UNITEDHEALTH GROUP®

Earnings Conference Call
Fourth Quarter 2024 Remarks
January 16, 2025

Moderator:

Good morning, and welcome to the UnitedHealth Group Fourth Quarter and Full Year 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 January 16, 2025, 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

Jennifer, thank you very much and good morning, everyone.

I'd like to start by expressing a sincere "thank you" from my colleagues and me for the overwhelming expressions of condolence and support following the murder of our friend Brian Thompson.

Many of you knew Brian personally. You knew how much he meant to all of us and how he devoted his time to helping make the health system work better for all the people we are privileged to serve. He would dive in with passion and caring to find solutions … to improve experiences … whether for an individual consumer, an employer or a public agency.

Right now … there are 400,000 nurses, doctors, case workers, customer service specialists, pharmacists, technologists and so many others in this organization … who share that commitment and are determined to advance that work.

The task in front of us … *all of us* … health care providers, payers, employers, drug companies and policymakers … is to continue improving quality and health outcomes for individuals and their families … while lowering costs for *everyone*. We need to build on the unique foundational strengths of health care in America … and address the areas we can make work better.

Among those strengths: world-leading innovation. The U.S. has developed the most advanced clinical approaches and patient-centric care at a pace not seen anywhere else. It's why, if provided with the option, people from all over the world come here to seek care for the most complex conditions.

Yet, the health ***system*** needs to function better. Through decades of federal and state policymaking and private sector innovation, we have a variety of programs, structures and processes. There are strong merits to that variety as they can be more tailored to meet the specific needs of individuals at various stages of life and health status and provide extra help for those who need it. It avoids a "one-size-fits-all" approach. But it needs to be less confusing, less complex and less costly.

America faces the same fundamental health care dynamic as the rest of the world: the resources available to pay for health care are limited, while demand for health care is unlimited. Every society wrestles with that issue and approaches it in various ways. We have incredible opportunities here to improve system performance both from a care and a cost perspective … while building upon the foundational strengths I just mentioned.

The mission of this company – why we exist – is to improve this system for everybody and help people live healthier lives.

That means getting more people into high-quality, value-based care and keeping them healthy in the first place, so fewer Americans find themselves with a chronic – and in many cases preventable – disease.

It means continuing to invest in programs like Medicare Advantage which, by providing coordinated care to seniors, is proven to deliver better health outcomes at lower costs to consumers and taxpayers compared to fee-for-service Medicare. Seniors recognize that value, which is why the majority of them choose Medicare Advantage.

It means making health care easier to navigate. We're enhancing digital tools for consumers … harnessing data and using AI so *they* can find the best-value care option and decide what is best for themselves and their families. People's health interactions should be as intuitive and seamless as every other aspect of their lives – banking, shopping, streaming. This past year we saw an extraordinary increase in the use of these modern channels. We know there is still a large gap there and we intend to keep at it until it is closed.

It means making coverage and cost easier to understand. Just one example where we already have advanced plans: we are eager to work with policy leaders to use standardization and technology to speed up turnaround times for approval of procedures and services for Medicare Advantage patients and to materially reduce the overall number of prior authorizations used for certain MA services. Some of this work we can do on our own and we're doing it – but we are encouraged by industry and policymaker interest in solving for this particular friction across the whole system.

Ultimately, improving health care means addressing the root cause of health care costs.

Fundamentally, health care costs more in the U.S. because the price of a single procedure, visit or prescription is higher here than it is in other countries. The core fact is that price, more than utilization, drives system costs higher. Tackling

that problem will require all parts of the system and policymakers to come together.

Yet there are participants in the system who benefit from these high prices. Lower cost, equivalent quality sites of service, for example, can be good for consumers and patients, but threaten revenue streams for organizations that depend on charging more for care.

Another example is the persistently high costs of drugs in the U.S, leaving American consumers, employers and public agencies to pay disproportionately more than people in other countries. Just look at GLP-1 prices: one drug which costs $900 in the U.S. costs about a tenth of that in Europe.

