MORNINGSTAR

Managed Care Organizations

The MCOs help clients manage risks around healthcare spending.

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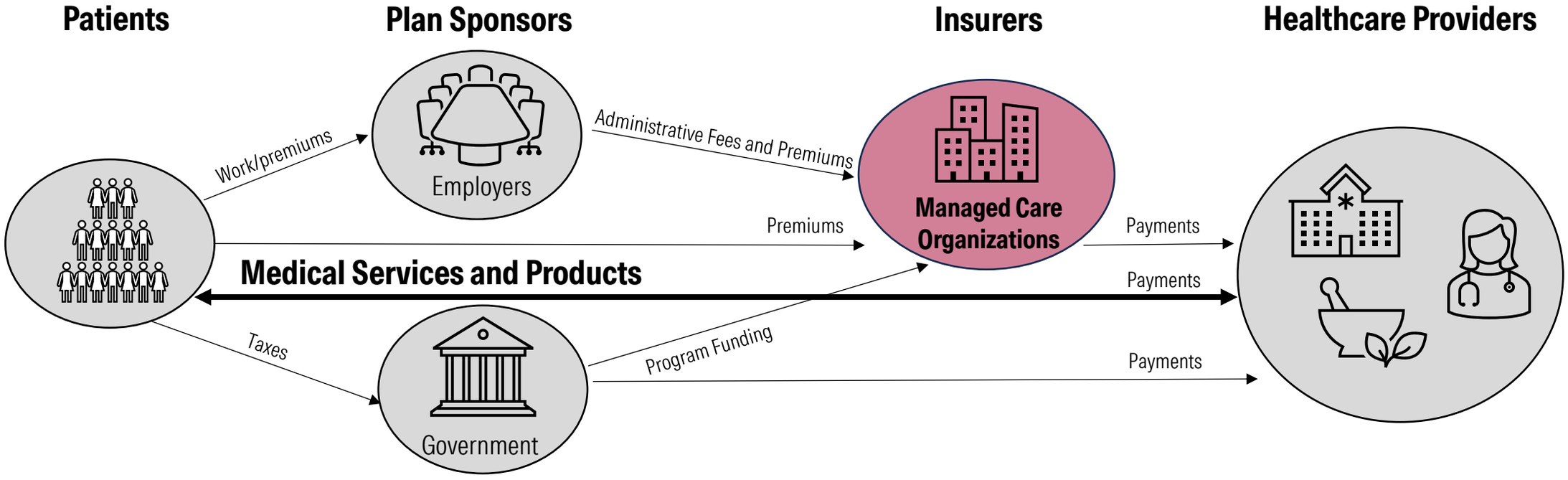
Executive Summary

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 offer health insurance plans directly to individuals and through sponsors like employers and the government. Some MCOs have also expanded into other business lines, too, including caregiving and pharmacy services.

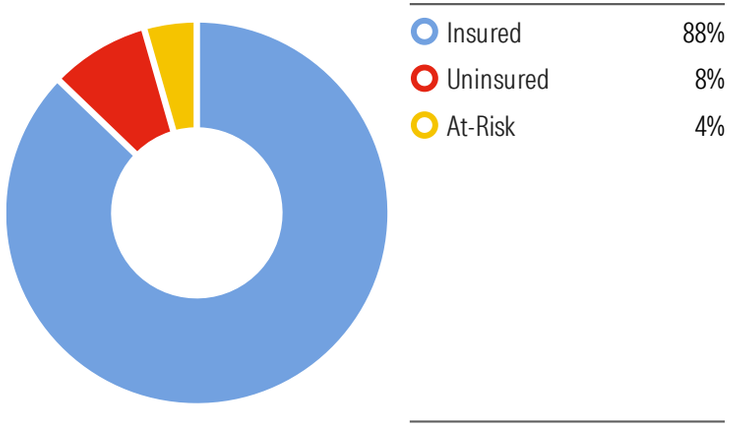
The US Uses a Multipayer Healthcare System That Relies Heavily on the MCOs for Plan Management and Payment Processing



Source: Morningstar as of September 2026.

Key Industry Themes

New Regulations Are Reducing US Insured Population

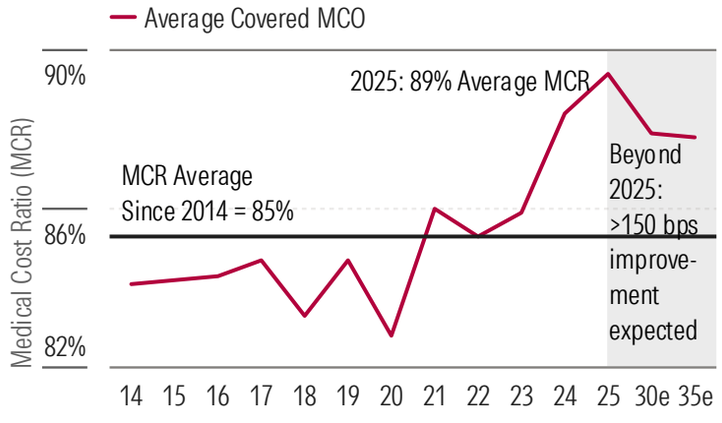


New regulatory policies are cutting into the US insured population:

- On the individual exchanges, about 5 million people may lose coverage after subsidies expired in 2026.
- In Medicaid, about 10 million people appear at risk from added work requirements and administrative hurdles expected by the end of 2027.

Insurers concentrated in those markets—like Centene, Elevance, and Molina—face more uncertainty than peers especially through 2027.

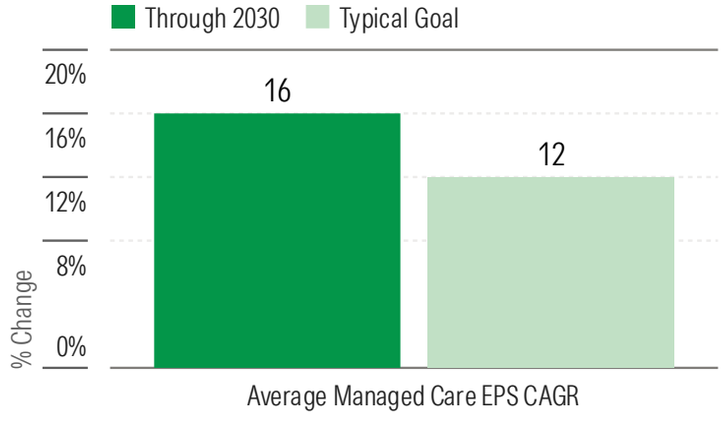
MCOs Aim To Balance Mismatched Rates/Utilization



To boost deflated profit margins, medical insurers need to balance mismatched rates and utilization that are currently inflating medical cost ratios, or MCRs.

- On average in 2026, covered MCOs are expected to generate MCRs about 400 basis points higher than norms since minimum MCRs began in 2014.
- We expect over 150 basis points of MCR improvement during the next 10 years, as Medicare Advantage margins are already improving and the rest may improve over time. However, higher growth in lower-margin markets may constrain overall improvement.

Despite Challenges, Profit Growth May Exceed Norms



MCOs are boosting margins through the following actions:

- Exiting unprofitable geographies
- Changing plan designs, like reducing extra benefits in Medicare Advantage, or MA
- Raising rates like the substantial boost to individual rates in 2026

Over time, we expect margins to expand materially from recent troughs, which could lead to higher profit growth through 2030 (midteens) than the industry's typical goal in the low double digits.

Source: Morningstar analysis of company reports and Congressional Budget Office estimates as of September 2026.

Industry Value Drivers

Financial Value Drivers: Elevance 2025 Example

		2025	Relevant Ratio
Premiums	1	$164,639	83% of Total Revenue
Product Revenue		$24,470	12% of Total Revenue
Service Fees		$8,475	4% of Total Revenue
Operating Revenue		$197,584	99% of Total Revenue
Investment Income and Other		$1,541	1% of Total Revenue
Total Revenue		$199,125	100% of Total Revenue
Benefit Expense	2	$148,223	90% of Premiums
Cost of Products Sold		$21,178	87% of Product Revenue
Gross Profit		$29,724	15% of Total Revenue
Operating Expense		$20,984	11% of Total Revenue
Interest Expense		$1,402	1% % of Total Revenue
Other		$628	0% of Total Revenue
Income Taxes		$1,049	16% Effective Tax Rate
Net Income		$5,661	3% of Total Revenue
Adjustments to Net Income		$1,906	1% of Total Revenue
Changes in Working Capital		-$3,277	-2% of Total Revenue
Operating Cash Flow		$4,290	76% % of Net Income
Capital Expenditures	3	-$1,116	-20% % of Net Income
Free Cash Flow		$3,174	56% % of Net Income
Acquisitions/Divestitures		$88	0% % of Free Cash Flow
Dividends		-$1,529	-48% % of Free Cash Flow
Share Repurchases		-$2,605	-82% % of Free Cash Flow
Net Borrowings		$2,327	73% % of Free Cash Flow

1.) Operating Inflows include a variety of potential revenue streams.

- Premiums can be earned when MCOs manage a client's medical risks.
- Product revenue from non-medical insurance operations can include drugs sold through pharmacy benefit managers.
- Clients pay service fees to MCOs to administer plans without risk sharing.
- Income from investment portfolios can flow through revenue, too.

2.) Operating and Financial Outflows include indirect and direct costs.

- Indirect costs include medical expenses from at-risk client relationships (benefit expense) and other items like drug costs (cost of products sold).
  - The medical cost ratio (MCR), or benefit expense per premiums, can show how an MCO has managed medical utilization risks.
  - Lower MCRs are better, and industry MCRs currently are inflated well above norms, cutting into industry profits.
- Operating expense represents the largest costs that MCOs can control directly and are typically related to labor, facility, and technology costs.

3.) Capital Allocation Activities reflect how management teams use cash flows.

- Internal (capital expenditures) and external (acquisitions/divestitures) investment activities can be important for MCOs.
- Dividends and share repurchases often add to total shareholder returns.
- Net borrowings can fund deficits from the above in this typically investment-grade industry.

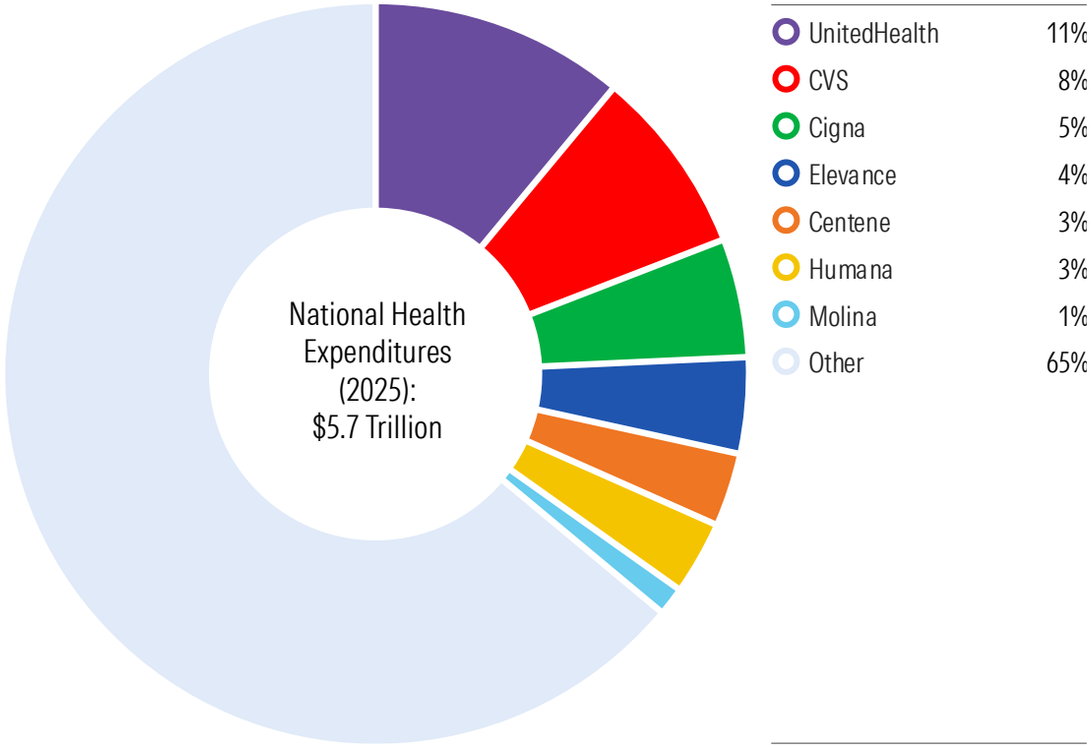
Source: Morningstar's analysis of Elevance's annual report as of September 2026.

MCO Share of National Health Expenditures

In the highly fragmented US healthcare system—that includes insurance, caregiving, and pharmaceuticals—the seven managed care organizations we cover generated gross revenue worth about 35% of the 2025 national health expenditures, or NHEs, shown below left, and nearly 70% of the slightly more than half of NHEs that private insurers manage cumulatively, shown below right. UnitedHealth leads the MCOs with 11% share of NHEs, followed by CVS (8%), Cigna (5%), Elevance (4%), Centene (3%), Humana (3%), and Molina (1%).

