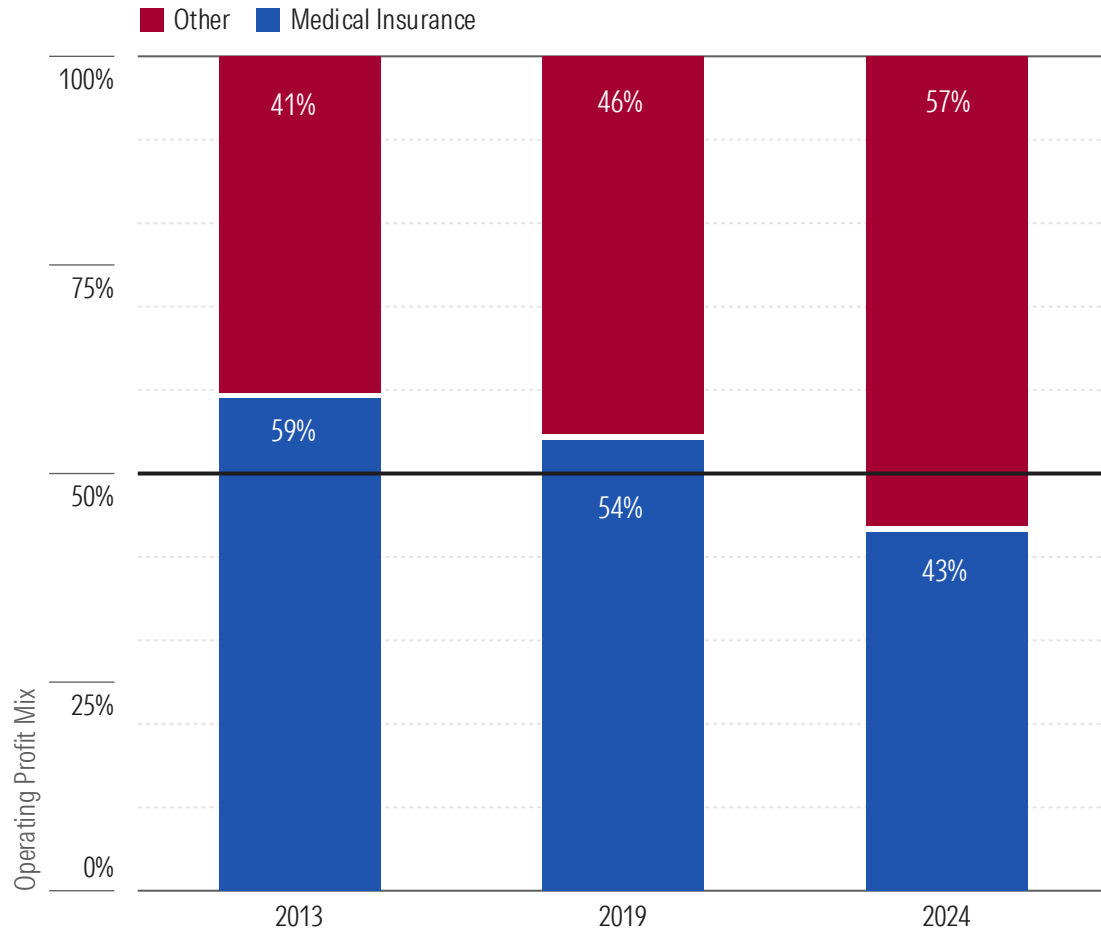
Individual Exchanges = Safety Net

Created by the Affordable Care Act

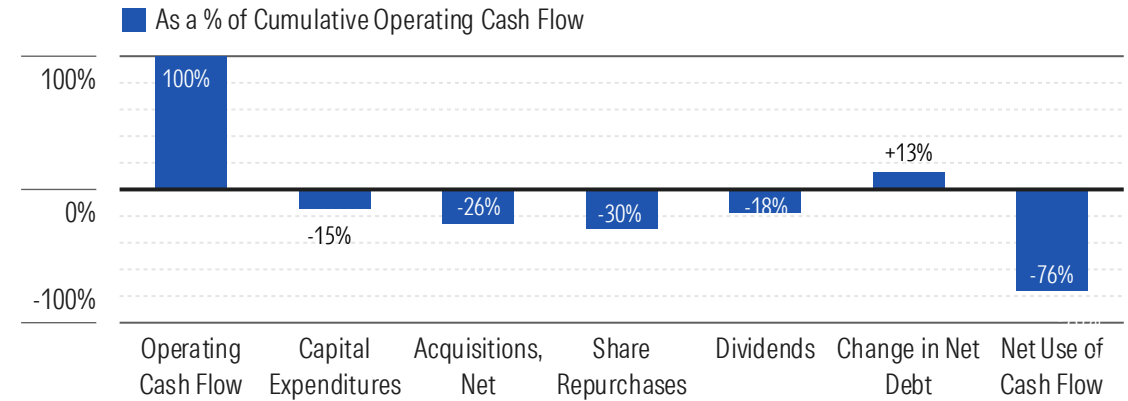
After the ACA, the MCOs Have Been Expanding Beyond Medical Insurance, Organically and Through M&A

The MCOs Have Expanded in Related Fields, Like PBM and Caregiving Services

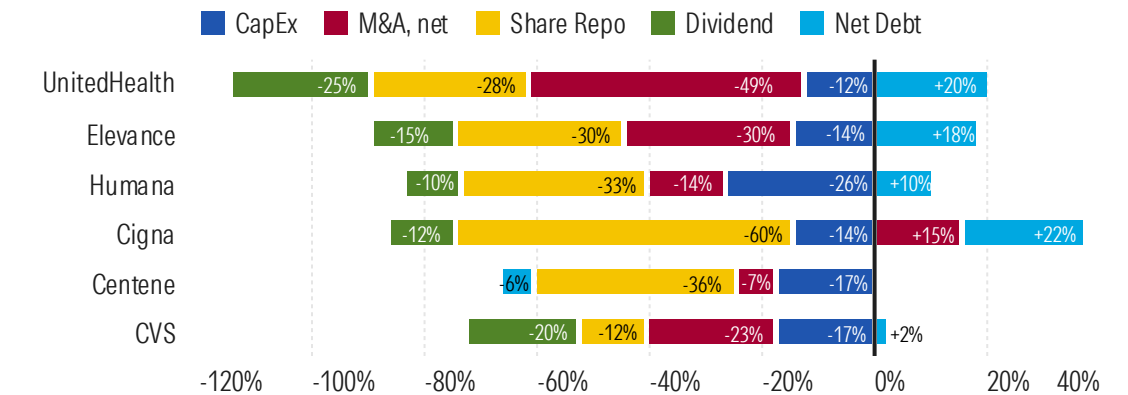
Cumulative operating profit mix at covered MCOs.



MCOs Typically Invest More Through Acquisitions Than Capital Spending to Grow



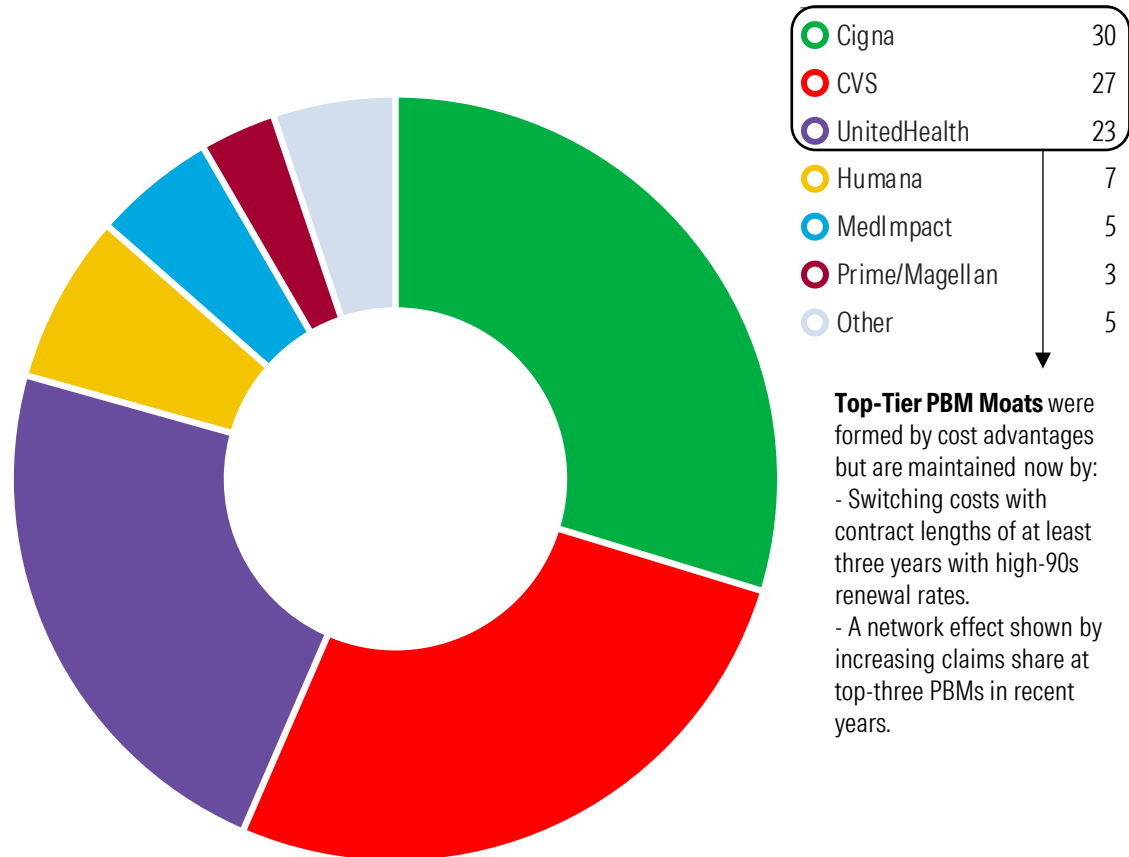
However, Capital Allocation Activities Vary by Company (2020-24)



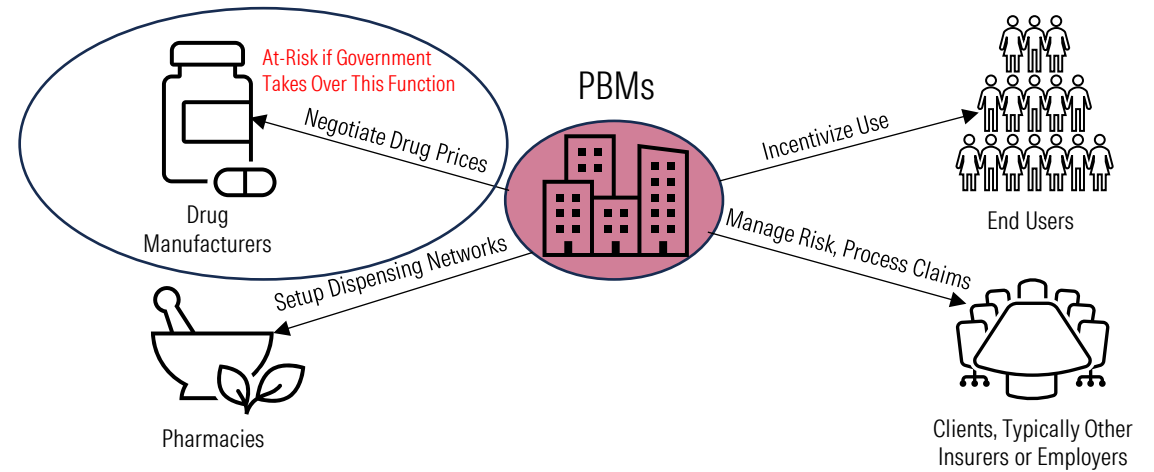
Top Pharmacy Benefit Managers Help Clients Manage Biopharmaceutical-Related Risks

Cigna, CVS, and UnitedHealth Dominate the PBM Market

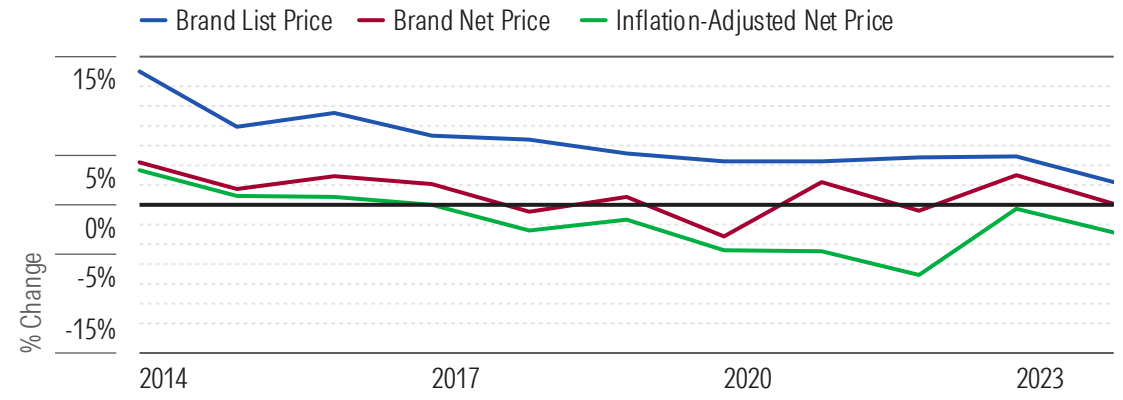
Market share by % of claims managed (2024).



