UNITEDHEALTH GROUP®

Earnings Conference Call
Second Quarter 2025 Remarks
July 29, 2025

Moderator:

Good morning, and welcome to the UnitedHealth Group Second Quarter 2025 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 July 29, 2025, which may be accessed from the Investor Relations page of the Company's website. I will now turn the conference over to the chairman and chief executive officer of UnitedHealth Group, Stephen Hemsley.

Stephen Hemsley

Thank you. Good morning and thank you for joining. Today our prepared remarks will be a little longer than usual so we will be allowing more time for your questions.

As we begin, I want to recognize our employees who have been so dedicated to serving our patients, consumers and customers during a prolonged, challenging period for our business. And I'd like to thank our leadership team, many of whom are new in their roles, for their willingness to join me in looking hard at our

businesses, getting a grounded assessment of our action plans, re-baselining our outlook and moving apace to advance the performance of each of our businesses.

This morning, I know you are eager to get into the underlying details of our revised financial outlook, which we will do. But at this moment, I believe it's also important to convey the tone we are setting at this enterprise.

More than anything, it is a tone of change and reform born out of a recommitment to our mission to help people live healthier lives and help make the health system work better for everyone. It's a mission that requires a commitment to a culture of values, of service, responsibility, integrity and humility.

We pair that mission-driven ambition of reform with a keen sense of the opportunity and the expectation to perform better than we ever have. As we continue to assess the state of our businesses, it is very apparent that some require a fundamental reorientation, others require building and nurturing, and others must be reconsidered and redirected to original purpose. We also recognize the need and the opportunity to revisit and address critical processes and fundamental business practices, both internal and market-facing. We are acutely aware we have an enormous responsibility for providing care for millions of people and for protecting the government and private programs we partner in. As such we have embarked on a real cultural shift in our relationships with regulators and all external stakeholders. We intend to be proactively engaged, constructive and responsive to the concerns of all stakeholders and in our engagement with them.

We have the chance to reposition our enterprise as a far more modern, reliable, consumer and provider friendly enterprise using new technologies and approaches, and we are going to pursue that course.

Pursuit of these opportunities aligns to and enables our reform and change mandate and allows us to better achieve our mission and to steadily perform better in doing so.

We are on this course against a challenging environment which includes:

- A generational pullback in Medicare funding, set in motion in 2023 and playing out through 2026.
- Unprecedented medical cost trend, measured in both intensity of services used as well as unit prices and more aggressive care provider coding and billing technologies.
- The prospects for further contraction of the Medicaid and Exchange markets.
- The growing need to invest in the opportunities new technologies offer and the expectation of all health care entities to offer a better experience for consumers, customers, care providers and employees.
- And finally, the continuing public controversy over long-standing practices and complexities across the entire health care sector, particularly managed care, which bears the critical roles for coverage, for care management and for pricing for the intensity and the cost of services used into the benefit products and programs for the entire health care market. As a leading provider of health services, we must help advance a better health system.

We are committed to engaging in these pursuits with a sense of purpose and better partnership with all stakeholders, transparency in our business and reporting practices and continued integrity in all we do.

Beyond the environmental factors that are affecting the entire sector and more specifically to us, we have made pricing and operational mistakes as well as others. They are getting the needed attention. Our critical processes, including risk status, care management, pharmaceutical services and others are being reviewed by independent experts and they will be reviewed every year and reported on. And these processes can be reviewed at any time by outside stakeholders. While we believe in our oversight and the integrity of these processes, wherever they are determined to be at variance with prescribed practice, they will be promptly remediated and we'll continue on this path.

All the foregoing is fully addressable. We can steadily restore our performance to levels consistent with our mission and stakeholder expectations – all as we strengthen an institutional culture aligned to that mission and accountable for performance

Over the last 60 days or more, we have made extensive management and operational changes aligned to this agenda of reform and performance. Other such changes –

- to leadership,
- to our businesses, our culture, approaches and practices,
- and to our board, governance and succession oversight, as appropriate,
- will continue to be made as we proceed through this period.