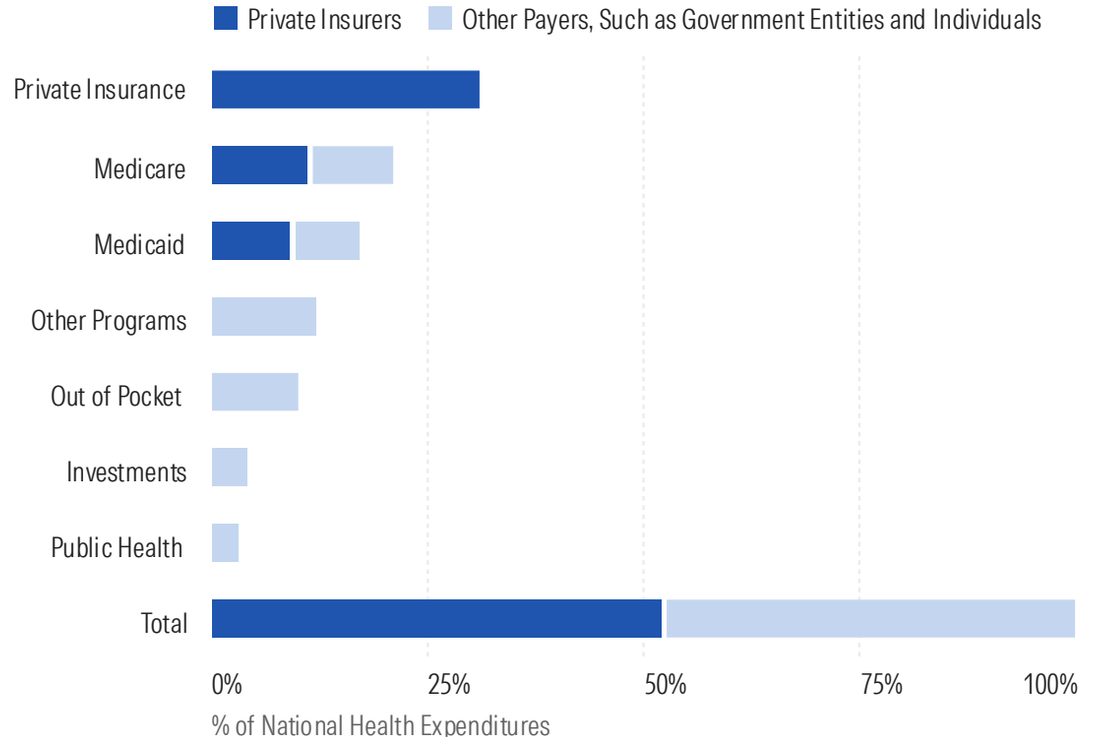
Key Managed Care Organization Share of US National Health Expenditures

Gross revenue as a percentage of $5.7 trillion national health expenditures in 2025.



Public-Private Partnerships Permeate the US Healthcare System

Just over half of national health expenditures were managed by private insurers in 2025.



Source: Morningstar analysis of company reports and data from the Centers for Medicare and Medicaid Services (CMS) and KFF on Medicare and Medicaid as of September 2026.

Coverage List and Ratings

After Medical Insurance Margins Hit Troughs in 2025, MCO Shares Rebounded About 35% on Average Over the Past Year and Trade at Fair to Moderately Undervalued Levels

Company	Ticker	Market Cap $ in Billions	Moat Rating	Uncertainty Rating	Star Rating	1-Year Return	Dividend Yield	Market Price	Fair Value	Price/Fair Value	Price/2026e Earnings	Adjusted EPS CAGR Through 2030e	PEG Ratio	US Members (12/31/25)	2025 Operating Profit % Med Ins	PBM	Other
UnitedHealth Group	UNH	$360	Narrow	High	★★★★	25%	2.3%	$401	$475	0.84	20x	18%	1.2x	50	50%	38%	12%
CVS Health	CVS	$123	None	High	★★★	37%	2.7%	$96	$110	0.87	12x	12%	1.0x	27	18%	44%	37%
Elevance Health	ELV	$87	Narrow	High	★★★★	31%	1.7%	$402	$474	0.85	15x	8%	1.9x	45	55%	32%	13%
The Cigna Group	CI	$73	Narrow	High	★★★★	-8%	2.2%	$276	$354	0.78	9x	9%	1.0x	16	37%	63%	0%
Humana	HUM	$48	Narrow	Very High	★★★	30%	0.9%	$403	$350	1.15	44x	13%	3.5x	12	55%	11%	33%
Centene	CNC	$32	None	Very High	★★★	123%	0.0%	$65	$75	0.86	13x	37%	0.3x	20	100%	0%	0%
Molina Healthcare	MOH	$10	Narrow	Very High	★★★★	9%	0.0%	$196	$262	0.75	36x	19%	1.9x	5	100%	0%	0%
Average						**35%**	**1.4%**			**0.87**	**21x**	**16%**	**1.3x**	**25**	**59%**	**27%**	**14%**

Source: Morningstar as of Sept. 8, 2026.

Economic Moat

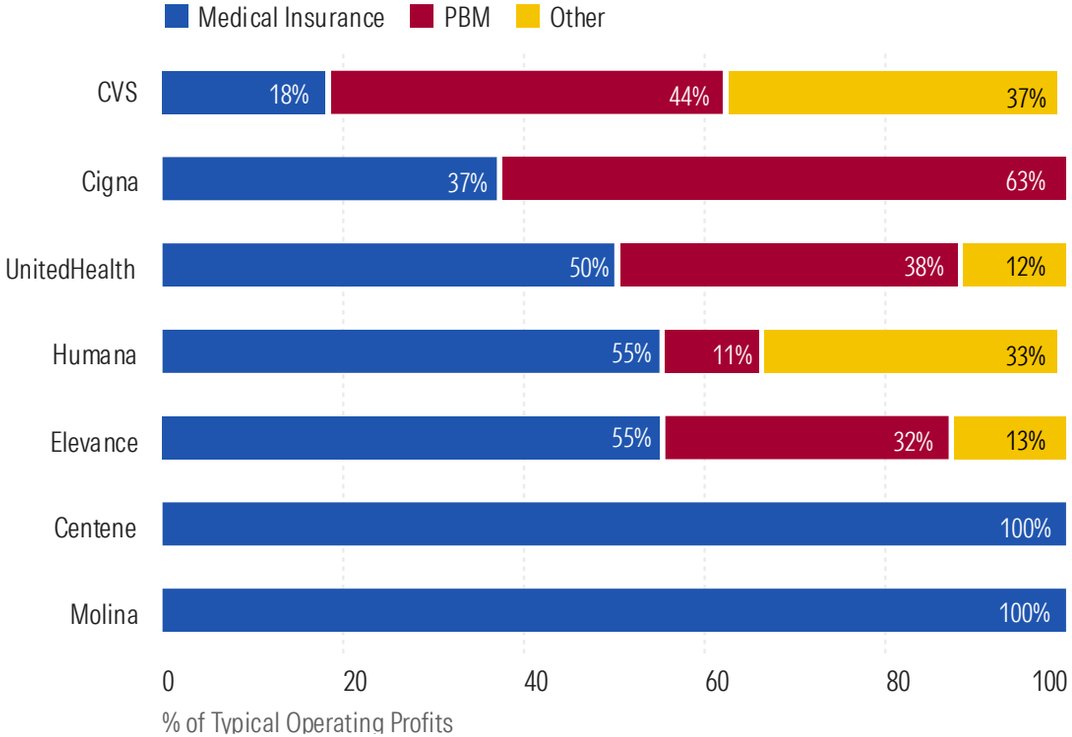
Due to regulatory risks, MCO moat ratings are capped at narrow.

Business Mix Helps Determine MCO Moat Ratings and Sources

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

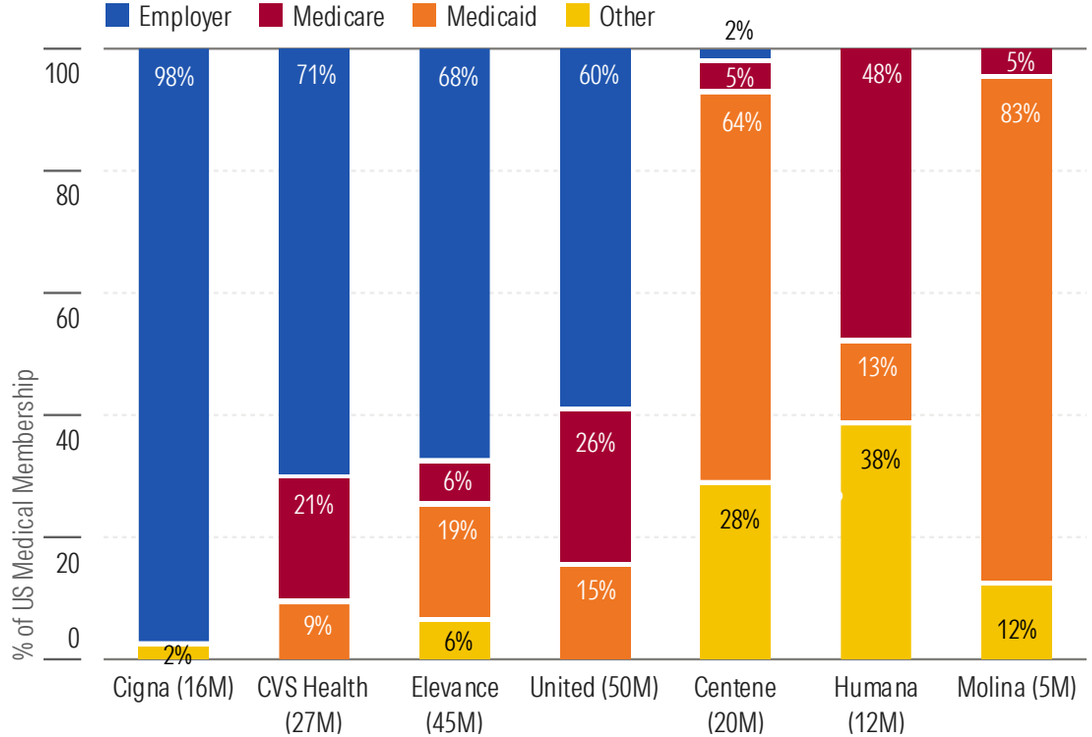
MCO Concentration From Least to Most Exposure to Medical Insurance

Operating profit mix (2025).



Medical Insurance Concentration, Sorted by Employer Plan Concentration

Medical membership mix as of December 2025.

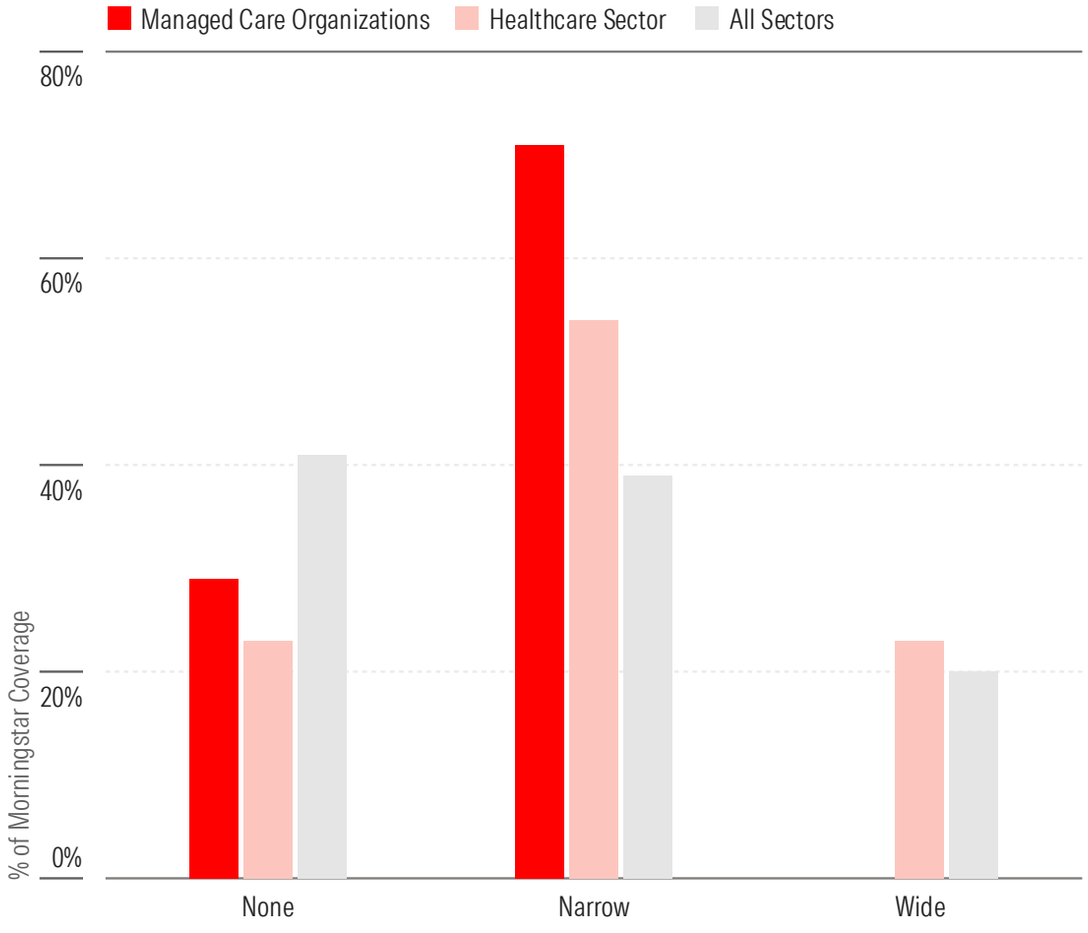


Source: Morningstar analysis of company reports as of September 2026.

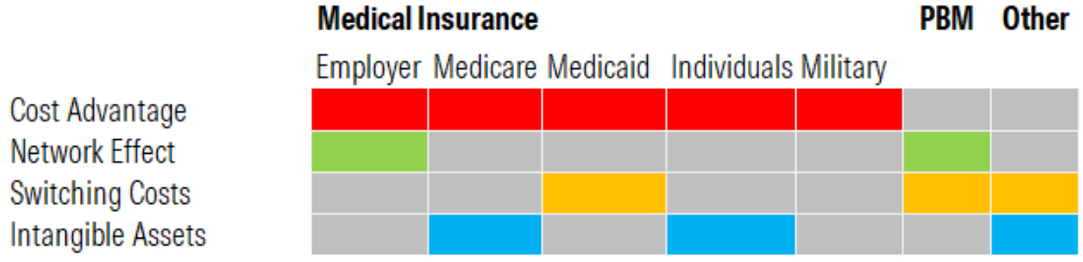
MCO Moat Ratings Are Capped at Narrow by Regulatory Risks, and Moat Sources Vary by End Market

Narrow Is the Highest Moat Rating Earned in the Industry Due to Regulatory Risks

Five of the seven covered MCOs have narrow moats while Centene and CVS have none.