PBMs Manage Risks for Clients in the Drug Supply Chain



PBMs Helped Keep Inflation-Adjusted Drug Price Growth Below 0% From 2018-24



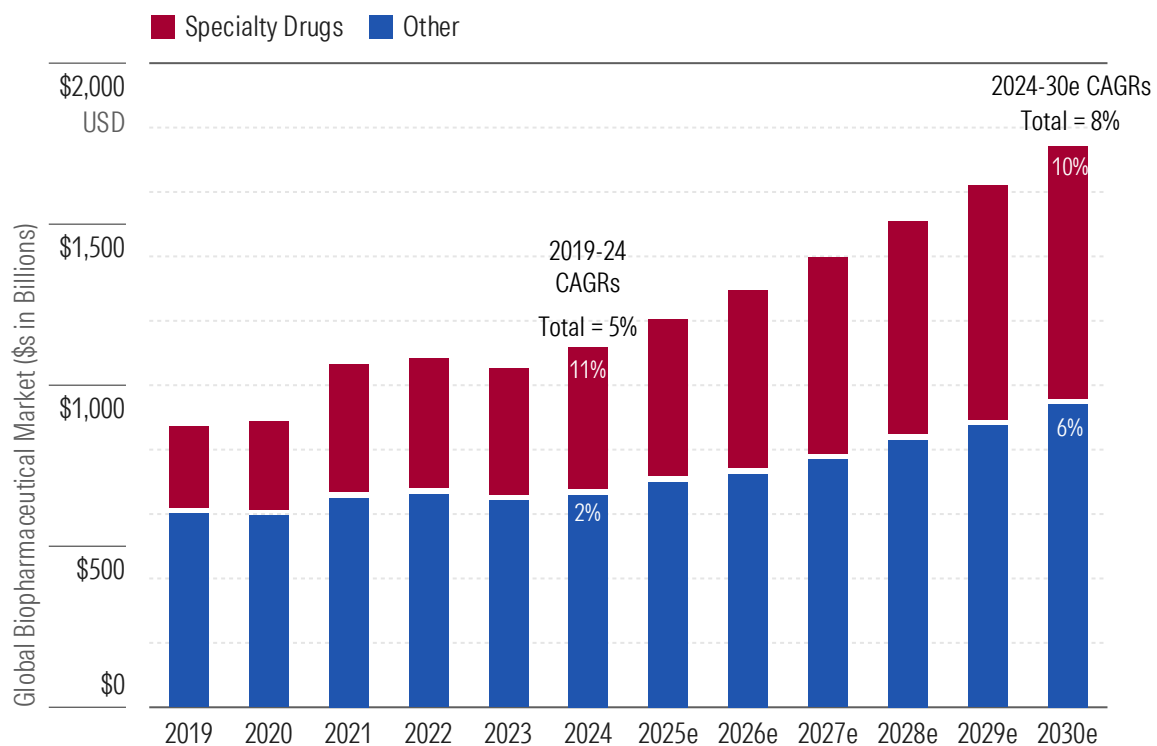
PBM Market Share

PBMs Also Target the Large, Fast-Growing Specialty Drug Market, Which Combines PBM and Caregiving Services

In the specialty drug market, pharmacy benefit managers provide traditional services like incentivizing appropriate drug use while also providing caregiving services, such as infusions to patients. With significant growth expected in branded large molecules and biosimilars, PBMs should benefit from the relatively high growth expected in the specialty drug market through 2030. CVS, Cigna, and UnitedHealth lead the US market, but emerging PBMs like Elevance are also acquiring assets in this market.

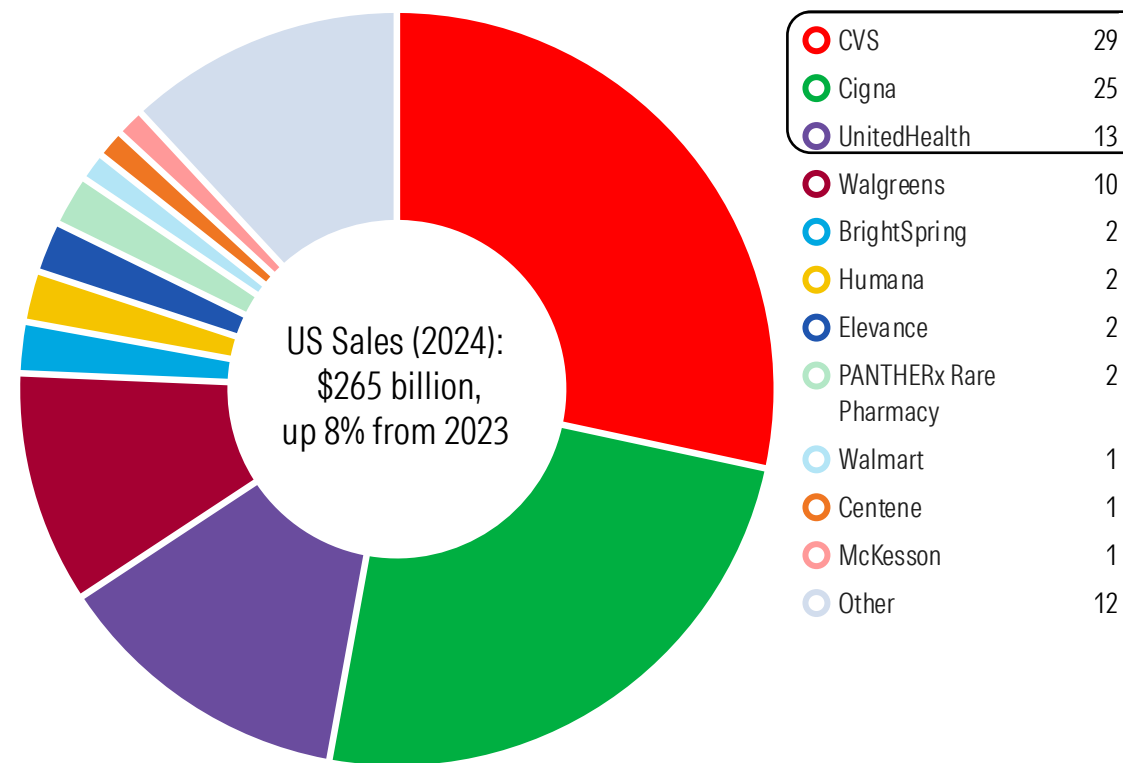
Specialty Drugs Are Growing at a Fast Pace

Worldwide prescription drug market forecast.



Major PBMs Lead US Specialty Drug Market

2024 market share as a % of US specialty drug revenue.



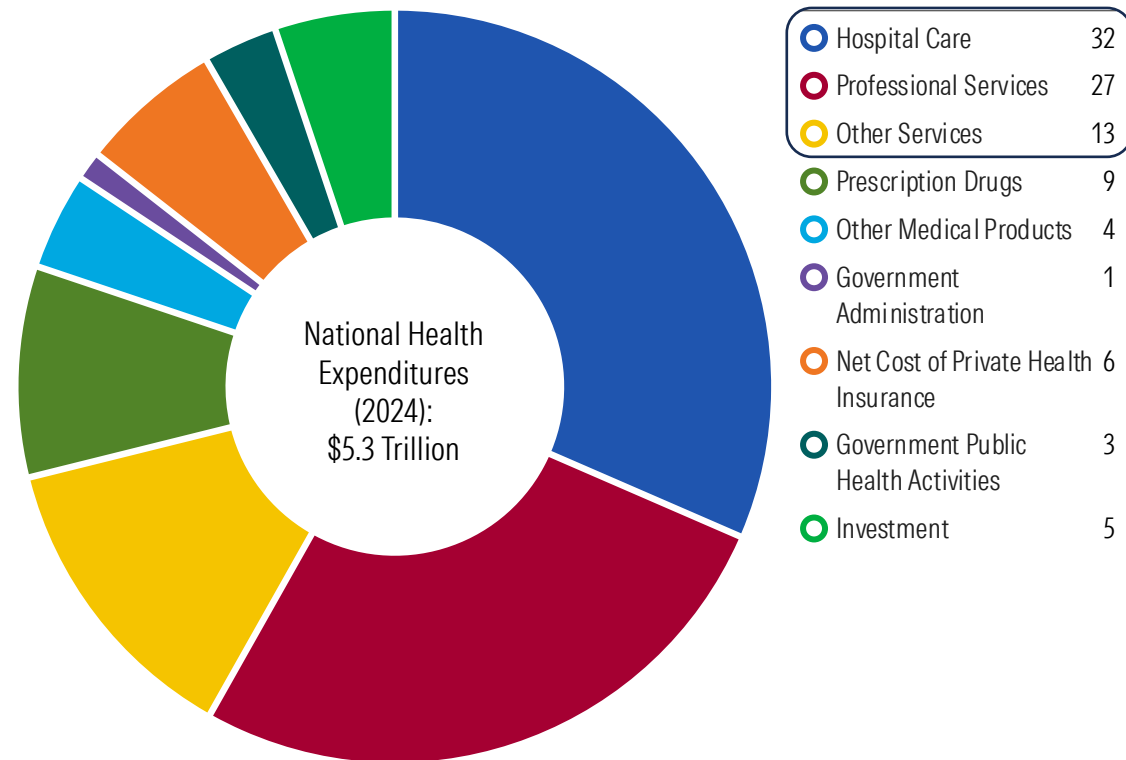
Sources: Morningstar analysis of EvaluatePharma estimates as of July 2024, and Drug Channels Institute estimates as of April 2025.

See Important Disclosures at the end of this report.