Pharmacy benefit managers play a vital role in holding those prices down – which is why drug companies and their allies have spent the past several years attacking them. Optum Rx alone delivers many tens of billions of dollars in savings annually versus the pricing set by the manufacturers – including on the GLP-1s. That sharply reduces the gap versus other countries, but even then, prices in the U.S. are still multiples of what the rest of the world pays for the same drugs.

Last year, our PBM passed through more than 98% of the rebate discounts we negotiate with drug companies to clients. While we offer customers 100% pass-through options, a small number have historically elected other models. We are committed to fully phasing out those remaining arrangements so that 100% of rebates will go to customers by 2028 at the latest. We will continue to encourage all of our clients to fully pass these savings directly to patients at the point of sale, as we already do for all of the people we serve in our fully insured employer offerings. This will help make more transparent who is really responsible for drug pricing in this country: the drug companies themselves.

Health care in every country is complex and the solutions are not simple. But you should expect this company to continue to work at it. Finding what is needed.

Developing solutions. Bringing those solutions to scale … making a positive impact on the lives of millions of people.

We deliver on our commitments to the people we serve, including our investors … even in highly challenging periods like 2024. Our results bear out that we find a way … even if it's not always how we may have initially envisioned the path.

Among some of the formidable challenges we navigated over the course of the year were:

- The first year of the three-year CMS Medicare rate cuts
- The effects of the state-driven Medicaid member redeterminations
- And the Change Healthcare cyberattack.

Our people found a way to deliver solidly within the range we first offered back in November of 2023 … all while improving patient and consumer health outcomes and experiences, focusing on quality and expanding upon our potential to help make the health system work better for everyone.

We are invigorated by the path ahead. There are so many areas that can be enhanced, reworked, reengineered or even scrapped to make the health system work better – as we know it needs to. That is both our responsibility and it's our passion. We begin 2025 with a strong outlook for the year as we continue to deliver on our commitments and excel for those we serve in all of our key growth pillars.

Now John will walk you through this performance in a little more detail.

John Rex

Thank you, Andrew … and I'll add my deep gratitude for the enormous outpouring of support over the past few weeks. Brian helped build this company and forged deep, trusted relationships for over 20 years and the positive impact he had on people will be felt for years to come.

This morning, I'll discuss both 2024 results and our performance expectations for '25, including some of what we had planned to discuss with you in December.

2024 revenues of over $400 billion and adjusted earnings per share of $27.66 were well within the outlook ranges we set out over a year ago.

To be sure, things played out differently than initially anticipated, but it is an enduring trait of this enterprise that we deliver on our commitments to the people we serve and to you, even amid unforeseen circumstances.

Over the course of '24 we undertook initiatives and made investments to strengthen us for the future … initiatives to:

- Improve consumer experience and bring new innovations to market more quickly
- Drive the most compelling ways to further our mission to help make the health system work better for everyone
- And continue to optimize and refine our offerings and business portfolio to enhance future growth potential … whether that meant moving into new opportunities, reconfiguring or moving out of areas which contributed historically, but may no longer be core … all with an eye to unlocking value.

We know you have a number of questions that we were not able to discuss last month. So today, I'll start by stepping through a couple you have indicated are top of mind.

The first one is why our '24 medical care ratio was 150 basis points above our original outlook.

It's important to frame up the challenges of '24 to offer some perspectives on the commitment and response of our people. Compared to the mid-point of the care ratio range we stepped out with over a year ago, that alone created a nearly $5 billion gap we needed to overcome. And that's before we get to the nearly $1 billion in business disruption impact due to the cyberattack.

So, we start with about $6 billion in unanticipated impacts just from these two examples … in addition to managing through the already known multibillion-dollar impact of the Medicare rate cuts as we sought to preserve as much benefits stability for seniors as possible.

Regarding the elements impacting our ’24 care ratio, we’ve spoken about the key factors on prior earnings calls, so no surprises here.