Potential Moat Sources Vary by MCO End Market



MCO Moats Dug With Cost Advantages, Network Effects, and Switching Costs

Company	Moat Rating	ROIC 2030e	WACC	Key Market	Cost Advantage	Network Effect	Switching Costs
Humana	Narrow	20%	8%	Med Ins - Medicare	x		
UnitedHealth	Narrow	18%	8%	Med Ins - Employer	x	x	
Molina	Narrow	15%	8%	Med Ind - Medicaid	x		x
Elevance	Narrow	13%	8%	Med Ins - Employer	x	x	
Cigna	Narrow	13%	8%	PBM		x	x
Centene*	None	34%	8%	Med Ins - Medicaid			
CVS	None	10%	8%	PBM			

Source: Morningstar analysis as of September 2026.

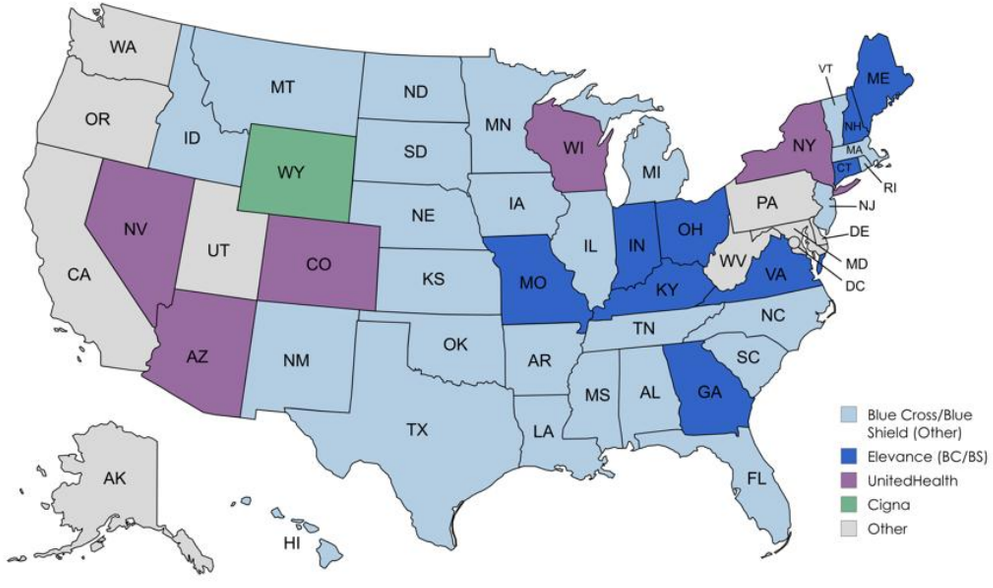
*In 2025, Centene's invested capital base fell roughly in half because it needed to writedown goodwill related to the fall in its stock price, inappropriately inflating ROICs for moat analysis purposes.

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

An MCO's negotiating power with providers relates to local market share, which helps it offer advantageous prices and benefits through local provider networks. 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 Sandusky.

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

Market leaders, according to AMA's competition in health insurance (2025 update).



Negotiating Power Dynamics Can Vary by Metropolitan Statistical Area

Ohio example.

Metropolitan Area	Insurer 1	Market Share	Insurer 2	Market Share
Akron	Elevance	34%	Medical Mutual	33%
Canton-Massillon	Medical Mutual	37%	Elevance	34%
Cincinnati	Elevance	75%	CVS	10%
Cleveland	Medical Mutual	33%	Elevance	32%
Columbus	Elevance	43%	CVS	21%
Dayton-Kettering-Beavercreek	Elevance	71%	CVS	9%
Lima	Elevance	49%	Medical Mutual	28%
Mansfield	Elevance	47%	Medical Mutual	35%
Sandusky	Medical Mutual	46%	Elevance	35%
Springfield	Elevance	67%	CVS	13%
Toledo	Medical Mutual	40%	Elevance	39%
Weirton-Steubenville	Highmark	39%	Elevance	26%
Youngstown-Warren	Elevance	50%	Medical Mutual	28%
Total Ohio	**Elevance**	**46%**	**Medical Mutual**	**22%**

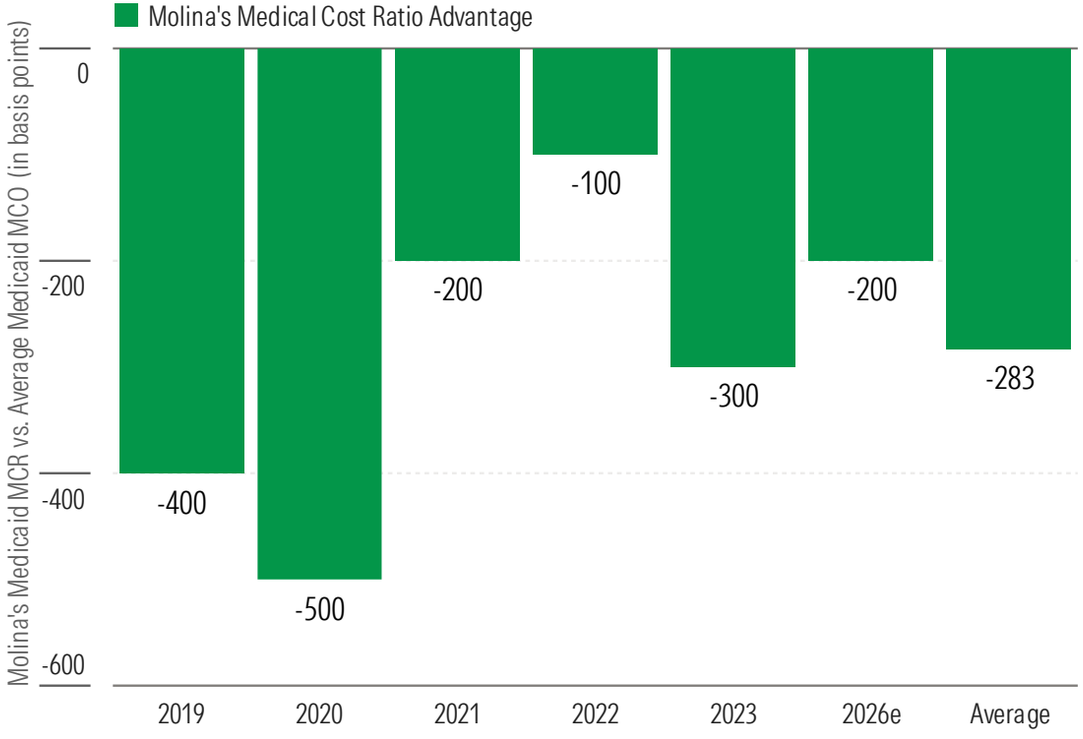
Sources: Maps created with mapchart.net based on Morningstar analysis of American Medical Association's 2025 Update to "Competition in health insurance: a comprehensive study of U.S. markets."

Cost Advantages Can Help MCOs in Other End Markets, Too, Including Medicaid Where Molina Shines

In Medicaid, Molina often wins business because of its ability to manage costs better than many of its peers, and that ability is even helping it stay profitable in a challenging 2026 environment when most other Medicaid MCOs are generating losses. Specifically, Molina is shooting for a positive 1.2% pretax margin in 2026 while the average Medicaid MCO looks likely to generate losses.

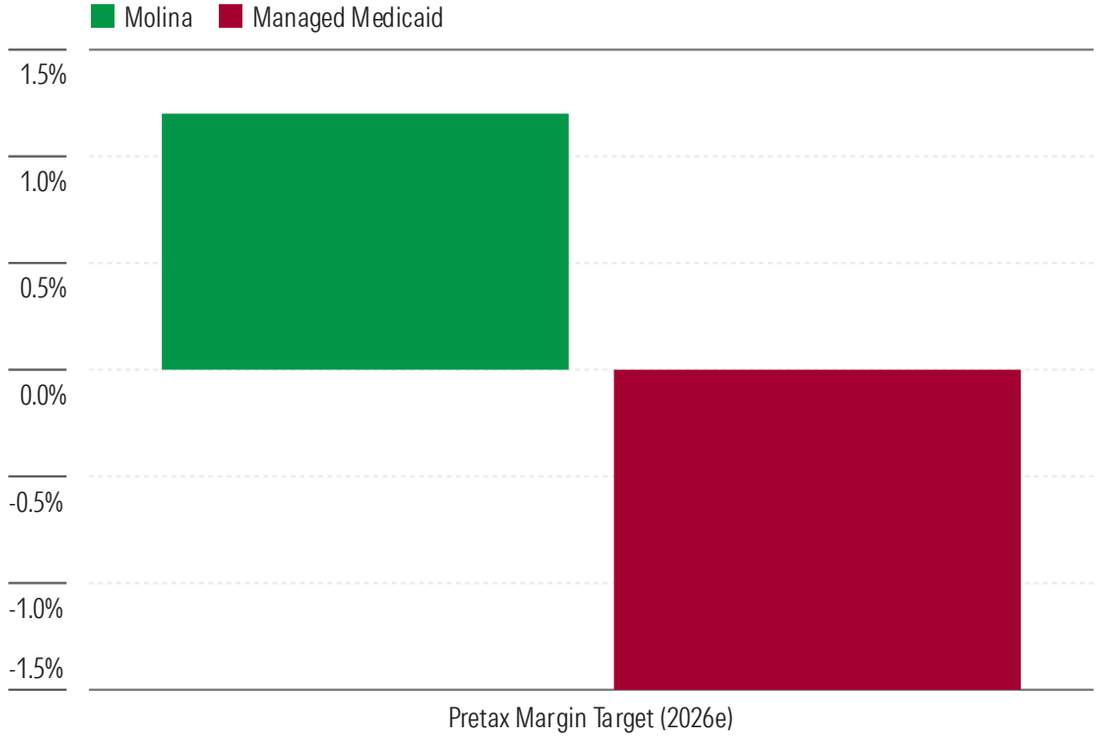
Molina Is Typically a Medical Cost Leader in Medicaid

Molina's Medicaid medical cost ratio is usually 200-300 basis points better than peers.



Molina's Cost Advantage Leads to Higher Profits in Medicaid

While most MCOs generate losses, Molina aims for a Medicaid profit in 2026.



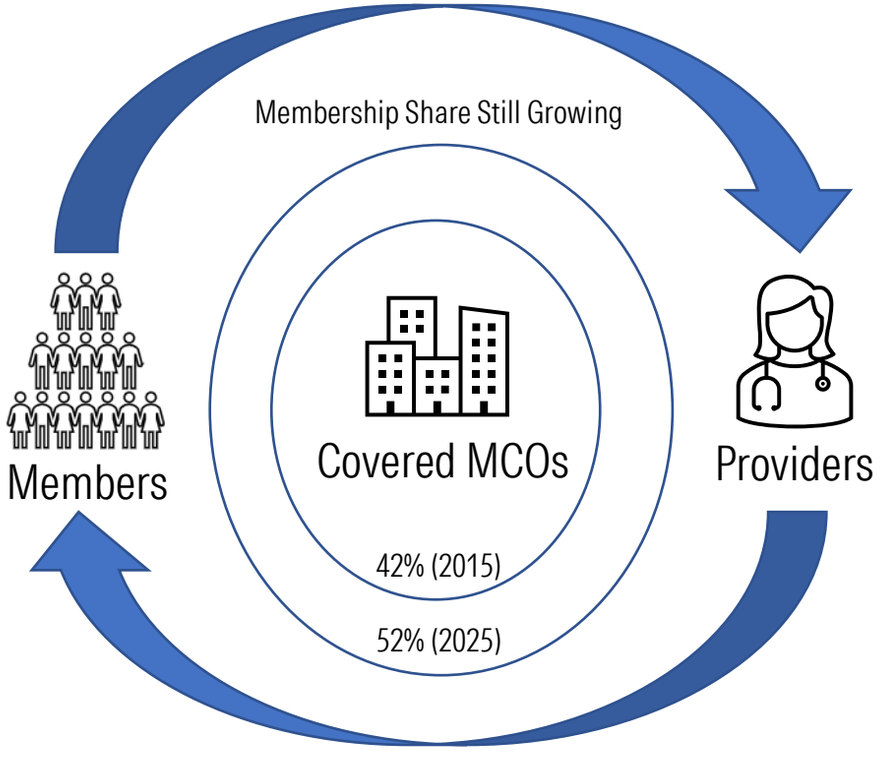
Source: Morningstar analysis of company reports and Molina investor day presentations (November 2024 and May 2026) as of September 2026.

Network Effects Help Top-Tier Players Get Bigger in Medical Insurance and Pharmacy Benefit Management

As an MCO's membership or PBM claim base grows, typically, it can more effectively negotiate with providers on medical service and product prices 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.