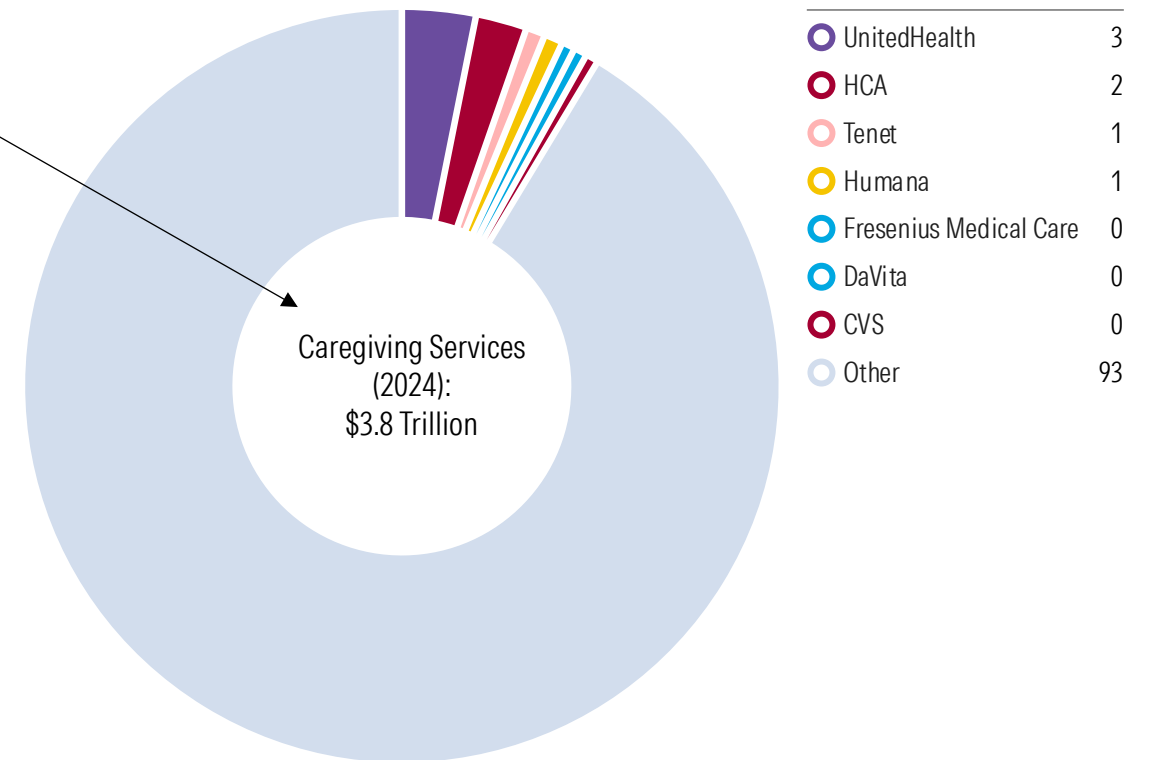
Caregiving Services Remain the Largest and Most Fragmented End Market Targeted by the MCOs

Providing care directly to patients remains a highly fragmented business served by many caregivers, including hospitals, primary-care physicians, home healthcare providers, and outpatient clinics. The seven US service providers that we cover only account for about 7% of the US market, cumulatively. While this high fragmentation suggests further consolidation is possible by the MCOs, consolidation appears to have slowed, as regulators have been investigating combined insurers and caregivers on antitrust concerns.

Caregiving Services Represent Over 70% of National Health Expenditures



The Provider Market Remains Highly Fragmented and Locally Focused



Outlook

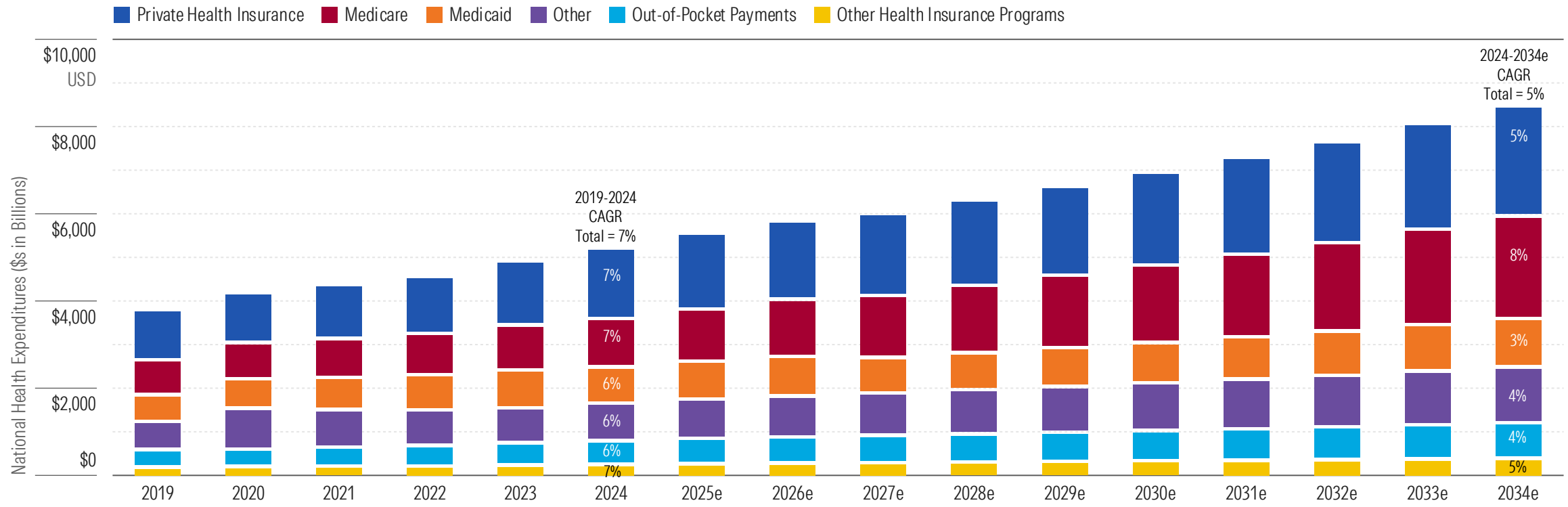
MCO target markets are growing in the midsingle digits.

US Healthcare Spending Is Expected to Grow About 5% for the Next Decade, Even With Medicaid Spending Cuts

US healthcare spending looks likely to grow about 5% compounded annually for the next decade, including expected cuts in Medicaid spending starting in 2027, based on our analysis of Centers for Medicare & Medicaid Services and Congressional Budget Office estimates. With the aging of the US population, Medicare spending looks likely to lead national health expenditure growth, with 8% annualized growth expected during the next decade.

US Healthcare Spending (5% CAGR) Will Likely be Led by Medicare (8% CAGR), Offset Somewhat by a Medicaid Deceleration (3% CAGR) Through 2034

\$s in billions.



Source: Morningstar analysis of Centers for Medicare & Medicaid Services and Congressional Budget Office estimates as of September 2025. CAGR = compound annual growth rate.

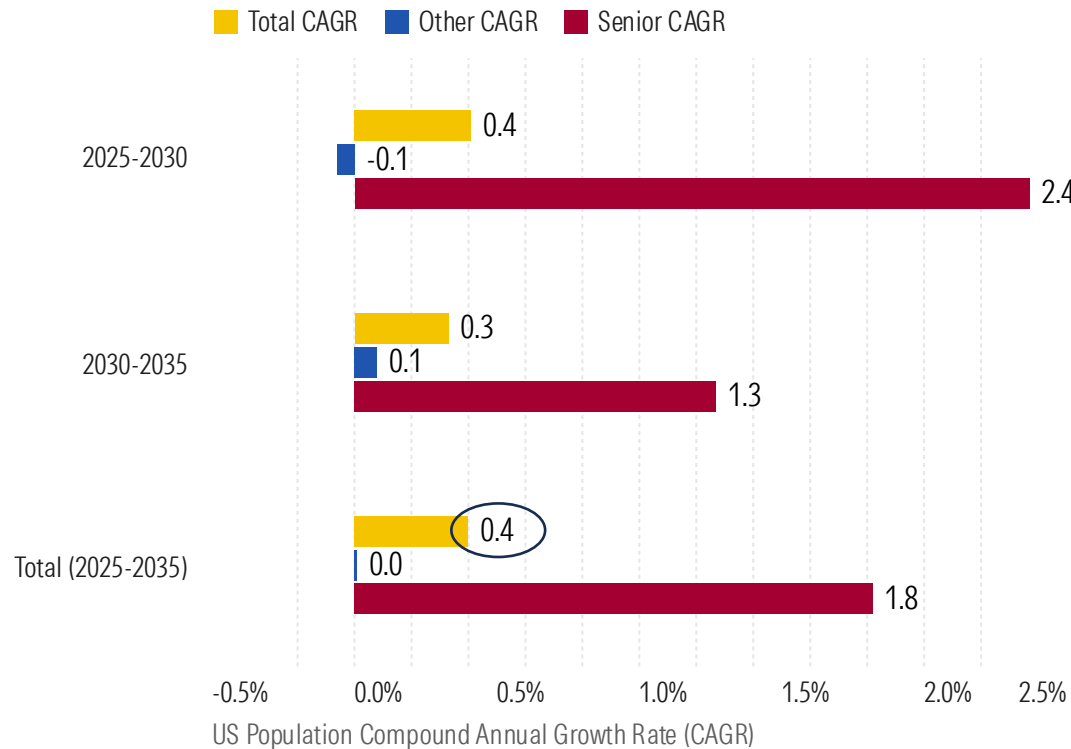
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Per Capita Growth Looks Likely to Drive US Spending Growth, as Population Growth Looks Meager Except Seniors

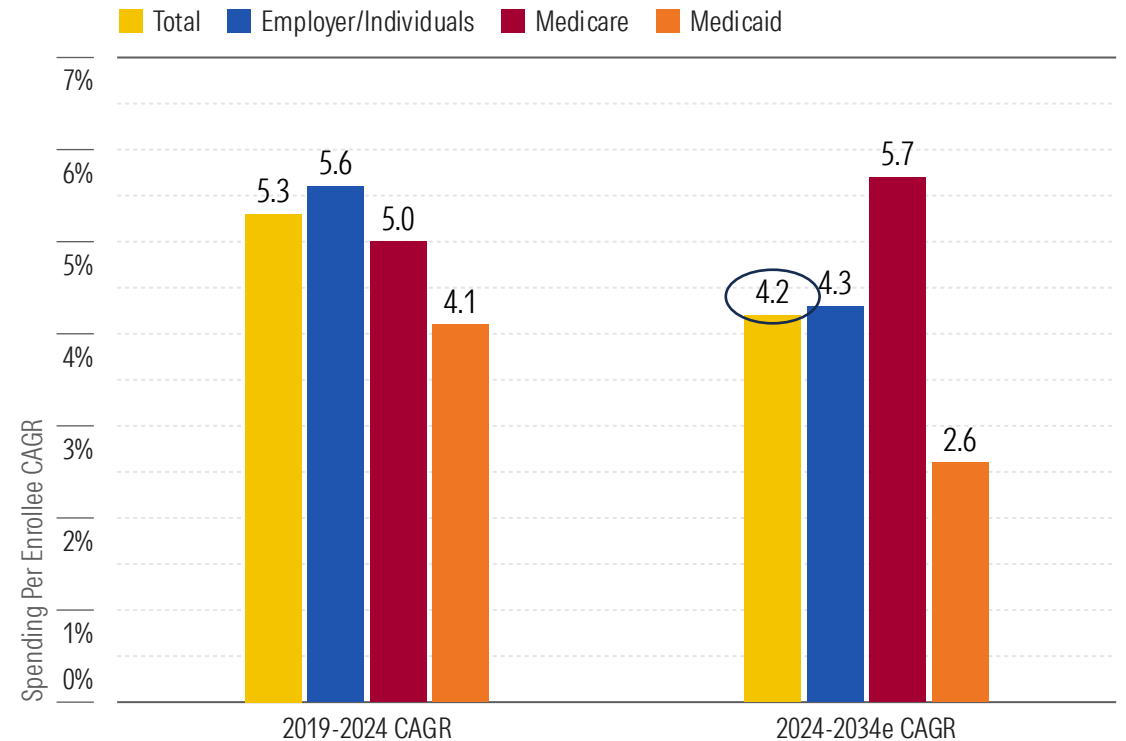
The US population is expected to grow 0.4% compounded annually through 2035 with seniors representing the highest growth opportunity (1.8% CAGR), making Medicare Advantage plans the highest industry growth opportunity, despite ongoing challenges.

Medical spending per insured person grew about 5% compounded annually over the past five years, and we expect similar 4% growth in medical spending per insured for the next decade, as well.

US Population Growth Driven Entirely by a 1.8% CAGR in Seniors Through 2035



Spending per Member Looks Likely to Rise in Midsingle Digits for Next Decade



Source: Morningstar analysis of US Census Bureau estimates, Centers for Medicare & Medicaid Services, and Congressional Budget Office estimates, as of September 2025. CAGR = compound annual growth rate.