With those thoughts in mind, Tim Noel and Patrick Conway, heads of UnitedHealthcare and Optum respectively, will walk through some of the specifics in their businesses. John Rex will discuss financial performance and the elements affecting our outlook. And I'll come back with some closing thoughts, and then we will have ample time for questions and answers. Tim.

Tim Noel

Thanks, Stephen.

I want to start by emphasizing that we are approaching our business with greater humility, greater transparency, and a renewed determination to meet your expectations and our standards.

The primary driver of the UnitedHealthcare earnings shortfall for 2025 is that our pricing assumptions were well-short of actual medical costs. Our current view for 2025 reflects $6.5 billion more in medical costs than we anticipated in our initial outlook.

A little over half, or $3.6 billion, of this is in our broad-based Medicare portfolio. About one-third, or $2.3 billion, is in the commercial business, split evenly between ACA plans and our employer business. The remaining trend pressure is related to Medicaid, most notably due to elevated behavioral trend.

In addition to trend-driven issues, the updated 2025 outlook removes about $1 billion from previously planned portfolio actions that we are no longer pursuing. It also reflects about $850 million of other items including unfavorable prior period items – primarily from 2024 – and recognition of several one-time settlements. We know these are serious challenges. We are humbled by them and will carry that sense of humility more deeply into our culture. But we also believe we can resolve our current issues and recapture our earnings growth potential.

Let me now provide an update on where each business stands, starting with Medicare.

When we prepared our 2025 Medicare Advantage offerings back in the first half of 2024, we significantly underestimated the accelerating medical trend and did not modify benefits or plan offerings sufficiently to offset the pressures we are now experiencing. This was compounded by the magnitude of plan exits across the sector and the extent to which we now see care providers placing further service intensity into the health system. The increasingly flexible orientation to which our Medicare networks and plan designs have evolved over recent years left us less able to address these trends in-year.

On trend specifically, the increase in care activity across Individual and Group Medicare Advantage we saw earlier this year has now affected complex populations and our Medicare Supplement business as well.

Across Medicare Advantage, physician and outpatient care together represent 70% of the pressure year to date; however, inpatient utilization has accelerated through Q2 and we expect will comprise a relatively larger portion of the pressure over the full year.

We continue to see utilization increases in ER and observation stays, and consistently see more services being offered and bundled as part of each ER visit and clinical encounter.

In short: most encounters are intensifying in services and costing more. The higher trend is broad-based geographically and across our membership, including our large retained membership base.

To put this into context, we had initially assumed Medicare Advantage medical cost trend of just over 5% when configuring our 2025 bids, in line with our normalized trend experience in 2024. We now expect full year 2025 trend to be approximately 7.5%.

Medicare Supplement, which typically is representative of overall care activity levels and cost trends in Medicare fee for service broadly, is up similarly in 2025 compared to historical levels. We expect that trend to be over 11% this year vs. 8 to 9% in recent years -- further confirming the broad-based nature of the care activity, and the coding and billing patterns trends we are seeing.

On Commercial: We are seeing higher-than-expected medical cost increases, particularly in outpatient care and, although to a lesser extent, inpatient care. Orthopedic spending and pharmacy infusions are notable factors here. In the ACA business, the revenue impact resulting from a difference between the morbidity that we priced for and what we experienced is the primary cause of our underperformance.

One example of the elevated Commercial trend is group fully-insured. There, trend is approaching 11%, which is approximately 100bps higher than our initial expectations.

Moving to Medicaid…Similar elevated trends are apparent and are further affected by increasing and unanticipated acceleration of costs in behavioral health, where trend is running at 20%, as well as in pharmacy and home health.

We anticipate the existing rate and acuity mismatch will extend well into next year.

Beyond these segment-specific factors, there are other broad drivers of higher medical costs. There has been a marked increase in health care costs due in part to increases in service intensity per encounter. For example, in Medicare Advantage, higher frequency of physician rounding, testing and related services of specialists and in ER settings are contributing to elevated outpatient spend.