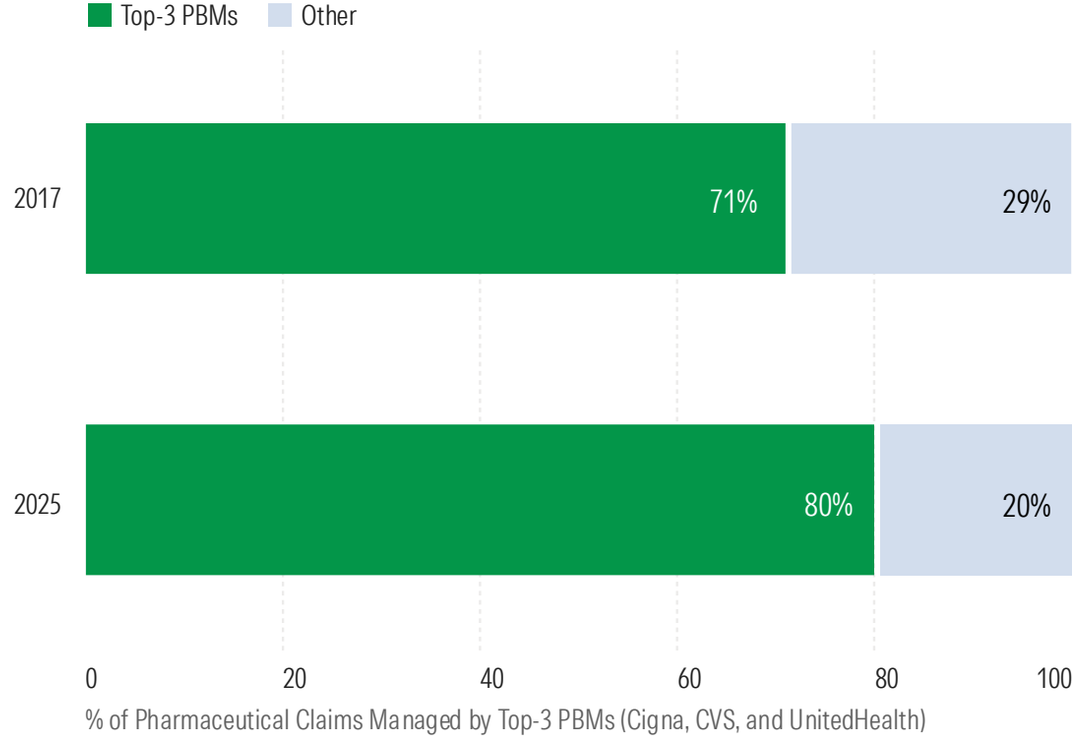
Top Medical Insurers Continue To Gain Membership Share

Medical membership at covered MCOs rose to 52% of the US in 2025 from 41% in 2015.



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

Pharmaceutical claim share of the Top-3 PBMs grew to 80% in 2025 from 71% in 2017.

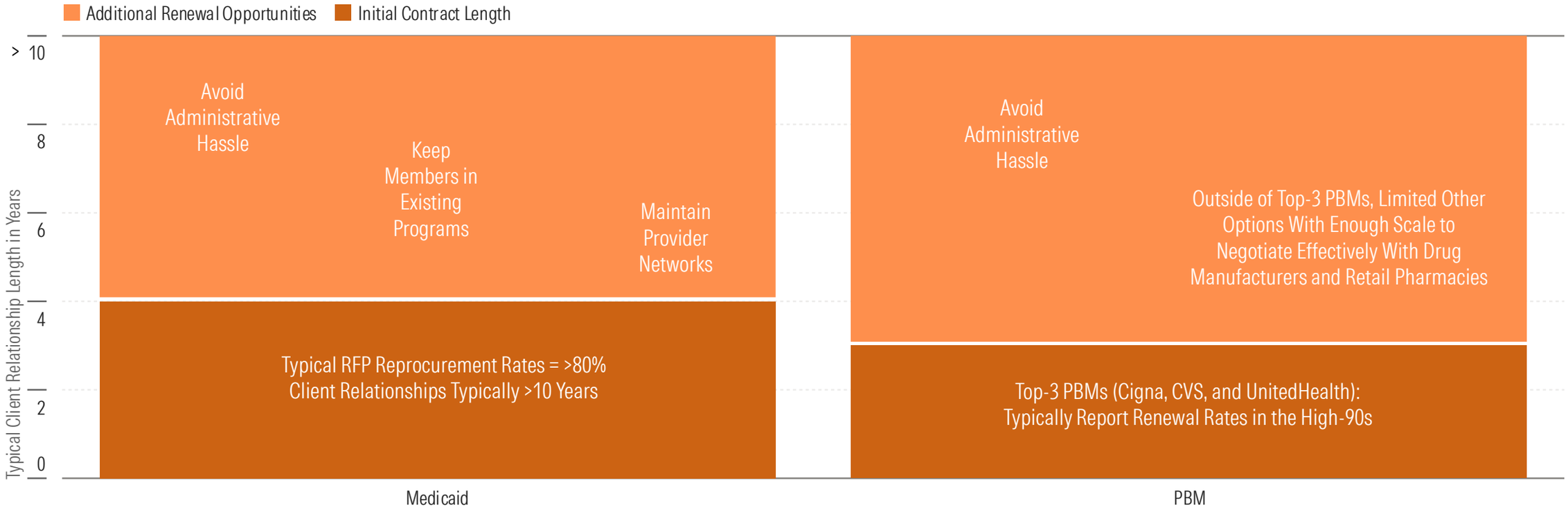


Source: Morningstar analysis of company reports, population data from the US Census Bureau, and Drug Channel Institute reports for 2017 and 2025 as of September 2026.

Switching Costs Can Add to Moats in Certain MCO Niches, Like Medicaid and the Pharmacy Benefit Managers

We see switching cost moat sources primarily in the Medicaid and PBM markets, which benefit from contractually enforced relationships with enough inertia to extend beyond the 10-year standard for narrow-moat firms. In Medicaid, for example, states often extend contracts with satisfactory incumbents to avoid the request for proposal, or RFP, process and maintain programs and provider networks. When contracts expire in the PBM market, incumbents appear to benefit from inertia in an industry with limited other scaled options.

Long, Contractually Enforced Client Relationships Can Contribute to Narrow Moat Ratings at Top-Tier Medicaid (Molina) and PBM (Cigna) Players



Source: Morningstar analysis of company reports as of September 2026.

Industry Basics

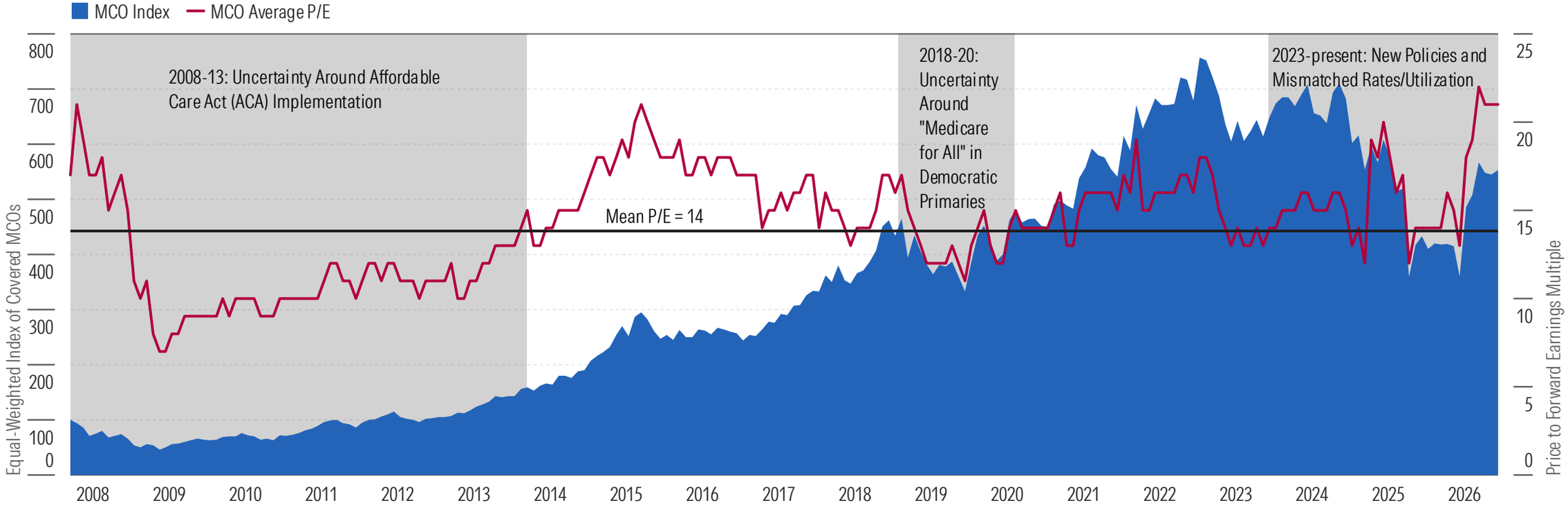
MCOs aim to improve margins while fending off regulatory challenges.

MCO Shares Rebounding in 2026 After Period of Regulatory Uncertainty and Mismatched Rates/Utilization

Covered MCO shares collectively returned 9% on 9% EPS growth compounded annually since late 2007, but it was a bumpy ride for investors, especially during election cycles when uncertainty around healthcare policy changes deflated P/E multiples. Also, industry profits declined since 2023 as medical utilization surged without an adequate increase in rates, especially in government plans. Shares are rebounding in 2026, though, in anticipation that margins will improve and new regulations will remain manageable.

Over the Long Term, the MCOs Have Produced Solid Shareholder Returns, but Shares Have Been Challenged by Regulatory Scrutiny and Underwriting Cycles

An equal-weighted index of covered MCO shares returned 9% on 9% adjusted EPS growth, compounded annually from December 2007 through September 2026.



Source: PitchBook and Morningstar as of September 2026.

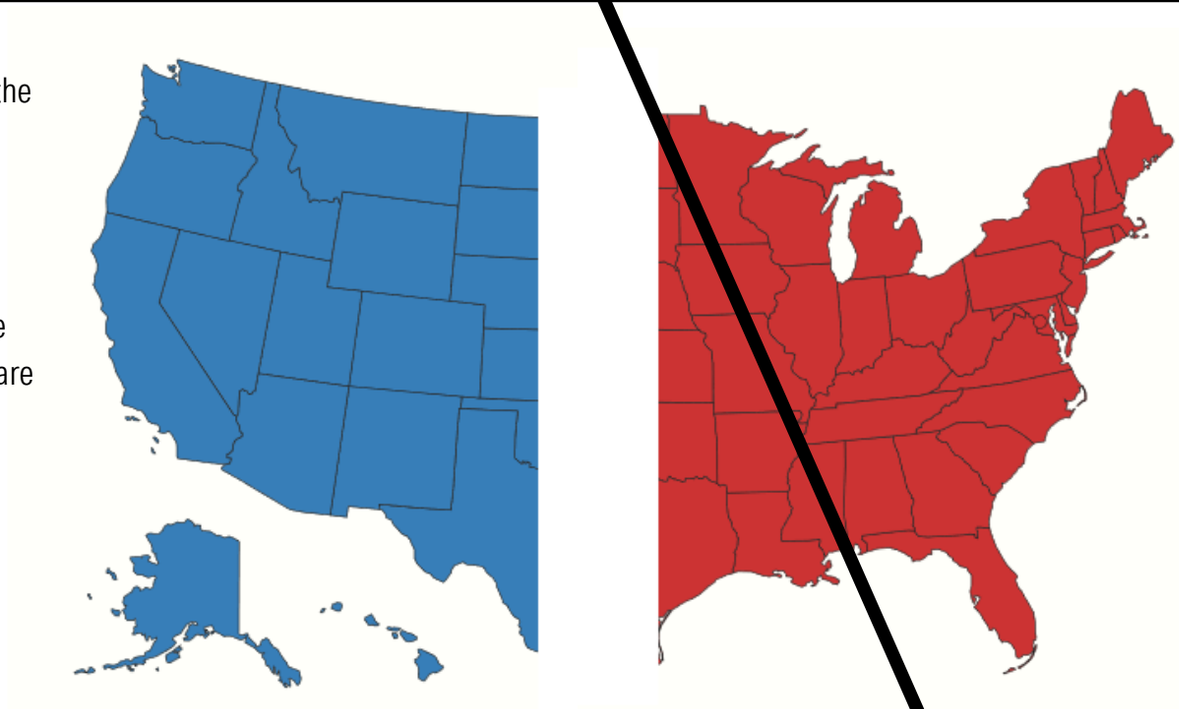
Regulatory Risks Can Loom Large Over the MCO Industry but Have Been Manageable, So Far

Since 2008, Both Major Political Parties Have Enacted Laws That Have Roiled MCO Shares, When the Pendulum of Federal Government Control Swung Their Way

Now in control of the federal electable bodies, Republicans are focused on lowering spending and scrutinizing MCO operations, while Democrats aim to reinstate safety nets.