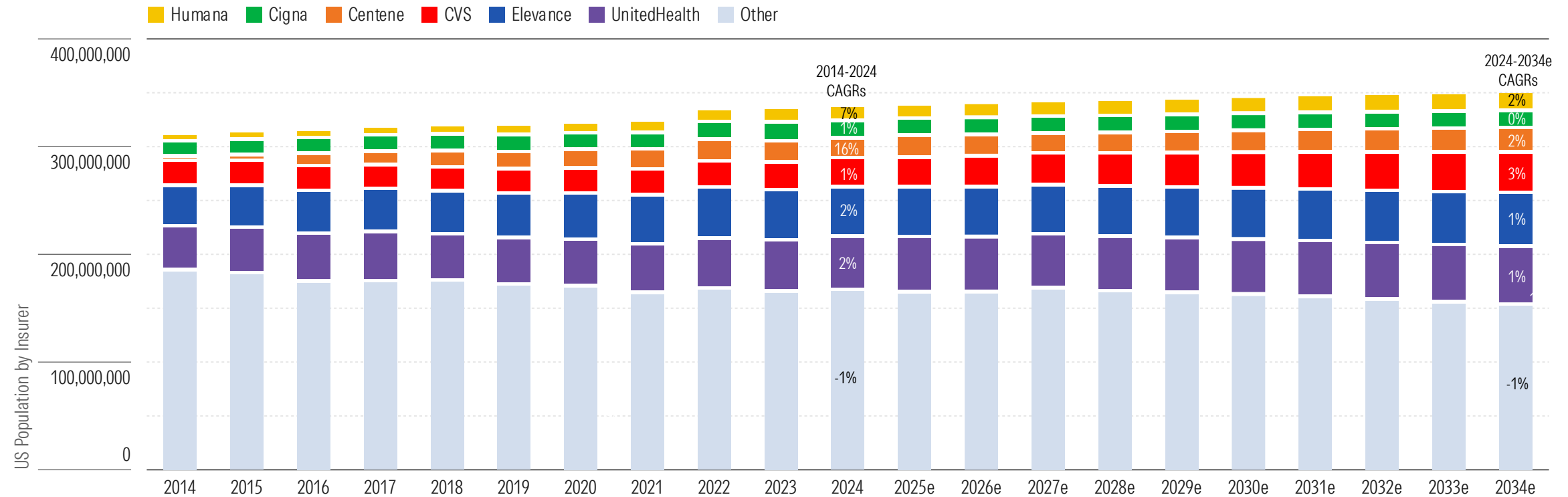
See Important Disclosures at the end of this report.

Competitive Advantages Help MCOs Gain Membership Share Beyond Population Growth

Given their advantaged competitive positions and the ongoing outsourcing of government-sponsored programs to the MCOs, the six MCOs we cover look likely to continue expanding their share of the US population during the next 10 years. We expect these six MCOs to cumulatively grow around 1% compounded annually while the remainder of the US population declines 1% during the period. As a percentage of the US population, we expect these six MCOs to insure 56% of the US population by 2034, up from 52% in 2024 and 41% in 2014.

Top-Tier MCOs Look Likely to Continue Gaining Market Share in the Medical Insurance Industry and Grow Membership at 1% CAGR

Top MCO share of population to grow to 56% by 2034, up from 52% in 2024 and 41% in 2014.

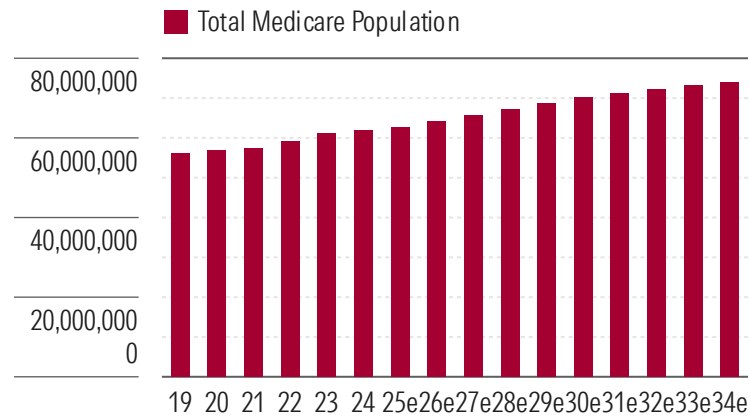


Source: Morningstar analysis of company reports and US Census Bureau data as of September 2025. CAGR = compound annual growth rate.

See Important Disclosures at the end of this report.

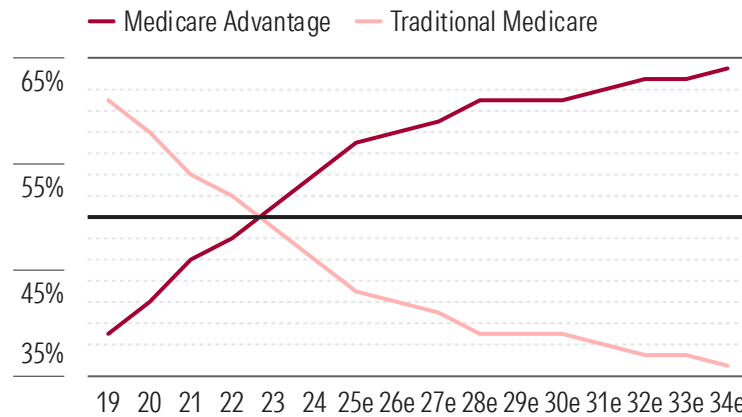
Medicare Advantage Spending CAGR of 8% Expected Through 2034, but Risk Adjustments Add Margin Uncertainty

Senior Population Growth = +2% CAGR Through 2034e



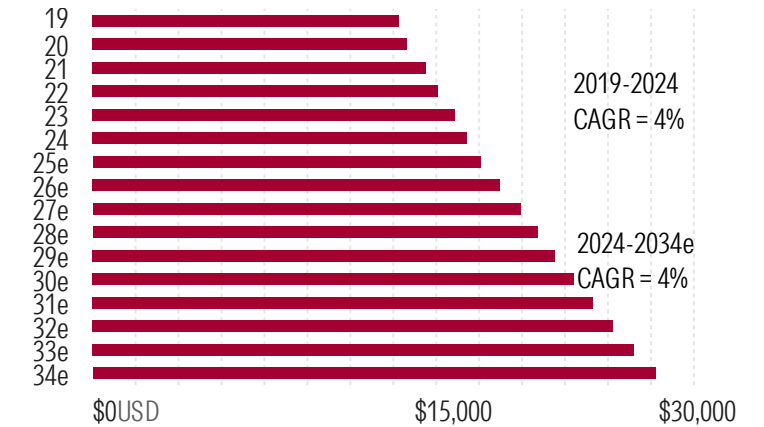
The total Medicare population (age 65 and older) looks set to grow about 2% compounded annually over the next decade, or well above the rest of the US population.

Increasing MA Popularity = +2% CAGR Through 2034e



More benefits and lower potential out-of-pocket payments should help Medicare Advantage plans continue stealing market share from traditional Medicare plans, adding about 200 basis points to the Medicare Advantage population's growth prospects over the next decade.

Spending per Member = +4% CAGR Through 2033e



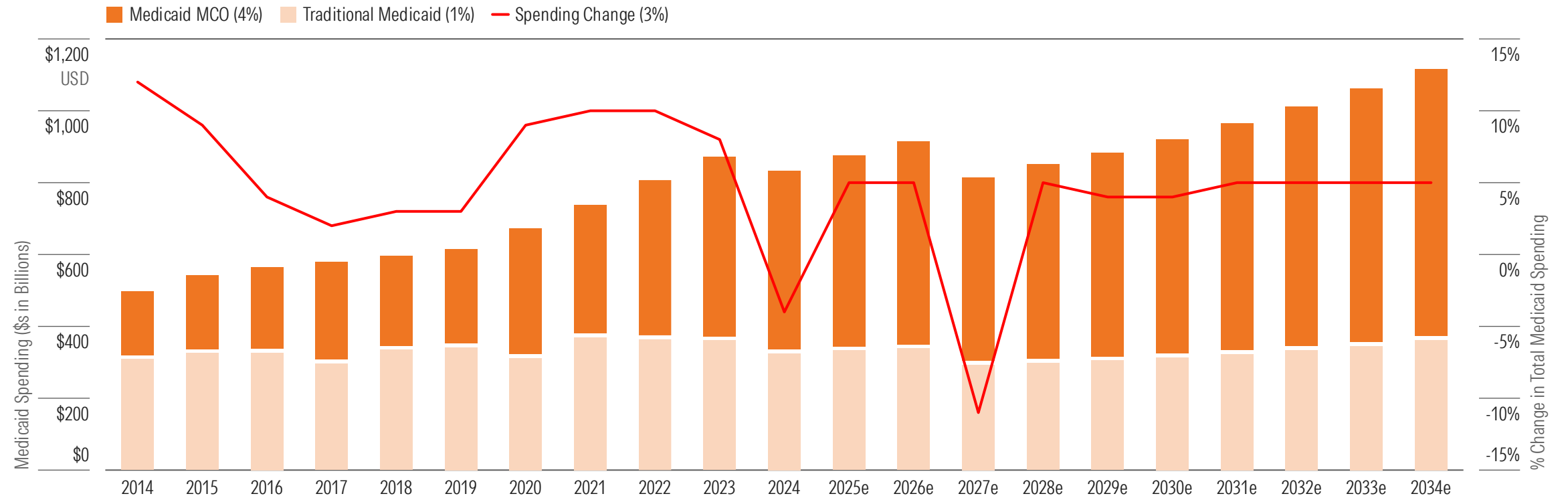
After a strict Biden era in which rates did not keep up with surging medical utilization, Medicare Advantage rate increases may accelerate a bit in the near term. However, eventually, we expect more constrained rate increases to reemerge because of increasing scrutiny on risk assessments in the Medicare Advantage population relative to the traditional Medicare population.

Medicaid Spending Cuts Expected in 2027, Although More Outsourcing by States May Still Help MCOs Grow 4%

After enacting work requirements, additional administrative checks, and other initiatives, the federal government aims to reduce spending on Medicaid (for low-income people) starting in 2027. According to Congressional budget estimates, this new legislation could cut into Medicaid membership by about 10 million people. Overall, during the next decade, Medicaid spending looks likely to grow about 3% compounded annually, with Medicaid MCO spending growing a bit faster at 4%, as states increasingly outsource to insurers to save money.

With Federal Spending Cuts in Medicaid Looming in 2027 and Beyond, Medicaid MCO Spending Is Only Projected to Grow 4% Compounded Annually Through 2034

2024-2034e CAGRs



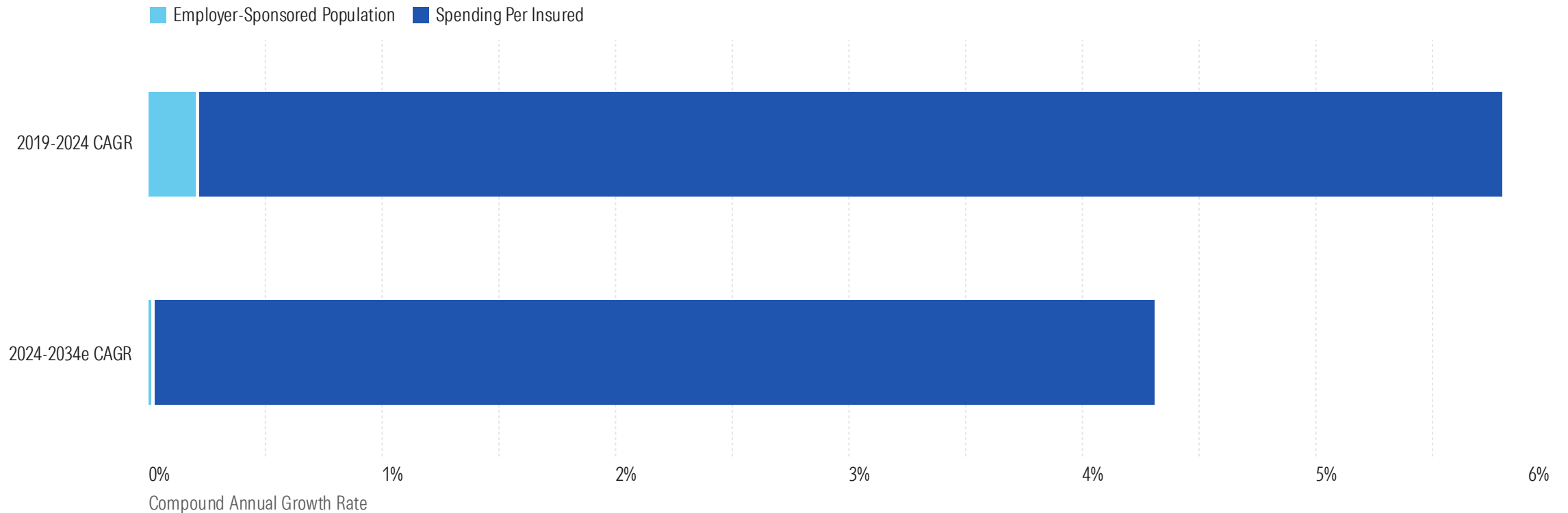
Source: Morningstar estimates and analysis of Centers for Medicare & Medicaid Services and MACPAC data and projections as of September 2025. CAGR = compound annual growth rate.