In addition to strongly responsive pricing for 2026, which I will speak to in a moment, we are intensifying our remediation actions.

We have stepped up our audit, clinical policy and payment integrity tools to protect customers and patients from unnecessary costs. These efforts ensure care is delivered in appropriate settings and grounded in safety and quality while also identifying waste and abuse in outlier coding and billing practices. We are shifting to narrower networks and focusing on more disciplined managed products, particularly in Medicare Advantage. And we have scaled our AI efforts across health plan operations, which improves the patient and provider service experiences while driving cost savings.

Lastly, in Medicaid, we continue to actively engage with state partners, using both past experience and data-driven insights to show the need for immediate and more regular rate updates.

Taken together, this work is helping restore our operational muscle and reclaiming executional rigor, helped by modern tools and driven by relentless focus on improvement.

Turning now to 2026…Our pricing strategy is intensely focused on margin recovery and moving back toward our earnings growth targets.

In Medicare, we have historically targeted an operating margin range of 3 to 5% . Now, with the changes from the Inflation Reduction Act on the Part D program,

which resulted in higher revenue, but do not impact earnings, the equivalent target margin range is in the 2 to 4% range.

We are working intensively to remediate Medicare through pricing, product design and benefit changes that will enable us to be within the lower half of the targeted margin ranges in 2026, and advancing further in 2027.

Our Medicare Advantage pricing strategy for 2026 assumes a trend approaching 10%, compared to our current 7.5% trend expectation. This accounts for trend acceleration and incorporates factors such as changes in fee schedules and the continuation of higher yields from provider coding and billing practices. Considering the continued cost trend and funding pressures, and the need to support margin recovery, we have made significant adjustments to benefits.

Additionally – and unfortunately – given these pressures we have made the difficult decision to exit plans that currently serve over 600,000 members, primarily in less managed products such as PPO offerings. We have taken similar approaches for Medicare Supplement, Group MA, and standalone Part D pricing for next year. We will be watching the market closely as the 2026 Medicare offerings become public so we can better assess our market positioning and respond quickly.

For Commercial, because renewals occur over the course of the year, we are able to price for changes more dynamically. Our pricing will anticipate higher trend continuing into 2026 and 2027. We expect increased membership decline, as well as shifts into both level-funded and self-funded product categories, because of higher medical cost trends.

In the individual exchange business, while we are prepared to continue to participate in the majority of the 30 markets we currently serve, we will approach them far more conservatively for 2026. We may need to make the difficult decision to exit select markets if we are unable to achieve the rates necessary for higher market-wide morbidity. Additionally, due to the projected expiration of premium subsidies across the ACA market our membership should decline

significantly and we are mindful of the potential for adverse selection dynamics as we re-price these offerings for next year.

In Medicaid, there remains a lag between funding levels and member health risk and we expect this to continue into 2026, resulting in additional margin compression in the business including a loss within the non-dual segment of Medicaid in 2026. Membership losses from early adoption of recent legislation is also factored into our initial views for 2026. Wherever states support responsible funding for Medicaid, we remain committed to serving people through that program and view this as integral to our mission.

The American health system's long-standing cost problem is accelerating. We are embracing our responsibility to continue to drive better health outcomes while trying to keep health care affordable for all Americans.

The operational and pricing strategies I have described reflect our understanding of the challenges we face as a company and a society, and our dedication to responsibly navigating the current financial pressures so that we can set a stable course for the future.

I'll now turn it over to Patrick Conway, CEO of Optum.

Patrick Conway

Thanks, Tim.

Clearly, Optum's performance this year has also not met expectations – yours or ours. Echoing Tim and Steve, we are approaching this with humility and the need for deep analysis of key issues, and commitment to substantially improved execution. Serving our patients and customers is at the heart of our mission and business and we have the opportunity to truly help make the health system better for everyone.

To do that, we need to refocus on our performance discipline with a bias for action and transparency for all stakeholders.