The first comprise about 70% of the total impact and are comparable in magnitude to each other.

- First, the mix of people served. We ended up with a different profile of consumer than expected. This is because of one factor: we didn’t grow as anticipated, due to the unusual Medicare Advantage benefit designs in the marketplace in ’24.

- Next, the timing mismatch between the health status of the remaining people being served by Medicaid and the lagging state rate updates.

- Then there were the costs related to the cyberattack and our South America business impacts.

The remaining two elements comprise about 30% of the impact and are evenly split. These include:

- A more-rapid-than-expected acceleration in the prescribing of certain high-cost medications as drug companies took early advantage of the Inflation Reduction Act

- And an aggressive upshift in hospital coding intensity. This is incorporated into our outlook – even as we work to get it back in line.

Those are the ’24 care ratio elements.

Next question: Given all that, are we confident in the adequacy of our pricing for ’25?

The answer is yes and here’s why.

To start, for ’25 the outlook we shared in December incorporates a view of care activity commensurate with what we saw in ’24 … even the care activity we experienced as we exited the year.

I’ll break that down with some business line perspectives.

In Medicaid – we see the gap between people’s health status and state rates narrowing over the course of the year. Our outlook assumes a measured pacing of that process. Actions to date, including the important January 1 renewal cycle, support this view.

In Commercial: pricing for ’25 is appropriately capturing the care activity we are seeing. This is evidenced by growth heavily weighted toward self-funded offerings. We will continue our disciplined approach.

In Medicare we had strong AEP results, which included winning back people we had served previously and near record retention. These are a direct result of our long history of offering sustainable benefits for seniors. With strong retention and the many returning consumers, we start the year with highly informed insights into the care needs of the people we will be serving.

In addition, this year we have seen a notable uptake of our more managed offerings – think HMO style – which provide strong value for consumers, effective care tools for doctors and more predictable performance.

We expect a ’25 full-year medical care ratio of 86.5%, plus or minus 50 basis points … 100 basis points above the ’24 result.

In addition to factors discussed earlier, the increase is driven by:

- I-R-A impacts
- The second year of the Medicare funding cuts
- A continued mix shift toward public sector offerings
- And a respectful view of care activity.

Our ’24 operating cost ratio improved about 150 basis points over the prior year. Roughly half of the change was driven by contributions from the business portfolio initiatives mentioned earlier. The other half was due to accelerating our efforts to realize operating efficiencies, even as we improve consumer experiences.

Some of these advances are a result of the very early-stage impacts we are beginning to realize from AI-driven initiatives to help our customer service representatives respond to consumers’ needs more effectively and quickly.

And we see continuing opportunities … both in the near-term, with operating costs for ’25 improving still further … and well beyond, given the rapidly expanding scope and impact of these initiatives.

These actions and the resourcefulness of our people … helped deliver upon the objectives set out over one year ago … and helped to partially balance the multiple billions of unanticipated impacts.

With that, I’ll run through our businesses, offering some key points for each – starting with Optum Health, where revenues grew to about $105 billion in ’24 and are expected to approach $117 billion in ’25.

Our care delivery business continues to deepen its presence in existing areas while expanding into new geographies and services.

In ’25, we expect Optum Health will serve about 5.4 million value-based care patients, growth of 650,000 over ’24. While our current position provides a solid

footing, it's a small fraction of the hundreds of millions of patients who can ultimately benefit from value-based care.

We see value-based care as foundational … it is perhaps the fullest expression of our mission. As Andrew noted, the outdated, activities-based, fee-for-service system won't help the health system work better for people. Value-based care is outcomes-based; aligning processes, actions and incentives … helping keep people healthy in the first place … rather than just seeing them when they are sick.

Optum Health is an integrated, multi-payer, care delivery company helping to lead the transition to a truly sustainable, value-based care system.