Democrat Near-Term Priorities:

- Reverse cuts to ACA safety nets—the individual exchanges and Medicaid expansion
- Add public option to improve affordability on the exchanges
- Reduce eligibility age for Medicare
- Rein in risk assessments in Medicare Advantage
- Reform PBMs
- Reduce MCO vertical integration



Republican Near-Term Priorities:

- Cut spending on the individual exchanges (2026) and Medicaid (2027), which is reducing insured volumes
- Rein in risk assessments in Medicare Advantage, which may result in fines and margin pressure
- Reform PBMs primarily by eliminating rebate and spread-based pricing and investigating group purchasing organizations
- Reduce MCO vertical integration with retail pharmacy and PBM combinations potentially up first

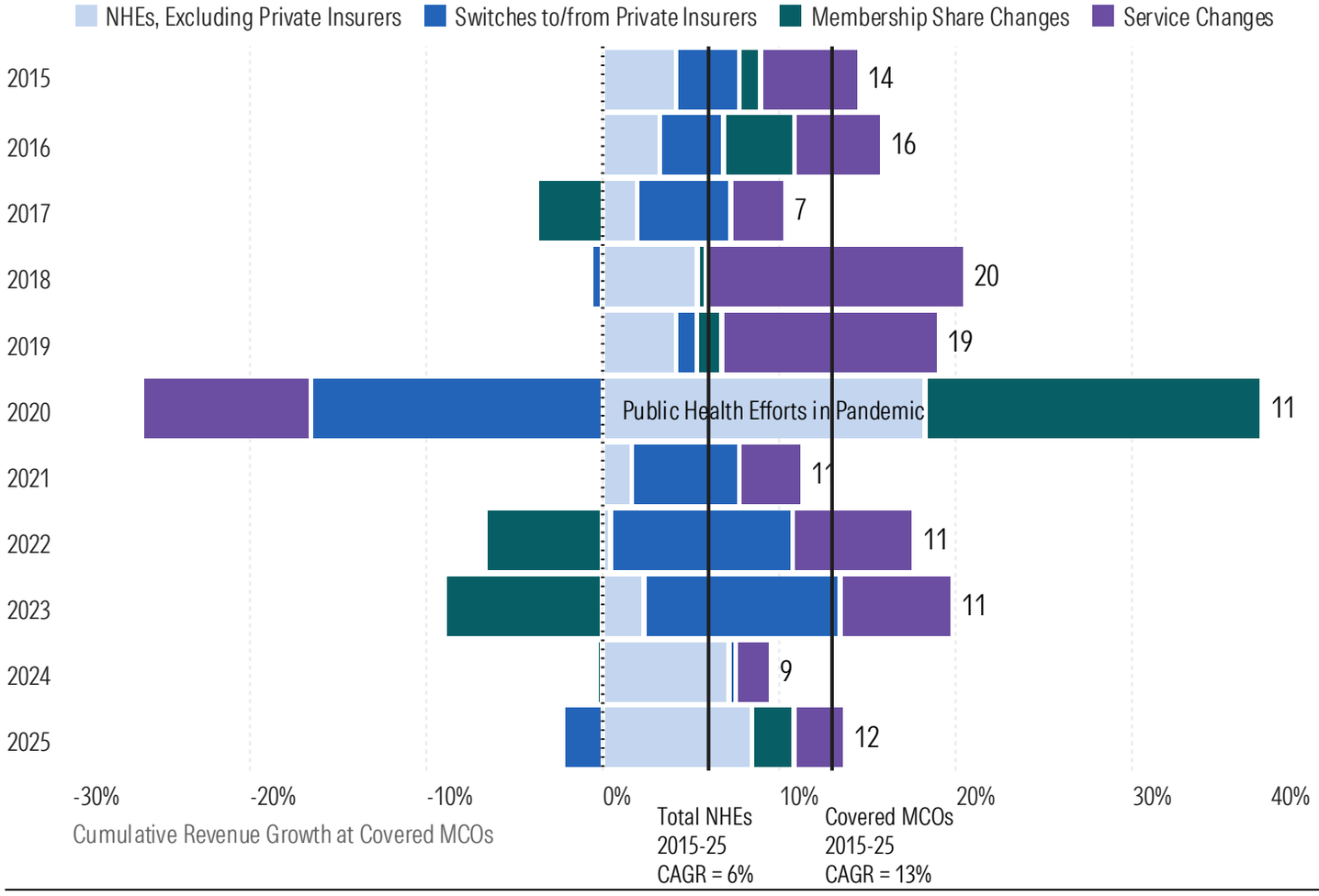
2008	2010	2014	2018-24	2024-Present
Democrats won control of the federal electable bodies, including a super-majority in Senate	Affordable Care Act (ACA) passed, adding new safety nets to the US system	ACA fully implemented, including individual exchanges and Medicaid expansion	Status quo maintained, but “Medicare for All” and a “public option” entered debate in Democratic primaries of 2020 election	Republicans won simple majority of the federal electable bodies and passed the One Big Beautiful Bill Act (OBBBA), which aims to reduce spending related to the ACA safety nets

Source: Map made with mapchart.net based on Morningstar analysis as of September 2026.

Covered MCO Revenue Growth (13%) Has Significantly Exceeded US Healthcare Spending (6%) Since 2015

Market Share Gains and Service Growth Helped Covered MCOs Grow Faster Than US Healthcare Spending

From 2015-25, covered MCO revenue grew at a 13% CAGR while US healthcare spending grew 6%.



Relative to 6% growth in total national health expenditures, or NHEs, during the past decade, covered MCOs have generated net revenue growth of around 13% compounded annually on a cumulative basis, the latter of which was driven by about:

- 500 basis points of baseline growth in national health expenditures excluding private insurance markets, which represent about half of US spending
- 200 basis points from private insurers gaining more share of NHEs, such as when government programs outsource more coverage to private insurers
- 100 basis points from share gains from other insurers
- 500 basis points from efforts to expand in related services like caregiving and pharmacy benefit management

Investors should note that:

- Annual service changes can be significantly affected by mergers, acquisitions, and divestitures.
- The industry's vertical integration faces some scrutiny by regulators, which has slowed the industry's expansion by services recently and may eventually lead to forced reversals.

Source: Morningstar analysis of company reports and data from the Centers for Medicare and Medicaid Services (CMS) of September 2026.
Major mergers and divestitures occurred in 2015 (UnitedHealth-Catamaran), 2018 (CVS-Aetna; Cigna-Express Scripts), 2020 (Cigna divestiture of life, accident, and disability plans).

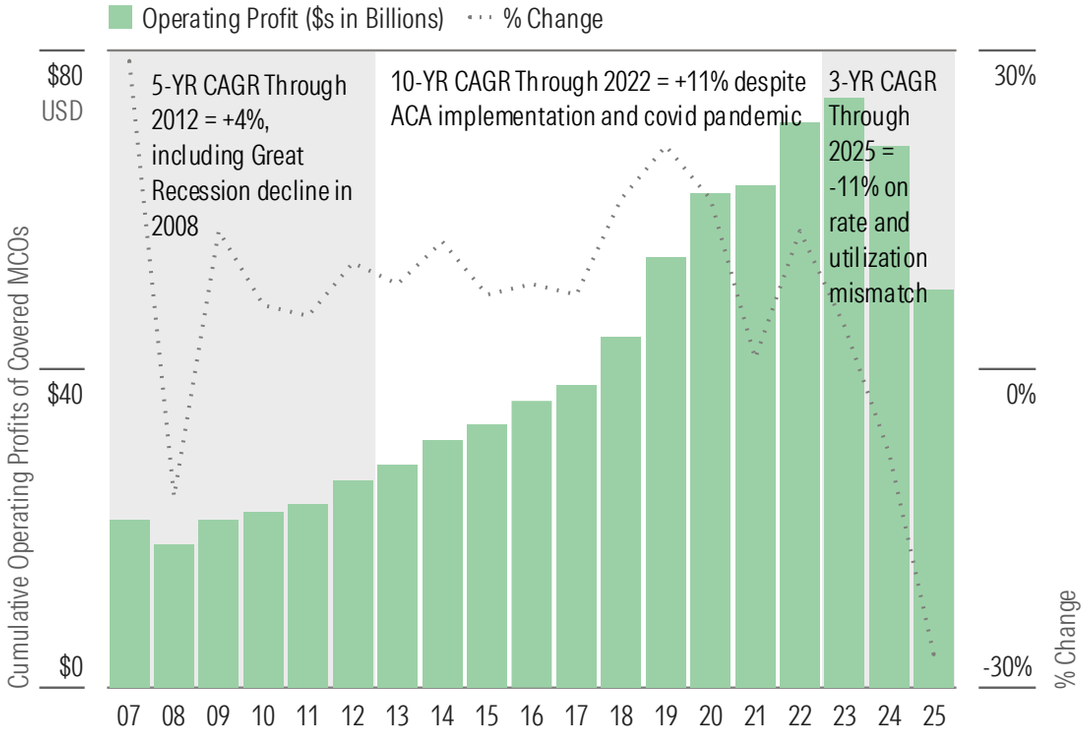
Recent Underwriting Challenges Cut Into MCO Profits More in 2024-25 Than in the Great Recession

Since 2007, cumulative annual operating profits have only declined three times in the industry. One was in 2008 during the Great Recession. The other two years—2024 and 2025—were after medical utilization surged without adequate rate increases.

After pandemic-era delays, surging utilization of medical care has not been adequately accounted for in medical insurance rates yet, especially in government-sponsored plans. MCRs spiked well above norms in 2024-25 and may remain elevated in 2026.

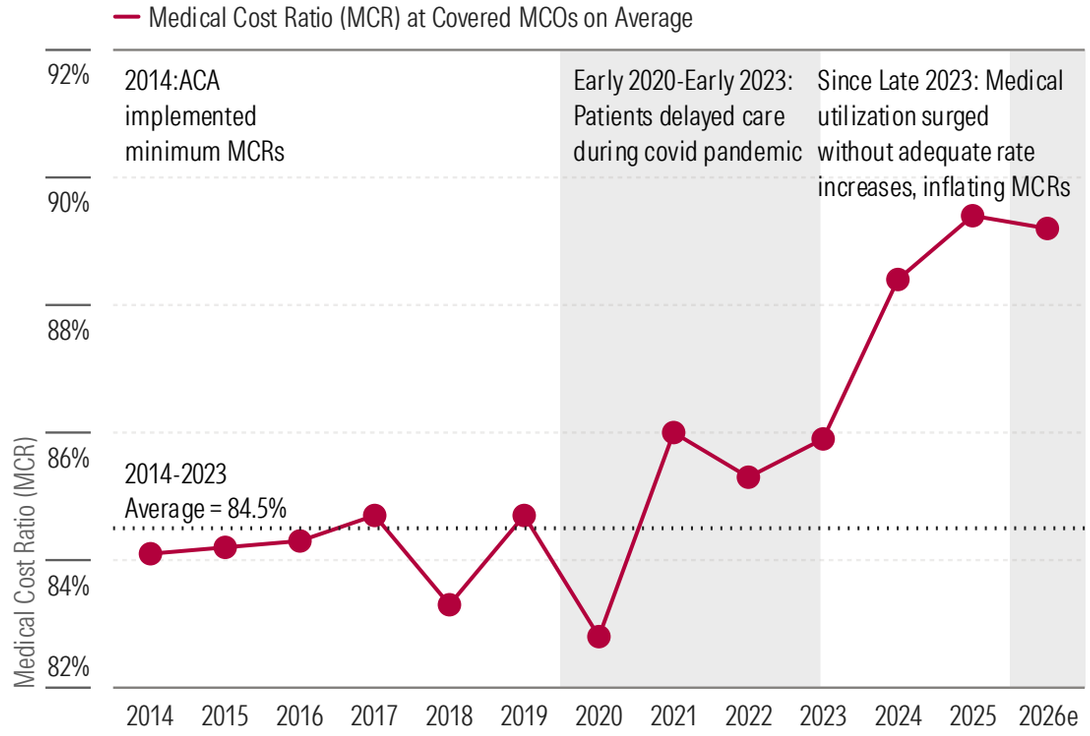
Underwriting Challenges Since 2023 Cut Profits More Than in the Great Recession

Cumulative MCO operating profits fell 12% in 2008 and 33% in two years ended in 2025.



Surging Utilization Has Inflated Medical Cost Ratios and Deflated Profits

MCOs project 2026 MCRs over 400 basis points higher than the 2014-23 average.

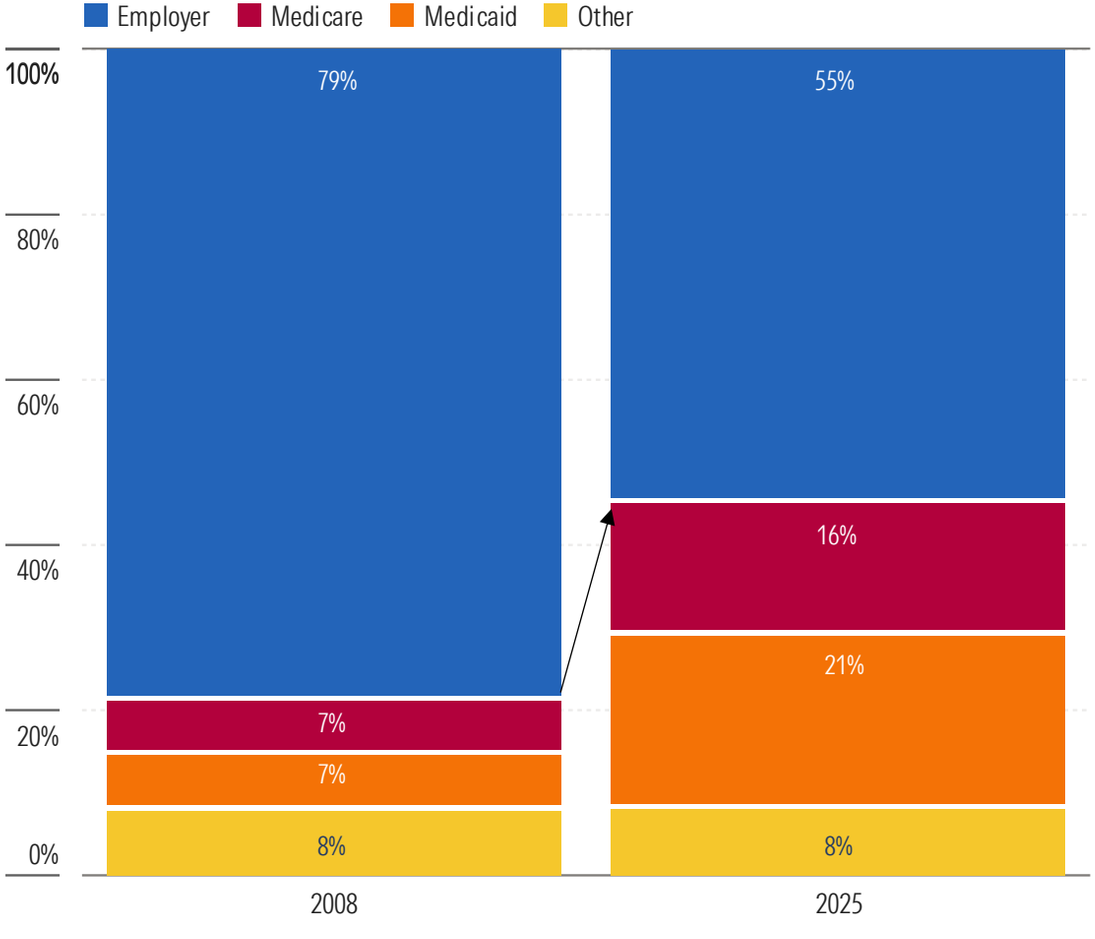


Source: Morningstar analysis of company reports as of September 2026.