We have launched our agenda of change at Optum, starting with the evolution of our leadership team. Roger Connor brings tremendous experience in organizational execution as our chief financial officer. Krista Nelson is a deeply experienced health care operator now in the new role of chief operating officer of Optum Health. Dhivya Suryadevara is already reenergizing product development, marketing and service as the new CEO of Optum Insight. And Jon Mahrt brings his unmatched pharmacy services experience to bolster the already compelling offerings of Optum Rx.

These are not the only people in new roles and there will be more. We are taking these and many other steps swiftly to enable Optum to recapture its historic momentum.

Let me turn now to a review of our businesses, starting with Optum Health – where improved execution is needed most and where we are experiencing the greatest pressures to our business.

Our belief remains steadfast: value-based care has the potential to transform health care. Yet even as we struggle to align this model with new funding dynamics, it consistently delivers better outcomes. Tim highlighted the challenges of rising health care unit costs, accelerating service volumes and provider coding intensity, which further underscores that value-based care remains the most effective method for compensating providers to improve and sustain a patient's health in contrast to simply increasing the volume and prices of services.

Research consistently supports this premise, showing Medicare Advantage patients in fully accountable arrangements are 20% less likely to be hospitalized and experience 11% fewer ER visits compared to those in fee-for-service. We are early in our value-based care journey. We know we have real and self-

inflicted executional challenges and we bear the responsibility to get this right, recognizing that urgent work lies ahead.

We have spent a decade assembling a care delivery model today serving nearly 20 million patients across three lines of business – value-based care, fee-for-service care delivery and services, the latter two of which help further enable value-based care.

The first category, value-based care, has grown to account for approximately 65% of Optum Health's revenues and serves 5 million patients in fully accountable arrangements. I'll provide more details on this in a moment but first will detail the gap to our original Optum Health outlook.

Overall, Optum Health earnings in 2025 are approximately $6.6 billion below our expectations. To break this down:

- Approximately $3.6 billion, or 55%, is concentrated in our value-based care business with three principal drivers of roughly equal weight:
    - 1: The mix of enrollment, including more complex and dually eligible members, and more new-to-Optum patients who were underserved;
    - 2: Accelerated medical trend, particularly physician and outpatient in Medicare and behavioral in Medicaid.
    - And 3: Under-estimation of new members' risk status as they come into our care and sub-optimal execution of the V28 risk model transition;

- Second category - Another $2 billion, or 30%, relates to the decision to discontinue previously planned portfolio actions.

- And about $1 billion, or 15%, is from a combination of lower service volumes in our services businesses, some non-recurring prior period impacts and the slowing of tuck-in acquisitions. For example, on lower service volumes, in 2025 we planned for approximately 20 million fee-for-

service visits in our care delivery clinics and we are tracking 19 million visits, or 5% below this expectationLet me dive a bit deeper specifically into factors affecting our value-based care business:

- First, V28. This industry-wide shift is effectively a price reduction that we now estimate created an $11 billion headwind over three years for Optum Health, with ~$7 billion that will be realized through 2025. That is $2 billion and $1 billion, respectively, more than our initial estimates while we also overestimated the impact and mis-executed the planned efforts to offset the V28 funding cuts.

- Second, enrollment mix. Consistent with Q1, in 2025 we have an unanticipated number of new-to-Optum Health patients who were previously underserved. These new patients are largely in markets where numerous plan exits occurred. They include complex patients who require time to be managed effectively by us. This mix impact implies negative margins near double-digits for these new patients, which will improve meaningfully in 2026.

- Lastly, the elevated medical trend we recognized in the second quarter was exacerbated by insufficient pricing within United Healthcare and other payer partners pulling through in the form of insufficient capitation rates for Optum.

Despite these headwinds, Optum's fully accountable value-based care business is delivering an operating margin of about 1% in 2025. This compares to full year operating margins of over 3% in 2024 and nearly 5% in 2023.