See Important Disclosures at the end of this report.

Employer Market Growth Looks Limited to about 4% Growth in Spending Per Member

We expect mid-single-digit growth in the employer market, compounded annually during the next decade. Similar to the projected growth of the US population excluding seniors, we expect employer-based plan membership near 0% for the next decade. Medical spending per insured person grew about 5% compounded annually over the past five years in this population, and we expect similar 4% growth in medical spending per insured person for the next decade, as well.

With Limited Growth Expected in the Employment-Age Population, Insurers May Have to Depend on Mid-Single-Digit Spending per Member Growth During the Next Decade



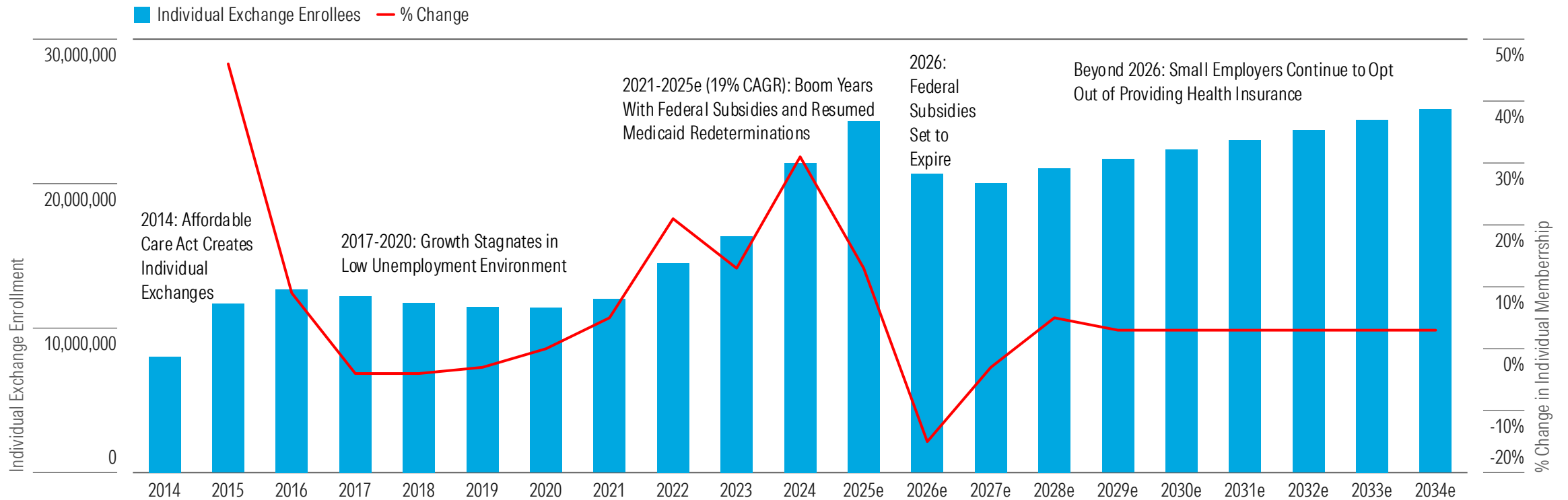
Source: Morningstar estimates and analysis of Kaiser Family Foundation data as of September 2025. CAGR = compound annual growth rate.

See Important Disclosures at the end of this report.

After a Recent Boom, Individual Plans Face Near-Term Risks but Should Recover in the Long Run

The individual exchanges have boomed since legislative subsidies improved affordability starting in 2021 and people were pushed off Medicaid during eligibility redeterminations in 2023-24. However, in 2026, the expected expiration of federal subsidies may price some people off the exchanges, which could cut 5 million people off these plans by Congressional Budget Office estimates. Beyond that, we assume enrollee growth returns to the midsingle digits, as small employers continue to opt out of providing health benefits.

Individual Exchange Enrollment Faces Big Growth Hurdle in 2026, as Affordability Subsidies Will Likely Expire

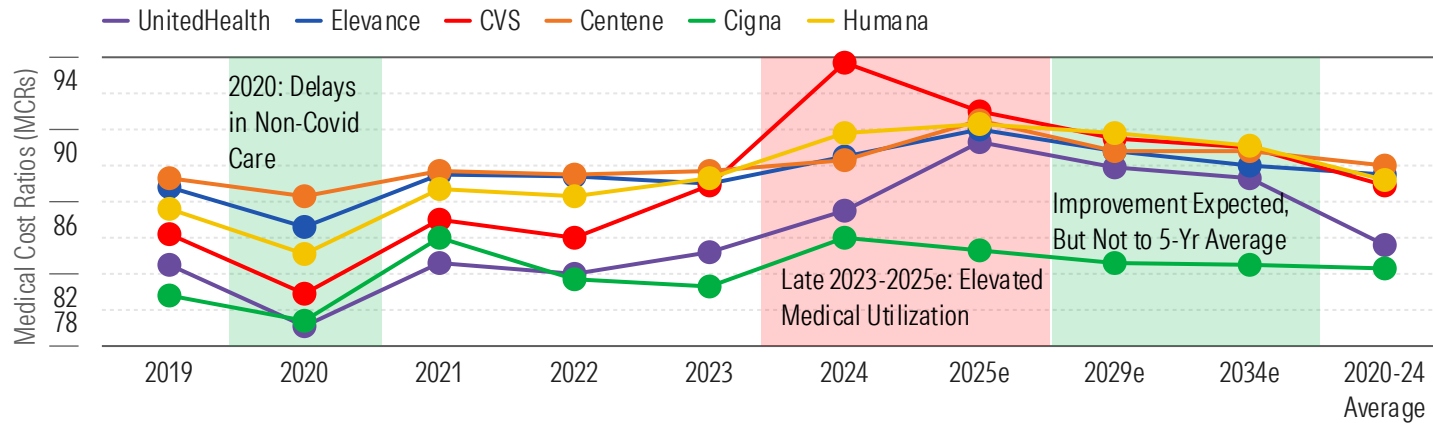


Source: Morningstar analysis of Kaiser Family Foundation data and Congressional Budget Office estimates as of September 2025.

See Important Disclosures at the end of this report.

Our Undervalued Calls on the MCOs Depend on Medical Cost Ratios Improving, Although Not to Five-Year Average

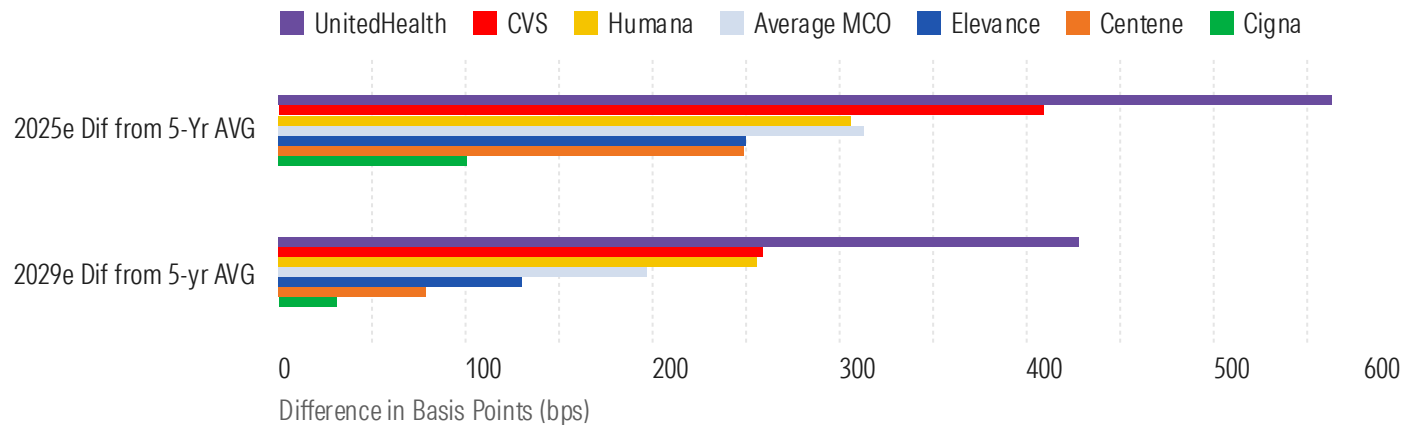
MCOs Can Pull Levers to Improve Their Medical Cost Ratios Over Time



Our undervalued calls on the MCOs rely on improving medical cost ratios, going forward, from recent peaks in 2024-25e.

- Geographic exits, plan design changes, and rate increases could drive most of that improvement during the next five years.
- We expect only mild improvement beyond that in our explicit 10-year forecast period.
- Overall, though, we do not expect these ratios to return to the 2020-24 average or even prepandemic levels.

MCRs Should Improve After Weak 2025 but Remain Higher Than Five-Year Average



While we expect all MCRs will improve in our MCO coverage, which could significantly boost profits at industry players, we see two major factors that could constrain that improvement:

- Concentration in lower-margin government plans, especially the fast-growing MA plans, looks likely to rise.
- With regulators increasing scrutiny on the MA program, we expect more margin pressure in the MA program, in particular, going forward.

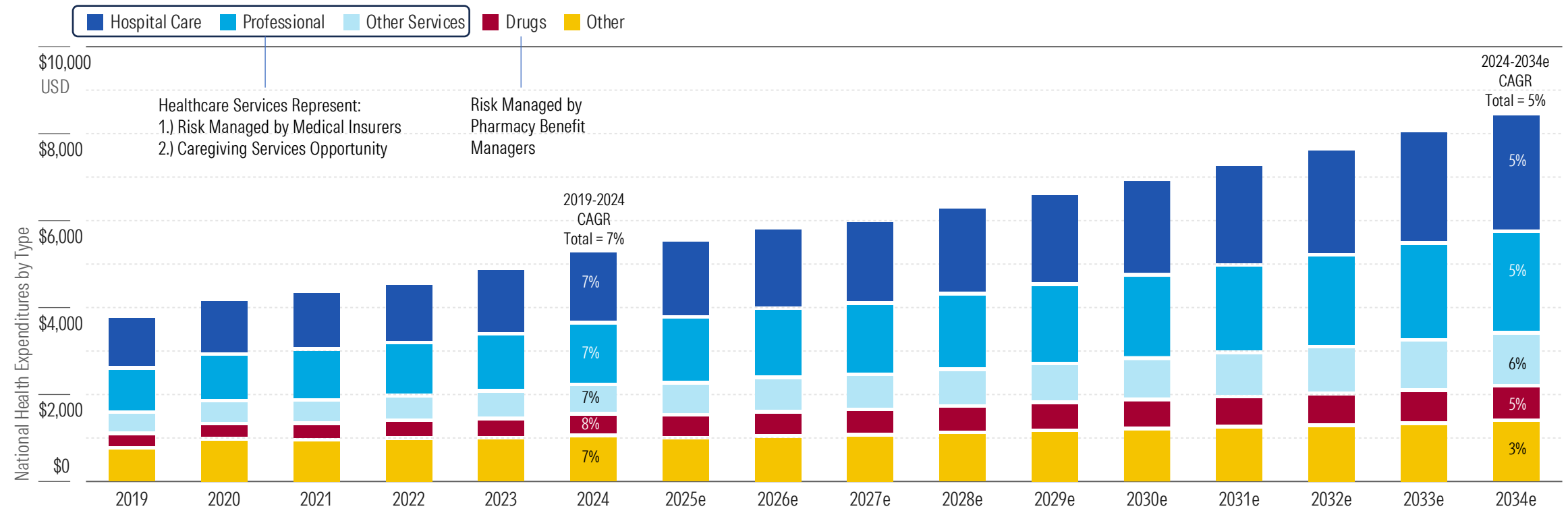
These factors could constrain MCRs at the leading MA firms, like UnitedHealth, Humana, and CVS, especially, relative to historical patterns.