Shift Toward Government-Sponsored Plans Has Accentuated Profit Pressures, Despite Ongoing Economic Strength

Focus on Recession-Resistant, but At-Risk, Plans Increased After Great Recession

Cumulative medical membership concentration at covered MCOs.



Government Plans Outsource Risks to MCOs, Leading to More Underwriting Risk

Typical Risk Characteristics for MCOs

Plan Type	Medicaid	Individual	Medicare	Employer
At Risk	x	x	x	x-small
Fee Only				x-large

Government Plans Experience Less Economic Cyclicality Than Employer Plans

Cyclicality of Insurance Plans

Counter		Neutral		High
Medicaid	Individual	Medicare		Employer

Source: Morningstar analysis of company reports as of September 2026.

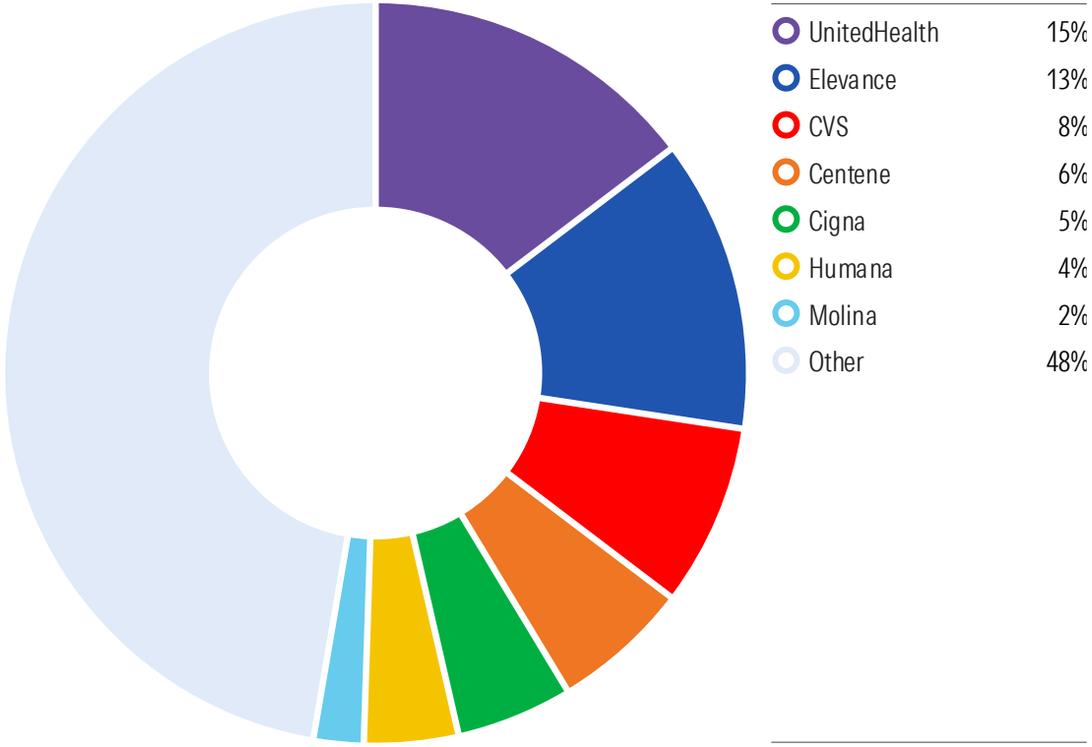
Medical Insurance Represents the Common Denominator at MCOs, but Market Focus Varies by Insurer

At the end of 2025, covered MCOs insured 52% of the US population. UnitedHealth and Elevance both covered a midteens percentage of the population, followed by CVS, Centene, Cigna, Humana, and Molina.

MCOs typically operate in multiple end markets. However, UnitedHealth, Elevance, CVS, and Cigna operate with more exposure to employer plans than government-focused insurers like Centene, Humana, and Molina.

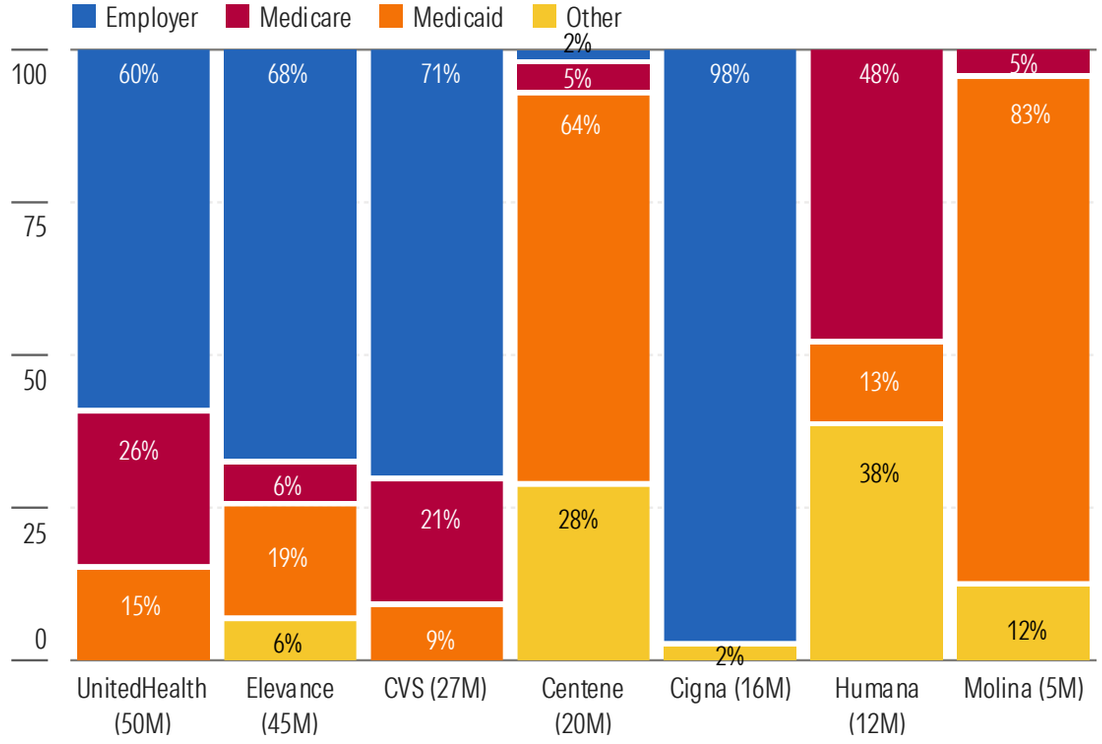
Covered MCOs Insure Over Half of the US Population

As a percentage of US population.



Medical Membership Concentration of MCO Leaders by End Market

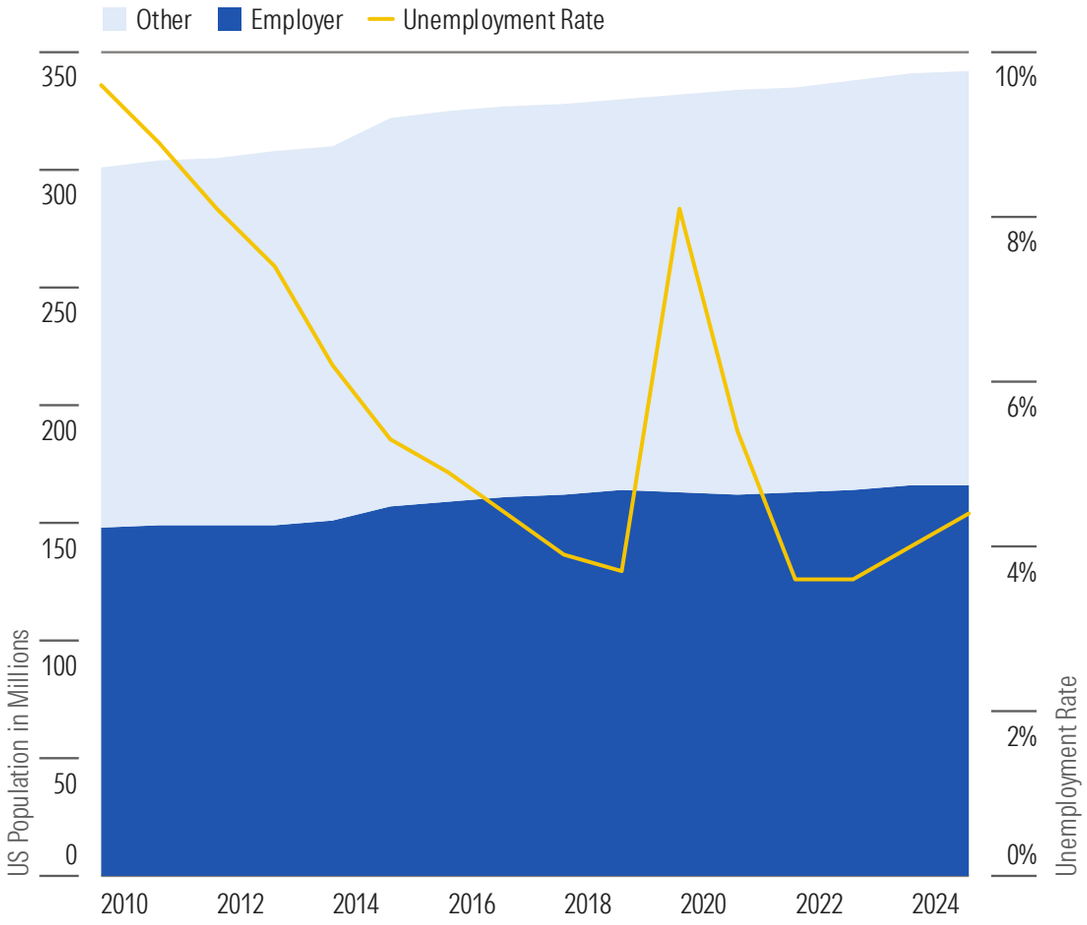
Sorted by membership size.



Source: Morningstar analysis of company report and US Census Bureau data as of December 2025.

Employers Cover About Half of Americans, but Volume Growth Appears Stalled by Weary Employers

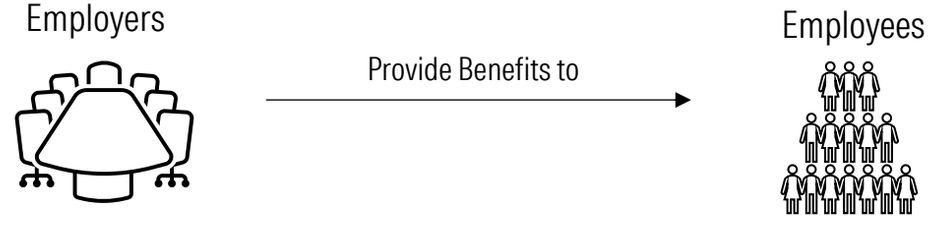
Employer Plans Plateau, Even as Unemployment Rates Stay Near Historic Lows



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

Elevance	18%
UnitedHealth	18%
CVS	11%
Cigna	10%
Centene	0%
Other	42%

Lowest Cost, Widest Local Network Typically Wins in the Employer Market



Employers Want:
- Happy Employees
- Lowest Prices on Medical Services/Products
- Management of Long-Term Employee Health Risks

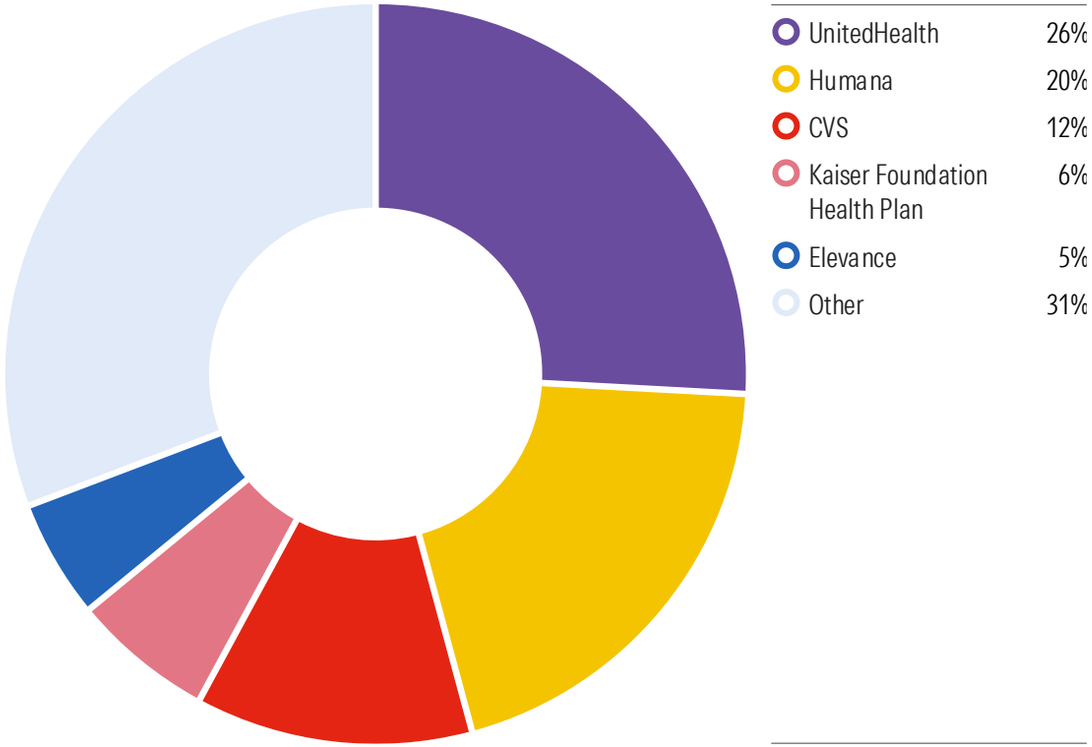
Employees Want:
- Easy Access to Reputable Providers
- Low Out-of-Pocket Payments
- To Stay Healthy

Source: Morningstar analysis of company reports, FRED, KFF, and US Bureau of Labor Statistics data as of September 2026.