A large part of the mis-execution in addressing the V28 funding cuts was due to a non-standardized and overly localized management approach which we are addressing with urgency. We are driving to a consistent and much more concentrated regional operating model with four market leaders. We are evaluating our position in each market. We will shift risk back to the original underwriters until we have the hardened capacity to navigate it under value-

based constructs.

And Optum will be much more disciplined in taking risk arrangements in product designs and constructs that allow value-based care to have its intended impact.

The margin compression reflects significant growth in new membership cohorts – with nearly 40% of the patients served today having come in since the beginning of 2024. It also reflects the pull-through from Medicare Advantage pricing dislocation Tim described, and the V28 payment cuts.

Regarding patient cohorts: in our value-based care practices, margins improve the longer patients remain. Our most mature value-based care cohorts – those from 2021 and prior – are operating at an estimated 8%+ margin in 2025. Those in 2022 and 2023 cohorts are operating at a 2% margin; the 2024 through 2025 groups are at negative margins.

Strong physician engagement, appropriate medical diagnosis, and improved, consistent quality of care continues to drive year over year improvement in a cohort's financial performance and in their health. But it's taking too long and there is too much variability in results among practices, and we are actively addressing those factors.

That's the overall picture of what is happening. I'll turn now to remediation. Our plan for improvement has four key elements:

First and foremost, we are improving the implementation and consistency of our clinical model, which is anchored in primary care and supported by wraparound services that continue to outperform on quality and cost.

Second, we are committed to margin recovery in value-based care. We've aligned our 2026 benefits and product portfolio and footprint with our payor partners to address the final year of V28 headwinds. We plan to cease arrangements for about 200,000 patients largely in fully accountable PPO

products, representing approximately 40% of the PPO patients we serve today. We expect to keep narrowing our exposure beyond 2026.

We are increasing rates to reflect the higher risk profiles and acuity we are seeing and expect to continue. We believe the combination of these activities will mitigate about half of the remaining $4 billion V28 headwind in 2026. The remainder of our offset will come from operating cost discipline and consistent execution of our care programs which enhance engagement, diagnosis accuracy and quality outcomes, and reduce overall cost of care.

With 2026 being the final year of V28 phase-in, you should expect 2026 value-based care margins to remain relatively consistent with the 1% margin we are achieving this year, and then begin to advance again in 2027 and beyond.

We are optimizing our portfolio of clinical practices. We are managing our fee-for-service and fully accountable risk practices to align with performance expectations, transitioning to partial risk or service arrangements where necessary, and exiting fully accountable products in certain markets.

Third, we are aggressively advancing operational disciplines across our portfolio of businesses. The more concentrated operating model I mentioned earlier plays into more standardized approaches, predictable outcomes and lower operating costs. We will complete the final stages of our technology integration, which will enable meaningful advances with emerging technologies like AI to drive efficiency gains. For 2026 we expect to deliver almost $1 billion in cost reductions.

Finally, beyond value-based care, Optum Health also includes fee-for-service care delivery, including home care, ambulatory surgical care and medical practices that are not yet fully accountable but support value-based care. These together account for 15% of Optum Health’s revenues. Most of these businesses are performing well and operate at low double-digit margins. However, the primary care and multi-specialty medical practices that are not yet fully accountable are running at negative margins – generating hundreds of millions of

losses this year alone – placing the overall fee-for-service care delivery business in the mid-single digit margin range.

So, we are actively working to improve payment yields and productivity while growing these high-value services and fee-for-service margins. We are targeting growth for these services which are projected to deliver strong year-over-year earnings growth in 2026.

The third component of Optum Health – services – is comprised of businesses including managed behavioral health, military and veterans and health financial services. These account for about 20% of Optum Health revenues and combined have an almost 10% operating margins.

Overall at Optum Health, while we expect continued pressure for the rest of this year, we anticipate meaningful improvement in our operations and with earnings growth in 2026, albeit with a longer path to recovery in our value-based care business. We now see Optum Health long-term margins in the 6-8% range, and at about 5% for value-based care specifically, as we see significant growth opportunity for the decade to come. The overall blended margin will reflect the early year investment losses generated by new cohorts. Optum Health is early in its development and mis-execution is a clear setback, but the long-term growth potential and expectations remain intact and significant.