Beyond Medical Insurance, Some MCOs Target Healthcare Services and Drug Spending

Healthcare services and drug growth look likely to drive US healthcare spending growth of about 5% compounded annually during the next decade. Healthcare services, which are expected to grow 5% compounded annually during the period, represent both the risks that medical insurers manage and the direct caregiving opportunities that some MCOs target. Prescription drug spending is also expected to grow around 5% compounded annually and represents the risk that some MCOs manage through their pharmacy benefit managers.

US Healthcare Spending Growth Driven Mainly by Healthcare Services and Drug Spending, Two Areas That MCOs Target

\$s in billions.



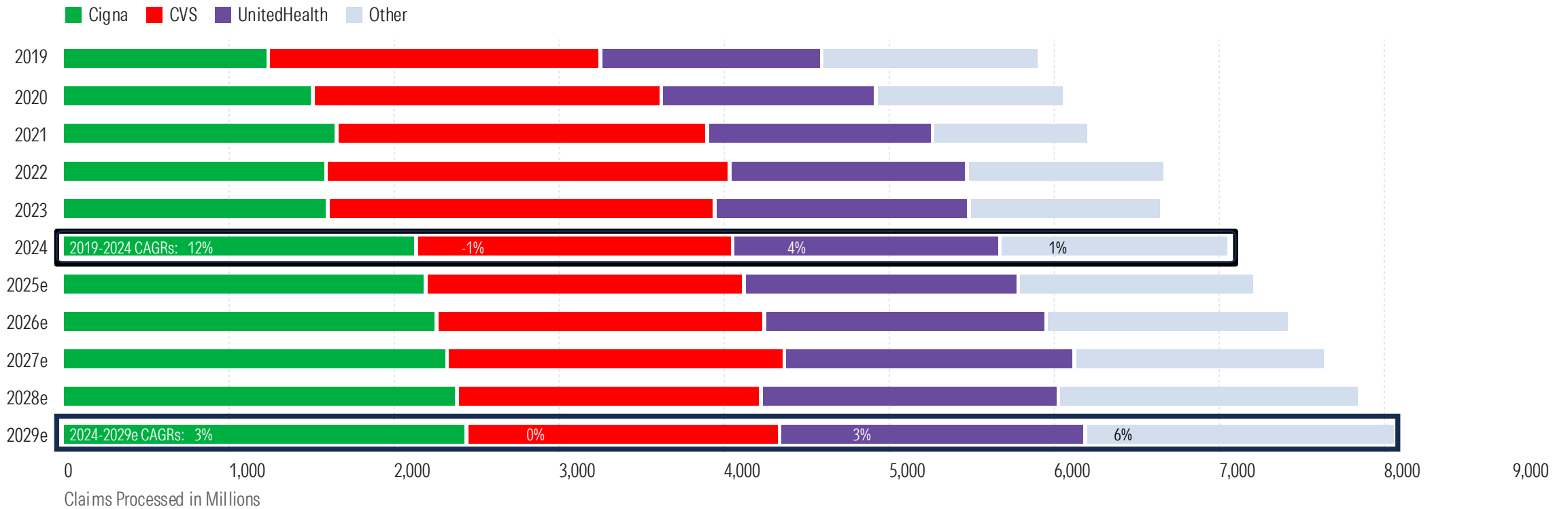
Source: Morningstar estimates (2034e) and analysis of Centers for Medicare & Medicaid Services, Office of the Actuary data and projections (Through 2033e) as of September 2025. CAGR = compound annual growth rate.

See Important Disclosures at the end of this report.

Top-Tier Pharmacy Benefit Managers Face Manageable Competitive Threats

While the door has cracked open to new PBM entrants like Mark Cuban’s Cost Plus, Elevance’s potential insourcing of PBM functions from CVS in 2028 looks like the biggest opportunity for claim share movement in the next five years.

New PBMs Aim to Steal Share From Big-Three PBMs, With Elevance Most Likely to Succeed by Eventually Insourcing More Functions From CVS



Source: Morningstar estimates and analysis of company reports as of September 2025.

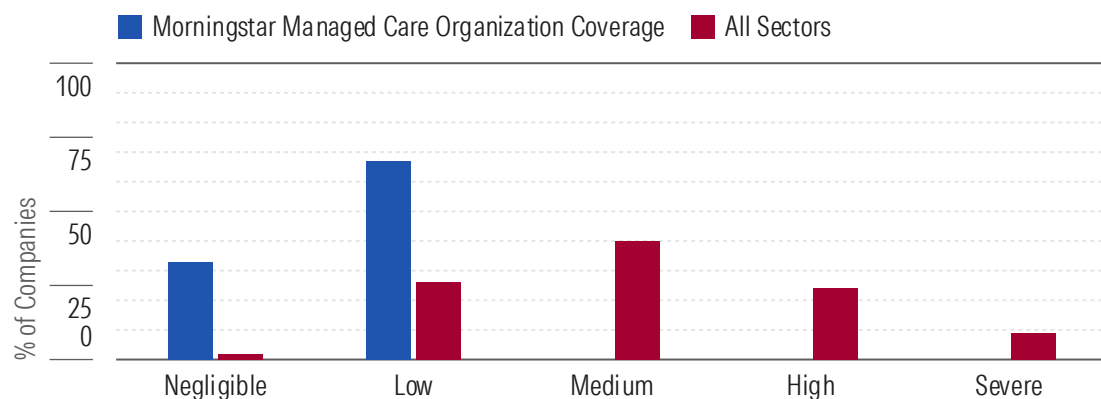
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ESG Snapshot

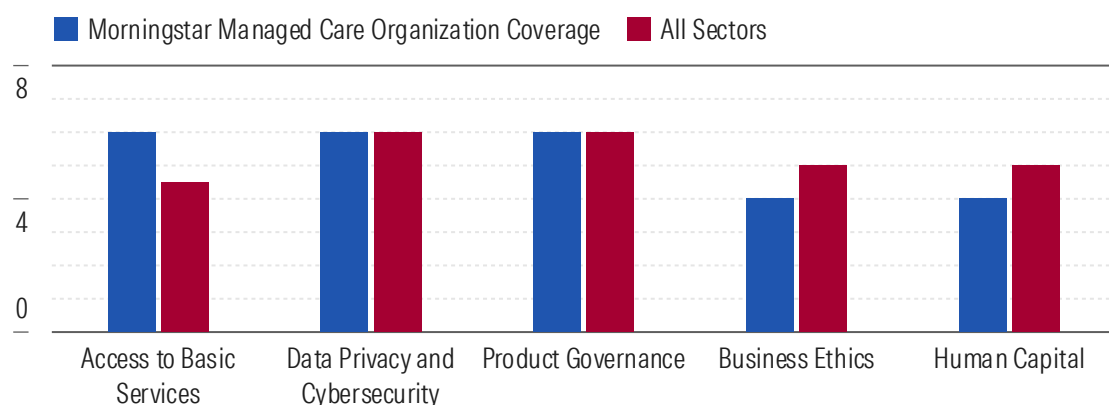
The MCOs face significant regulatory scrutiny.

Summary of Sustainalytics ESG Exposure Ratings

Distribution of Sustainalytics ESG Risk Ratings for MCOs and All Sectors



Material ESG Issue Exposure Scores



Potential Regulations to Solve ESG Issues Create Risks for the MCOs

Sustainalytics assigns Negligible (33%) and Low (67%) ESG Risk Ratings to the managed care organizations we cover. However, the top environmental, social, and governance risks surrounding how the US achieves universal, affordable coverage may continue to roil MCO shares and constrain some of the industry’s moat and uncertainty ratings. The following are the biggest ESG risks that MCOs face:

- **Access to basic services:** We think investors should recognize that how the US eventually achieves universal, affordable coverage may come at the expense of the MCO industry’s profits.
- **Data privacy and cybersecurity:** MCOs must store and protect highly sensitive data about their members, and a breach of this information can have significant consequences for end users and create risks for the MCOs. A prime example is the Change network outage at UnitedHealth in 2024, which resulted in extra expenses and reputational concerns that are still affecting growth in that business.
- **Product governance:** Regulatory oversight, especially in government-sponsored plans, can result in lawsuits, fines, and margin constraints for the MCOs. Currently, CMS looks focused on clawing back previous overpayments and avoiding overpayments in the future in Medicare Advantage, which could hurt cash flows and margins at the MCOs, going forward.

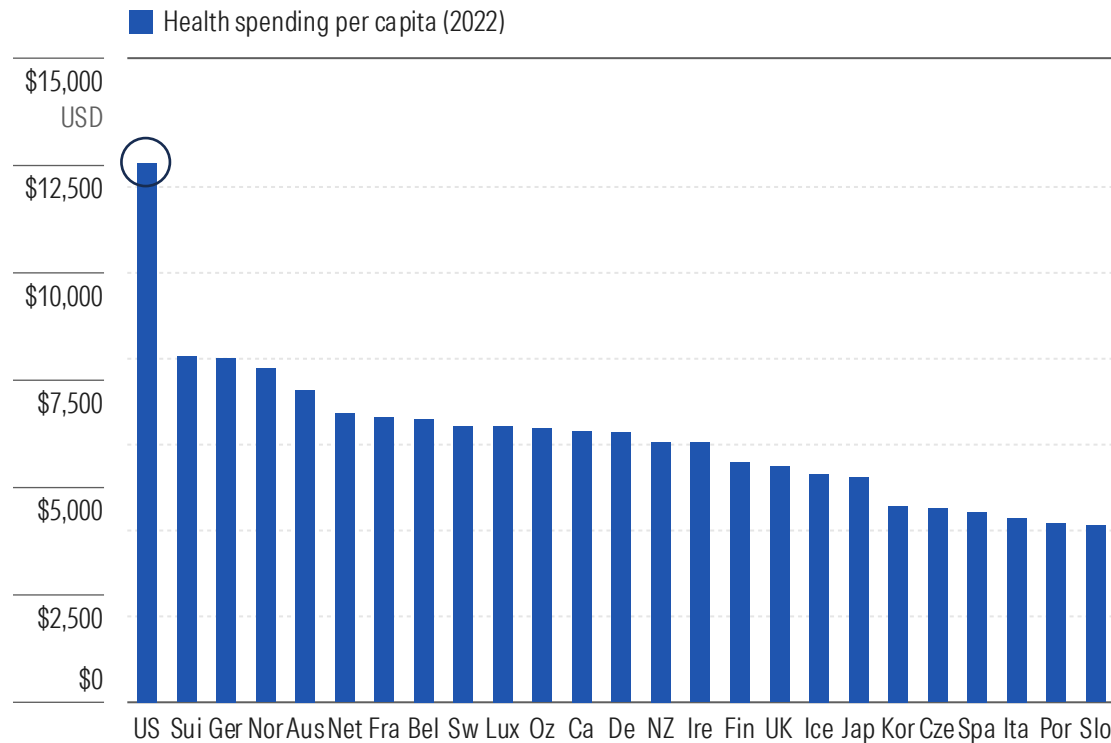
Although we think a single-payer system that eliminates the private health insurance industry remains unlikely in the foreseeable future, potential policy changes that constrain MCO profits continue to create uncertainty for industry players.