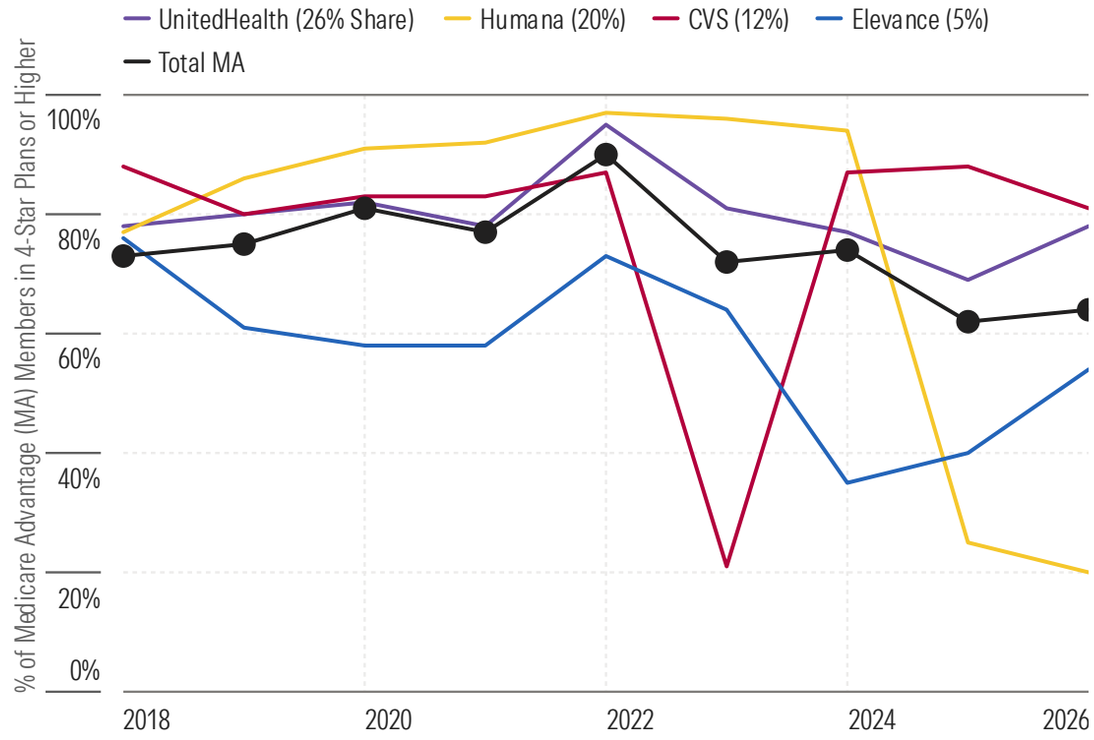
Medicare Advantage's Leaders Typically Shine in Star Ratings, Although Humana's Look Weak Currently

For senior citizens, private insurers offer Medicare Advantage, or MA, plans and supportive plans for traditional Medicare, although the latter are much less important to MCO profits than MA. End users directly choose their Medicare plans annually, and UnitedHealth, Humana, and CVS stand out as MA leaders with 58% cumulative membership share. This leadership relates to their high-quality plans that are typically recognized by regulators with above-average star ratings, although Humana ratings currently stand well below norms.

Medicare Advantage Market Led by UnitedHealth and Humana



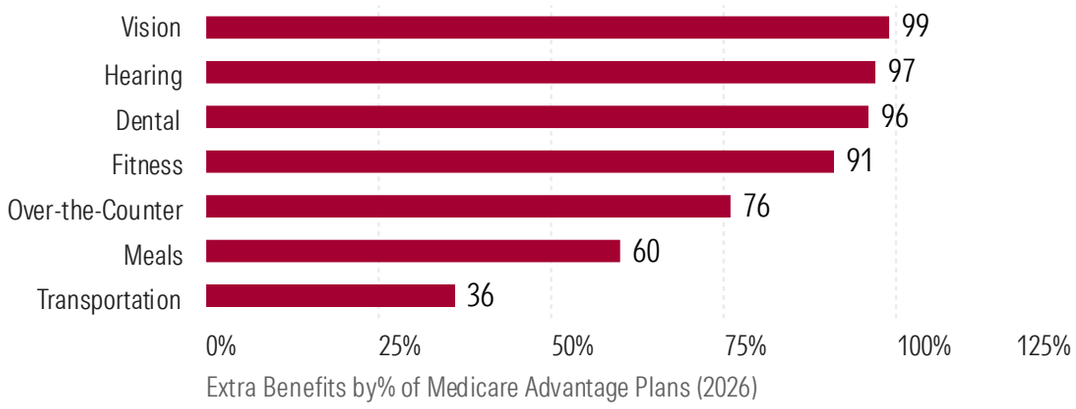
MA Plan Quality Highlighted in Star Ratings



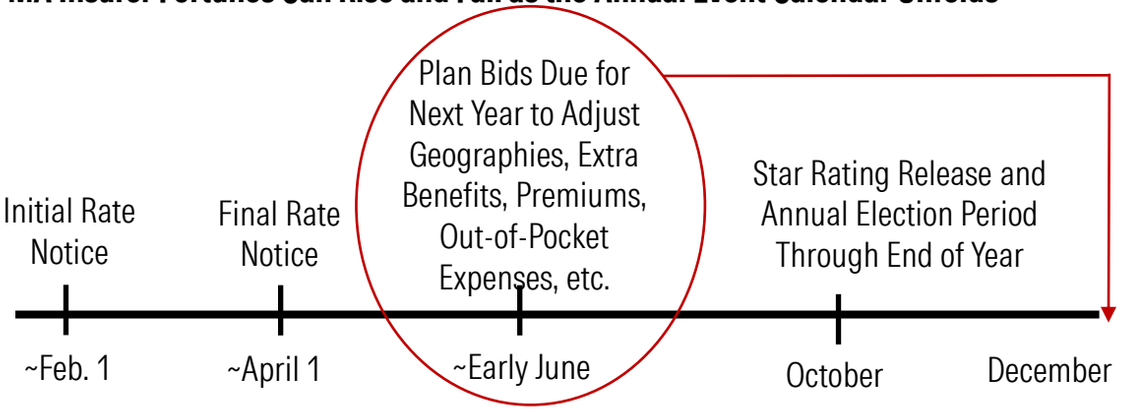
Source: Morningstar analysis of KFF and Modern Healthcare data as of September 2026.

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

Medicare Advantage Plans Offer Seniors Extra Benefits Worth About $2,400/Year

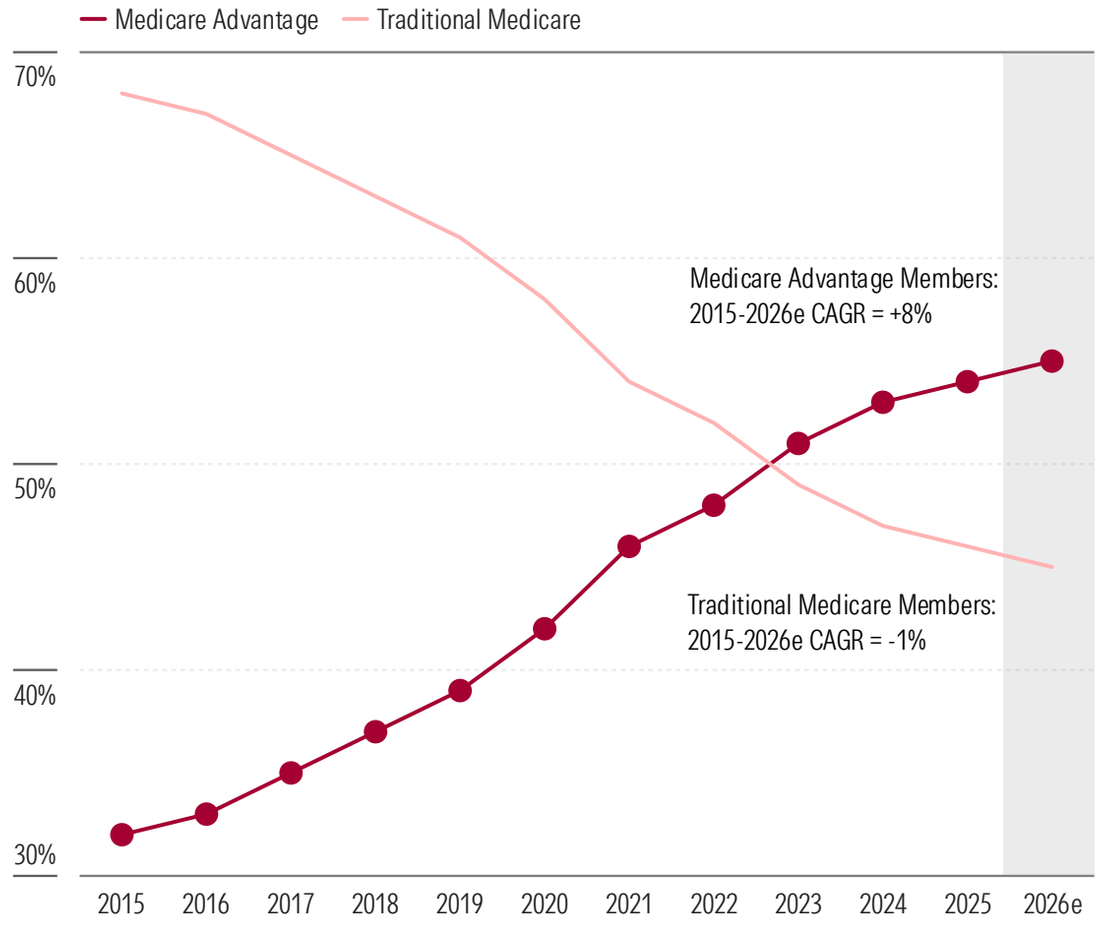


MA Insurer Fortunes Can Rise and Fall as the Annual Event Calendar Unfolds



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

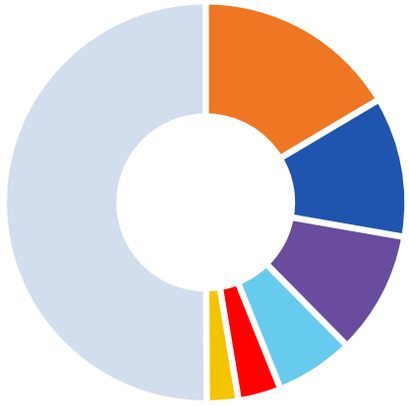
% of Medicare population.



Source: Morningstar analysis of KFF data as of June 2026 and HealthScape Advisor's "2026 Medicare Advantage supplemental benefit landscape analysis as of December 2025." https://www.healthscape.com/insights/2026-medicare-advantage-supplemental-benefit-landscape-analysis

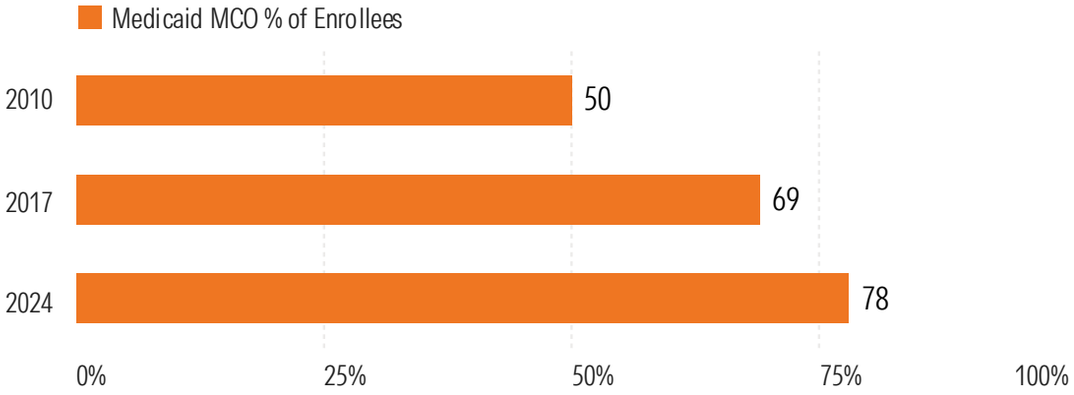
Medicaid States Outsource Risks to MCOs To Save Money and Limit Intra-Year Budget Fluctuations

Centene Leads the Medicaid Market by Membership Share at End of 2025



Centene	17%
Elevance	11%
UnitedHealth	10%
Molina	6%
CVS	3%
Humana	2%
Other	51%

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%-77% 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 costs in the Medicaid population.
- Fund balance of Medicaid budget that federal government does not provide.

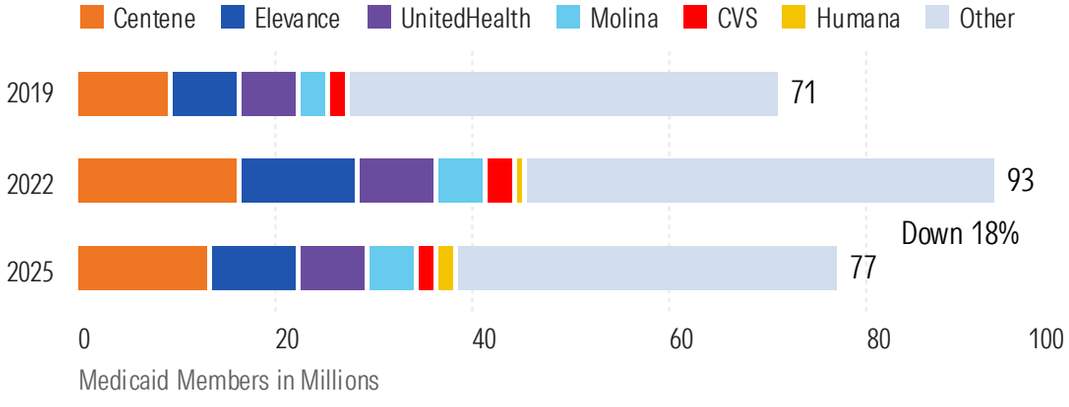
MCOs:

- 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.