Moving to Optum Insight – there is a great need and appetite for technology and data products to help the health system perform more efficiently and effectively yet Optum Insight has not fully capitalized on this opportunity. That's largely due to an unfocused suite of products, lagging innovation, and longer than expected impact from last year's cyberattack, which, unfortunately, came at the expense of being able to drill down on business innovation, operations and growth.

But as I mentioned earlier, we have a talented team in place now and continue to recruit talent to develop the next generation of products rooted in AI.

As it relates specifically to 2025, we are adjusting our outlook downward by $1 billion. About half of this is due to a more gradual recovery than initially expected in some of our volume-based businesses due to Change Healthcare and one-time cyber-related expenses.

The other half is due to pausing previously planned portfolio actions so that we can prioritize growth and innovation across our broader portfolio.

At Optum Rx, client retention remains high and consistent with past years. We expect revenue growth of $18 billion, or 13%, and earnings growth of just over $200 million, or nearly 4%, driven by low-margin specialty drugs.

Compared to the strong revenue growth rate, our earnings growth has been constrained by four main factors: the removal of portfolio actions from our plan is a roughly $150 million headwind; another $50 million is from a couple of ancillary businesses, where we are taking aggressive corrective actions and adjusting plans; and the impact of the initial launch phase of our private label business, Nuvaila, is a roughly $150 million headwind. As it matures, we see Nuvaila delivering affordability for clients and consumers and strong earnings for Optum Rx.
Additionally, GLP1s, which can benefit appropriate patients, continue to impact earnings, representing a $160 million headwind for our pharmacy business.

After three months in this role, I want to thank the thousands of people serving in Optum, and to let external stakeholders know that the problems are fixable, and that Optum will continue to drive long-term growth and make the most of our opportunity to serve people.

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

John Rex

Thanks, Patrick.

I'll first walk through second quarter results, then provide some color around the underlying assumptions within our re-established `25 outlook.

Starting with the second quarter, UnitedHealth Group reported revenues of nearly $112 billion, a 13% increase over the prior year, which reflected growth across UnitedHealthcare and Optum.

Adjusted earnings per share of $4.08 was below the same period last year. This was due primarily to the pricing and medical cost trend factors at UnitedHealthcare and Optum Health. Included is about $1.2 billion in discrete items. A little over half reflects the recognition of unfavorable impacts to our ACA exchange offerings, which I will describe later in more detail. The remainder is the settlement of several outstanding items which have been in dispute or for which collection has recently become questionable. Most of these items arise from prior years. The full year '25 outlook we've offered today accommodates $1 billion in additional potential such items that we may seek to resolve in-year. Now on to business overviews.

At UnitedHealthcare, second quarter revenues grew by over $12 billion to $86.1 billion, while operating earnings declined by $1.9 billion to $2.1 billion primarily due to the medical trend factors Tim discussed.

Within our Medicare businesses, year-to-date Medicare Advantage growth is 650,000 people, including those who are dually eligible for Medicaid and Medicare.

As noted, the second quarter results reflect just over $600 million of unfavorable impacts from our ACA exchange business, which includes acceleration of anticipated second half losses with the establishment of a premium deficiency reserve. This is due to the higher patient morbidity that is pervasive across the entire exchange market.

Given competitive market dynamics, we have less member growth within our commercial offerings than initially anticipated. ACA exchange drives about one-third of our reduced commercial risk member growth outlook for 2025, with group-insured comprising much of the rest.

As outlined earlier, our Medicaid offerings continue to experience pressure from the lag in state rate updates relative to the health status of the members being served. Our state partners remain highly engaged in ongoing rate conversations and we are closely attuned to the federal funding changes and the continued pace of medical cost trends, particularly in behavioral health.

Moving to Optum.