Major Reforms Emulating Other Global Healthcare Systems Could Eventually Cut Into MCO Profitability

The US does not appear to be getting a good “life expectancy” return (78 years in 2023) on its “healthcare spending” investments (>\$12,000 per capita in 2022) relative to other high-income countries. Eventually, US citizens may balk at this discrepancy, which could usher in major reforms that push the US healthcare system closer to the systems of more regulated countries and cut into MCO profitability in the process.

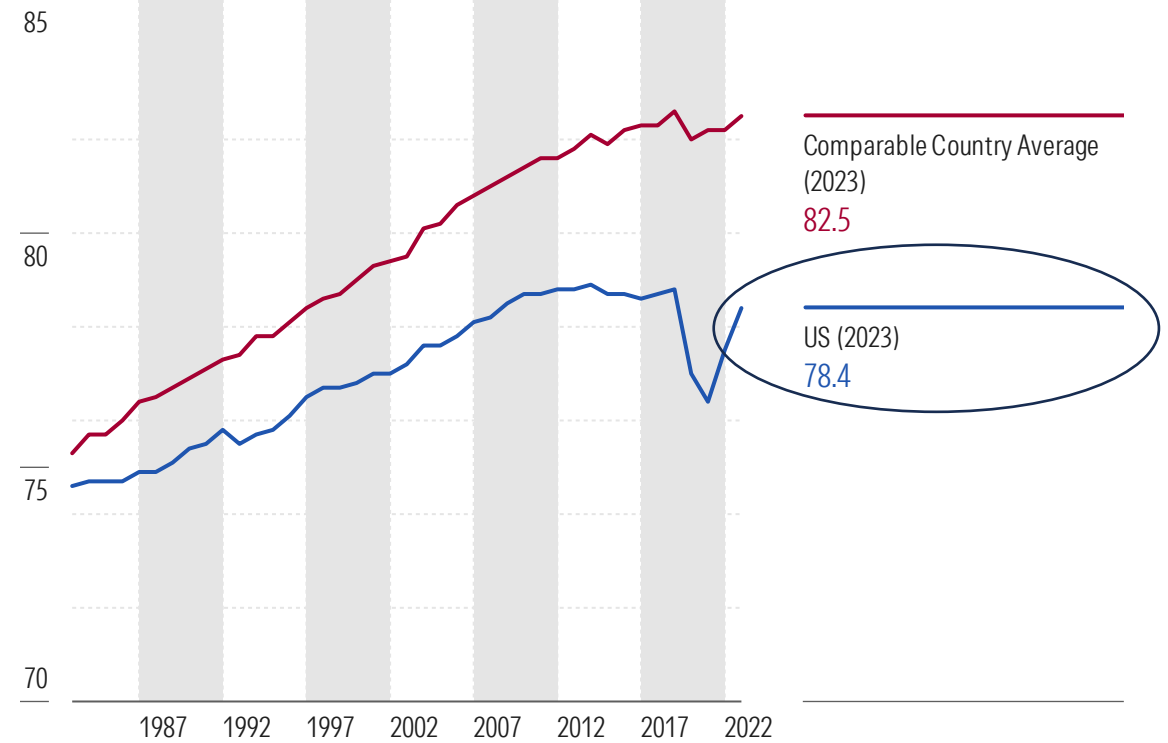
US Healthcare Spending per Capita Far Exceeds Other Countries

Relative to other high-income OECD countries.



US Life Expectancy at Birth (78.4) Trails Other High-Income OECD Countries (82.5)

Measured in years as of 2023.



Source: Morningstar analysis of OECD data and KFF analysis of CDC, OECD, Australian Bureau of Statistics, German Federal Statistical Office, Japanese Ministry of Health, Labour, and Welfare, Statistics Canada, and UK Office for National Statistics data as of January 2025.

See Important Disclosures at the end of this report.

Potential US Healthcare Policy Changes Typically Depend on Which Party Controls the Federal Electable Bodies

The types of potential changes to the US healthcare system largely swing with control of the federal electable bodies. With Republicans firmly in control of the federal electable bodies, new policies surrounding that party's desire to cut federal spending may hurt key Affordable Care Act safety nets—Medicaid and the individual exchanges—and reduce the insured rate in the process. Also, both parties appear to support reforms to the PBM and Medicare Advantage end markets, which may create headwinds for the MCOs in the future.

The Potential for and Type of Healthcare Reforms Typically Depend on Which Political Party Controls the Federal Electable Bodies

Red = Significant cuts into MCO's long-term profits possible; Orange = Moderate cuts into MCO's long-term profits possible; Green = Roughly status quo likely.

Control of the Federal Electable Bodies:

White House, Senate, House of Representatives

Democrats Typically:

- Are Pro-Consumer
- Expand Federal Government
- Seek Universal Coverage
- Seek Key Benefit Guarantees
- Add Antitrust Hurdles
- Want PBM Reforms
- Want Increased Scrutiny of Medicare Advantage

Republicans Typically:

- Are Pro-Business
- Shrink Federal Government
- Seek Cheap Coverage
- Endorse Catastrophic Plans
- Reduce Antitrust Hurdles
- Want PBM Reforms
- Want Increased Scrutiny of Medicare Advantage

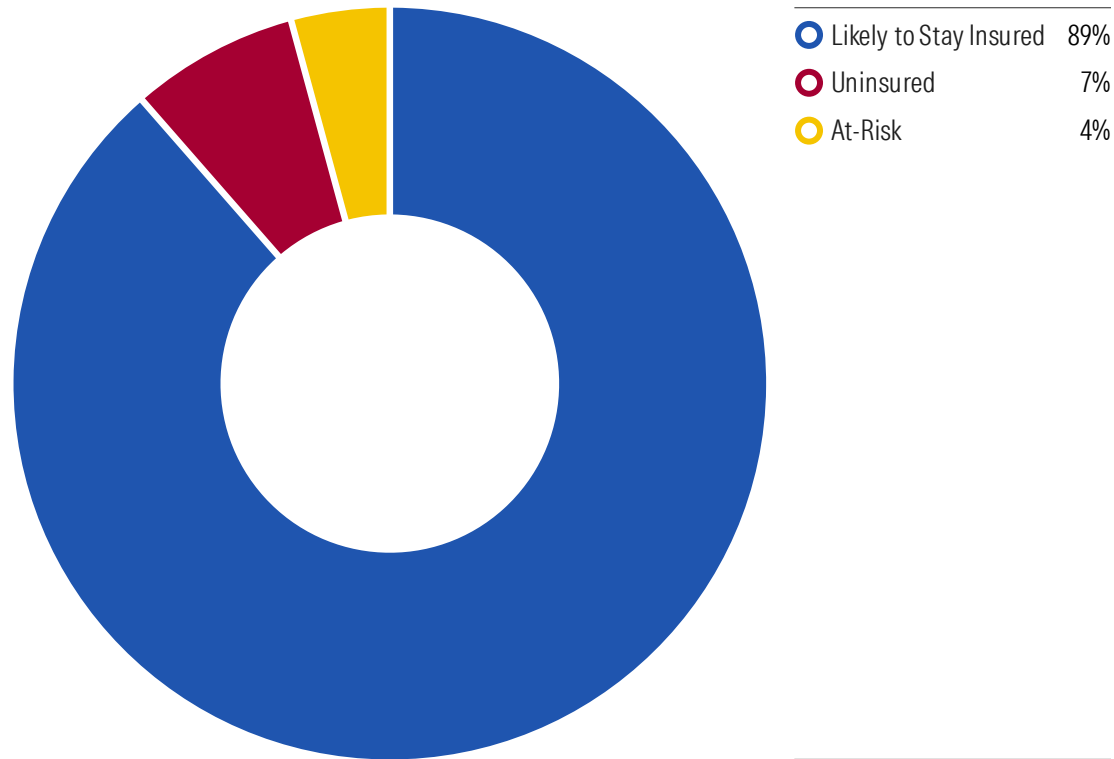


Insured Rates May Fall From Peak Rates Soon, and Affordability Remains a Challenge Even at High Insured Rates

Using Congressional Budget Office estimates of about 15 million people at risk of losing coverage due to recent legislation that would cut Medicaid spending and allow individual exchange subsidies to expire, the insured rate may decline by about 400 basis points from recent peaks (93% in 2023). Also, affordability remains a challenge even near peak insured rates, as many Americans still suffer from financial problems related to medical debt, including bankruptcies (3% of adults with medical debt) and lost homes (3%).

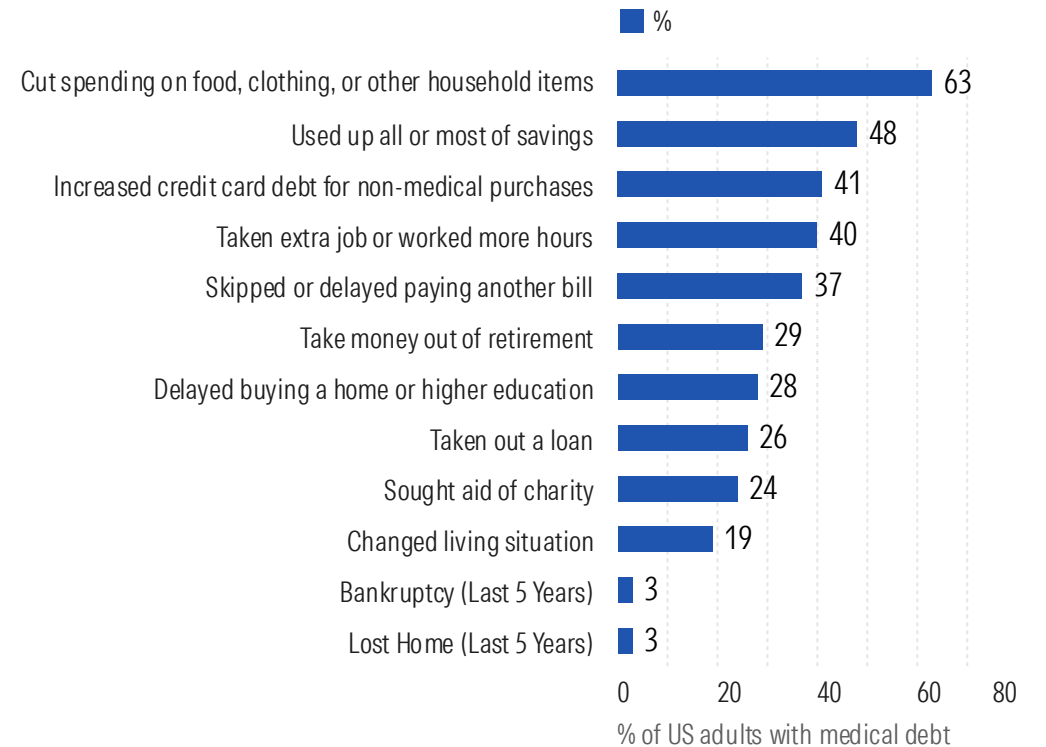
The US Insured Rate Looks Set to Fall From Recent Peaks

% of US population.



Also, Medical Debt Still Creates Many Financial Challenges for Americans

Consequences include the following for the 4 in 10 US adults that report medical debt.

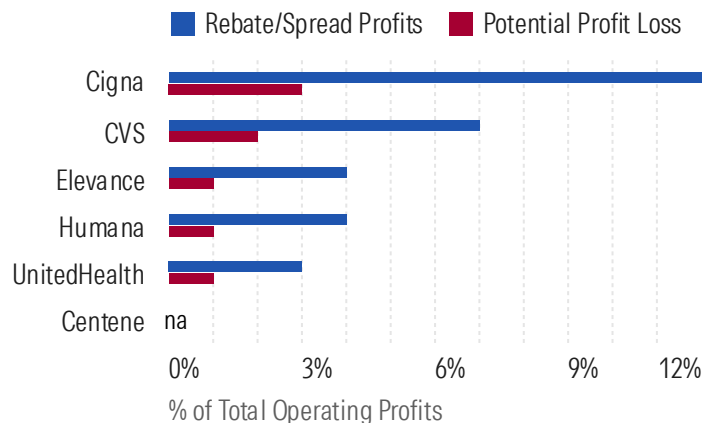


Source: Morningstar analysis of Congressional Budget Office estimates as of June 2025 (left) and KFF survey results as of June 2022 (right).