As we move into '25, we will continue to enhance access and care integration through the home, a much-needed area to help people with their health. More than three-quarters of our in-home patient visits result in a primary care visit within 90 days. Medicare Advantage patients with chronic conditions who receive a home care visit have a lower rate of ER visits, fewer inpatient stays, stronger health outcomes and a better experience … all while saving the health system billions.

Turning to Optum Rx, revenues in '24 grew to over $130 billion and will be about $146 billion in '25. Our pharmacy benefits management team again had customer retention exceeding 98%, while welcoming a record 750 new clients – further proof of the value sophisticated employers, health plans and labor unions see in Optum Rx's ability to negotiate lower drug prices for consumers.

Optum Rx's pharmacy care services support the entire system in the delivery of clinically driven pharmacy care, serving the highest need and hardest to reach patients. These offerings include community pharmacies, specialty and infusion drug services … all large, strongly growing areas, with our current presence quite small.

Optum Insight revenues were $19 billion in ’24 and in ’25 will approach $22 billion – with a backlog of $35 billion as sales of new products begin to take hold and the customer clearinghouse business continues to rebuild.

The solutions offered through Optum Insight and our health technology growth pillar ... delivered at scale, will:

- Improve consumer experience and payment and claims flows
- Enable access to the “next best action” guidance in a doctor’s workflow
- And help life sciences customers more rapidly bring innovations to market …

... and there will be much more to follow.

Shifting to UnitedHealthcare, full year revenues in ’24 approached $300 billion and for ’25 will approach $340 billion as we grow to serve upward of an additional 1.9 million people, balanced across both the commercial and public sectors.

Within our domestic commercial offerings, we grew to serve 2.4 million more people in ’24 and expect to continue to grow strongly in ’25, especially in our self-funded offerings, which serve some of the most sophisticated buyers of health care … large employers.

The fact that so many more people are choosing UnitedHealthcare is a direct result of our bringing much needed innovation to these more mature markets through consumer-centric offerings.

As noted earlier, UnitedHealthcare’s ’24 Medicare Advantage growth was impacted by the unusual benefit designs in the market. Our focus has always been on providing consumer stability and sustainable value, a factor that has built confidence and trust over the long-term.

As a result, in ’25 we expect growth of up to 800,000 people in individual, group and special needs offerings.

And the growth outlook for the years ahead remains strong, with nearly half of American seniors still in outdated Medicare fee-for-service offerings, which provide less value to them and cost taxpayers more.

In Medicaid, we expect to serve more people in ’25, with redetermination activities now concluded. UnitedHealthcare’s value proposition is resonating with state customers, consumers and provider partners and we are participating in a substantial number of expansion proposals. Most recently, we were honored to have been awarded a new opportunity in Georgia.

Our growing businesses support and are supported by substantial financial capacities and a strong balance sheet. In ’24, we deployed nearly $17 billion in growth capital to help build for the future … further strengthening our capabilities to serve more people, more comprehensively. We also returned over $16 billion to shareholders through dividends and share repurchase.

In ’25, we expect cash flow from operations will approach $33 billion, or 1.2 times net income. We will continue to deploy growth capital and remain committed to returning to shareholders as outlined in December.

Our growth capital deployment efforts deliver their greatest benefits over the course of two, four or even six years, and as new capabilities are scaled and deployed across the enterprise ... and beyond.

To summarize, our strong start to the year reinforces the growth objectives we shared last month and is underpinned by the broad growth drivers, operational excellence and strategic capital deployment you have come to expect from us.

Now I’ll turn it back to Andrew.

Andrew Witty

John, thank you.

The strength of this organization lies in the resilience of our people … and the fundamental belief that there is no higher calling than helping people … and nothing more vital to the human condition than health care.

Looking ahead to 2025 and beyond, we are confident in our ability to continue to add value to the health system through our focus on value-based care and consumer-oriented efforts, to help build the health system America deserves. And that is also why we remain solidly committed to our long-term 13-to-16% growth objective, a goal that reflects both the opportunities and the capabilities that we have.