Optum Health revenues were $25.2 billion in the second quarter, a decline of $1.8 billion from last year. This was driven by the previously noted contract adjustments and the effects of the Medicare funding reductions. Optum Health now expects to add 300,000 new value-based care patients this year compared to the initial 650,000 outlook as it seeks to focus on improving operating performance. As noted, we‘ve updated our long-term target margin objective for Optum Health to the 6 to 8 % range.

Optum Insight had revenues of $4.8 billion, an increase of $285 million or 6% year over year. We continue to progress on customer recovery following last year’s cyber event, albeit pacing more slowly than expected and this is a component of the reduced full year outlook. The contract revenue backlog at the end of the second quarter was $32.1 billion.

Optum Rx second quarter revenues grew $6 billion, or 19%, over last year to $38.5 billion, driven by new customer adds as well as continued contribution from specialty products. Total adjusted scripts were 414 million compared to 399 million in the year ago quarter.

Moving on to 2025 guidance.

Our adjusted earnings outlook is at least $16 per share. Revenues will approach $448 billion, growth of 11% over ‘24.

We now expect a full-year medical care ratio of 89.25%, plus or minus 25 basis points. This compares to the initial 86.5% mid-point we offered at the end of last year, with the increase driven by the factors discussed.

Within this, seasonal pacing compared to historical measures is impacted somewhat by the Part D coverage gap modifications due to the Inflation Reduction Act. With first half results, at the midpoint that places the second half at just under 91.5%, with the fourth quarter expected to be the highest and, at this distance, a relatively proportionate distribution on either side.

The full year outlook contemplates a total of $1.6 billion of potential settlement items, an incremental $1 billion over the $600 million recognized in the second quarter.

Our tax rate for the year is now estimated at about 18.5%, affected by our revised earnings outlook as expected benefits remain steady, while earnings declined. The lower tax expense in the second quarter reflects the year-to-date recognition of the updated full year effective tax rate. We expect the second half rate to be just over 20%.

Full year ’25 cash flows from operations are expected to be about $16 billion or 1.1 times net income.

In June, we increased our dividend by 5% and we will strike a balance as to how we use capital over the near-term, being thoughtful about maintaining a strong balance sheet and credit rating and mindful of long-standing commitments, including the pending Amedisys transaction. Our updated share count of 912 to 914 million compares to the original outlook of 918 to 923 million and considers only share repurchases completed earlier this year.

We will continue to balance and assess our capital priorities as we progress to returning to the performance levels we know we can achieve.

With that, I will hand it back over to Stephen before we head into Q&A.

Stephen Hemsley
Thanks, John.

This is a challenging year for our enterprise. But I feel strongly we can overcome these challenges – as we have done before. I can see the depth of the commitment of our team. We are regaining the intensity, the precision, and the executional disciplines required to perform consistently and reliably. Our customers and our shareholders deserve it. And the health system expects us to function to our full potential.

As we look toward 2026 and beyond, we expect the efforts we discussed throughout today's call to steadily improve our performance. It begins with respecting pricing basics, advancing our foresight acumen and just better, more intense, more decisive overall management.

We will be driving better business practices, better consumer and provider experience, and accelerating investments in key areas to both strengthen our foundations and modernize our businesses, anchored in practical innovations and scaled AI applications.

We are continuing to evaluate the investments we need to make in the near-term to meet our long-term growth potential while acknowledging the challenging environment in the year ahead.

As I mentioned at our shareholder meeting in June, we are rebuilding the trust through both change and through increased transparency. That includes work to ensure a wide range of stakeholders have confidence in the integrity of our Company and our business practices. This work is moving forward in our assessment of key policies, practices and associated processes by the end of

the third quarter and our first performance measures report in the fourth quarter. We have retained independent experts to oversee and assist in these reviews, including the Analysis Group and FTI Consulting. We will use this to continually strengthen and advance our strong compliance environment.

Looking to 2026, at this distance I would expect solid but moderate earnings growth. As we look further ahead, we see our earnings growth outlook strengthening quickly in 2027 and pacing steadily upward over the succeeding years.