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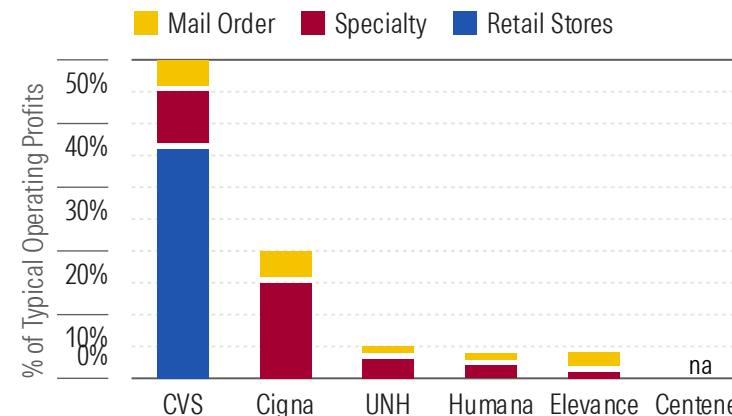
Potential PBM Policy Changes Create Some Uncertainty for MCO Profits

More Transparency Looks Likely and Manageable



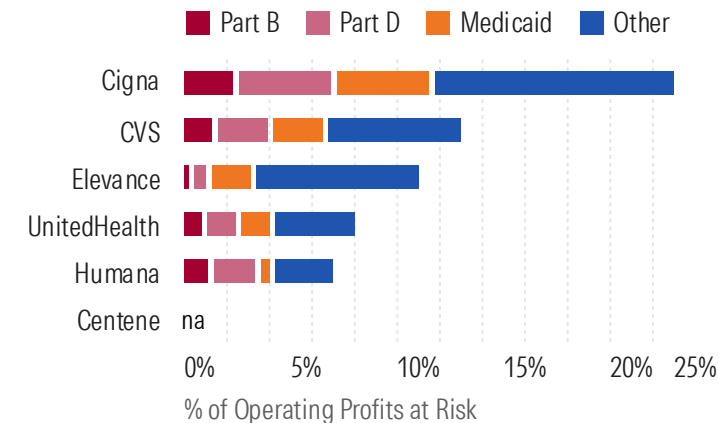
Although most PBM profits come from fees, variable arrangements—like rebate and spread-based pricing—remain an option for clients. Regulators may eventually eliminate these variable arrangements because they can create inappropriate incentives that inflate drug prices. We estimate that the potential profit loss from removing these variable pricing mechanisms looks low, though, because most profits related to rebates/spreads would likely be converted into fees. In this scenario, even the most concentrated PBM, Cigna, only faces a low-single-digit risk to operating profits, by our calculations.

Separating Medication Dispensers Creates Mild Risk



We estimate that CVS (about half of operating profits) and Cigna (about 20%) have the most to lose if they were forced to separate from their medical dispensers. However, those two companies may be able to spin those businesses off directly to shareholders, which could preserve the long-term earnings power of those businesses for investors, although valuations at the time of the spinoff may not fully reflect their long-term potential and some synergies may be lost. The other MCOs face more limited risks even in a sale situation due to their lower exposure to medication dispensing.

Losing Price Negotiations = Low Probability, High Risk



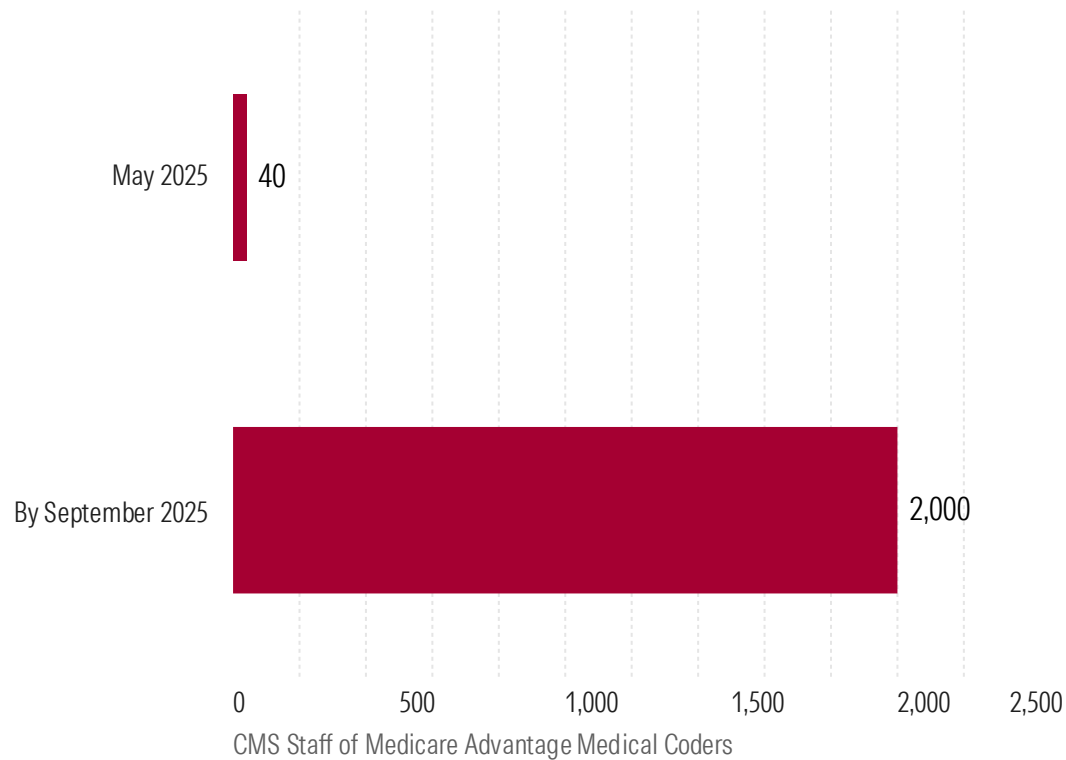
The federal government appears interested in taking over drug price negotiations, a function that PBMs currently provide to clients. However, we suspect an act of Congress may be necessary to change this practice broadly throughout the US healthcare system, which doesn't appear likely to us, currently. Going forward, government-sponsored programs, particularly Medicare Part B, look most susceptible to this risk, although from an MCO profit perspective, that Medicare Part B risk appears limited to the low single digits even at the most concentrated PBM—Cigna—by our estimates.

Medicare Advantage Plans Face Intensifying Regulatory Risks in the Intermediate Term

The Centers for Medicare and Medicaid Services aims to increasingly audit MA plans to make sure that risk assessments on members that determine payments to insurers are as accurate as possible, which may pressure MA margins, going forward.

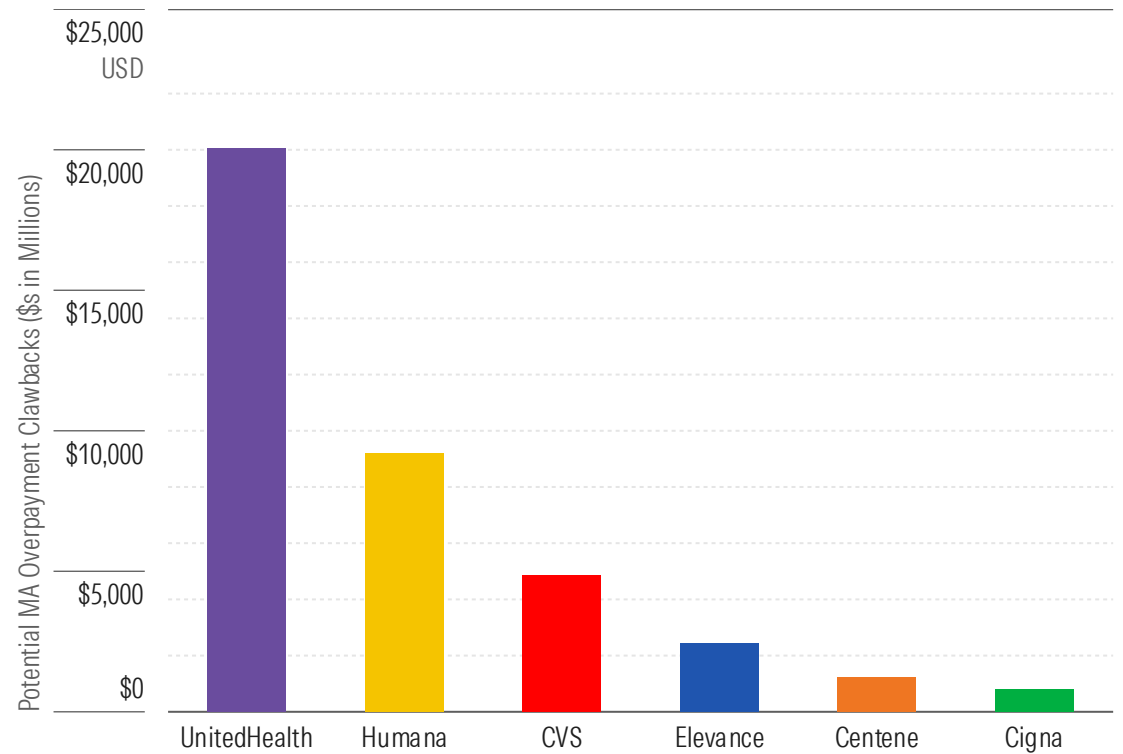
Regulators also intend to claw back any overpayments made from 2018-24 due to inappropriate risk assessments. Based on an Office of Inspector General report from October 2024, we have included the following clawbacks in our base-case scenarios.

Expanding CMS Staff to Audit MA Risk Diagnoses May Squeeze Insurer Margins



Potential Clawbacks of MA Overpayments Could Be Large, Even If Fraud Not Found

UnitedHealth and Humana face the biggest fallout from potential clawbacks.



Source: Morningstar Analysis of Centers for Medicare and Medicaid Services as of May 21, 2025, and Office of Inspector General as of October 2024.

See Important Disclosures at the end of this report.

Glossary

Managed Care Organization Terms

Affordable Care Act of 2010 (ACA) – Legislation that primarily created the individual exchanges, expanded the Medicaid program, and put minimum requirements on medical loss ratios to move the US healthcare system closer to universal, affordable health coverage.

Healthcare Provider – A caregiver in the US healthcare system that directly serves patients, including hospitals, outpatient facilities, physicians, pharmacies, etc.

Individual Exchanges – These government-regulated marketplaces provide a forum for health insurers to sell plans directly to individuals who are not eligible for government-sponsored programs like Medicare or Medicaid, do not have access to insurance through employer-sponsored plans, or previously may have been priced out of individual plans due to preexisting conditions.

Managed Care Organization (MCO) – A provider of health insurance plans that aims to improve health and related costs for clients.

Medicaid – A government-sponsored health insurance program that covers low-income individuals in the US. Private insurers can participate in the Medicaid program when states decide to outsource the management of their Medicaid spending.

Medical Cost Ratio or Medical Loss Ratio (MCR or MLR) – The cost of caring for members as a percentage of premiums generated by each insurer. The lower this ratio is, the better for insurer profitability. However, this ratio is regulated at minimums determined primarily by client size that effectively caps the gross margin a health insurer can earn on at-risk plans.

Medicare – A government-sponsored health insurance program that covers senior citizens, age 65 and older, in the US. Private insurers participate in the Medicare program through Medicare Advantage plans, supplemental insurance plans for traditional Medicare members, and Part D pharmaceutical plans for traditional Medicare members.

One Big Beautiful Bill Act of 2025 (OBBBA) – Legislation that aims to reduce federal spending on Medicaid, putting an estimated 10 million enrollees at risk of losing coverage in that program starting in 2027, and does not continue the federal subsidies on the individual exchange plans, which puts another estimated 5 million people at risk of losing their insurance coverage in 2026.

Pharmacy Benefit Manager (PBM) – A provider of biopharmaceutical benefit and distribution plans for clients, such as employers and other health insurers.

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