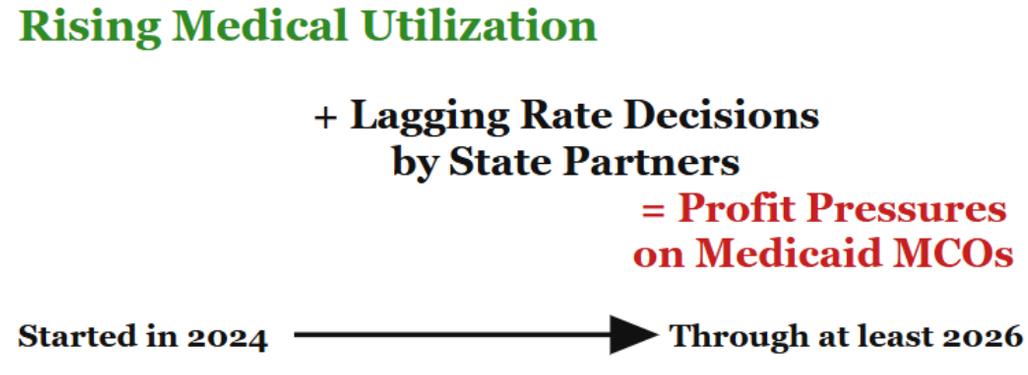
Source: Morningstar analysis of company reports and KFF data and analysis as of September 2026.

Medicaid Still Reeling From Redeterminations and Utilization Surge as Policy Changes Begin

Eligibility Redeterminations Reduced Medicaid Population After the Pandemic



Mismatched Rates and Utilization Are Constraining MCO Profits



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 they were eligible or not.

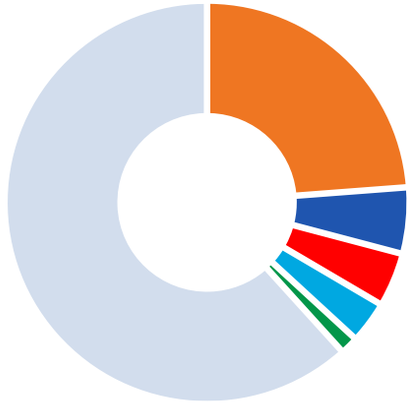
Resumed Eligibility Redeterminations (started in April 2023): That federal mandate expired at the end of the public health emergency in April 2023. Since then, states resumed eligibility redeterminations to see if Medicaid members still qualify for this low-income program. With many members now ineligible, about 18% were pushed off Medicaid since the end of 2022 or toward prepandemic levels. However, with increased outsourcing by states to the MCOs and new contract wins, the highlighted MCOs all gained Medicaid membership and market share from 2019 to 2025, despite recent redetermination activities.

Mismatched Rates/Utilization (Ongoing): Medicaid MCO margins have contracted since mid-2024, when medical utilization surged in the Medicaid population while rates received from state partners failed to keep up with that trend. This mismatch in rates and utilization has been hurting profits, and MCOs now expect this mismatch to continue through at least 2026 and potentially into 2027 when another 10 million Medicaid members (13% of members) could lose coverage due to new provisions in the One Big Beautiful Bill Act, or OBBBA, including work requirements.

Source: Morningstar estimates, Morningstar analysis of company reports, and KFF. Data as of September 2026.

Individual Exchanges Provide Another Safety Net for Individuals, but Subsidy Expiration Is Hitting Enrollment

Individual Market Share by MCO as a Percent of Members (2025)



Centene	24
Elevance	5
CVS	4
Molina	3
Cigna	1
Other	63

The ACA Exchanges Provide a Safety Net for Individuals

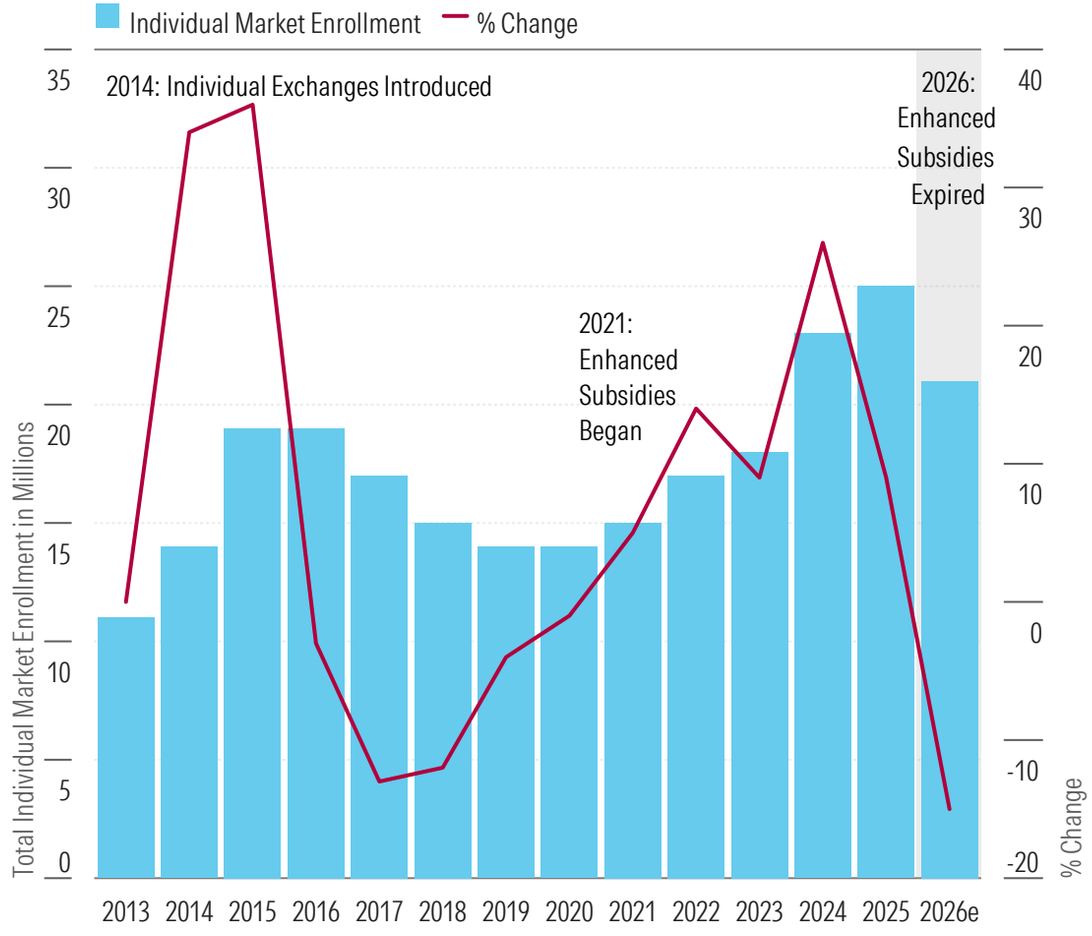
Typical End Users:
- People who do not qualify for Medicare (>65) or Medicaid (low income)
- Seasonal workers when employed
- Employees of businesses that do not offer health benefits

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

Recent Individual Plan Growth Is Reversing After Enhanced Subsidies Expire

Expired subsidies are threatening approximately 5 million people in individual market.

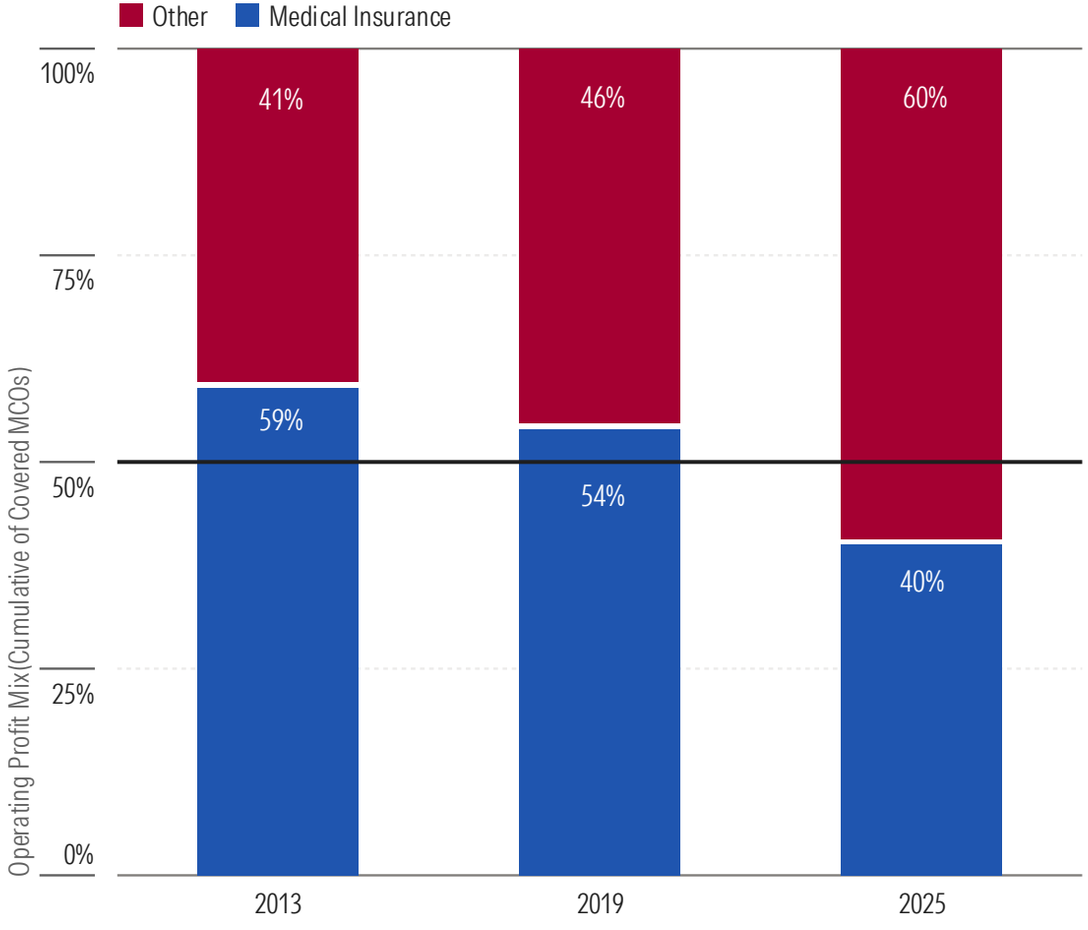


Source: Morningstar analysis of company reports, KFF, and Congressional Budget Office estimates as of September 2026.
Bottom left image created by Claude.

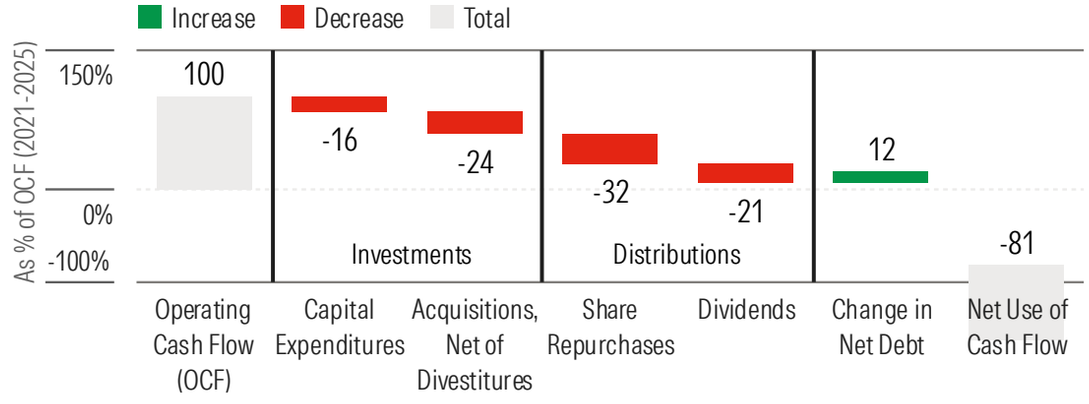
After the ACA Limited Margins, the MCOs Invested Beyond Medical Insurance, Organically and Through M&A

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

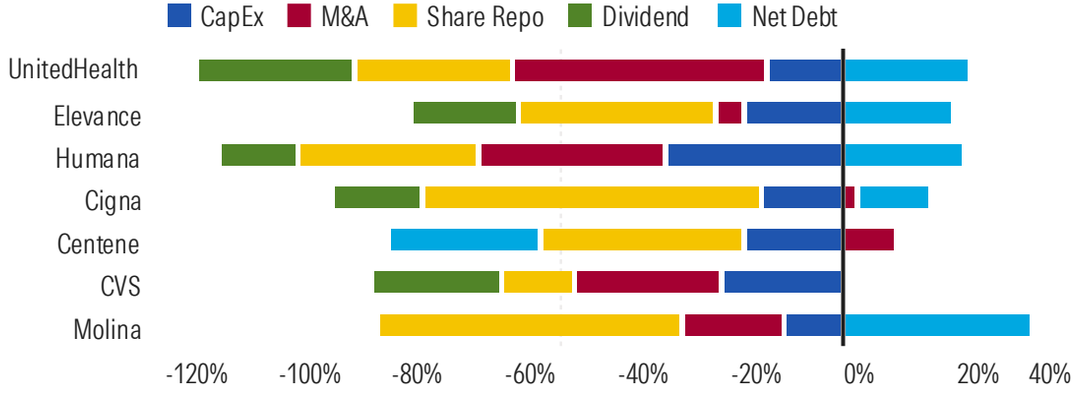
Cumulative operating profit mix at covered MCOs.



Distributions Have Outweighed Investments in MCO Cash Flow Use, Cumulatively



Capital Allocation Activities Varied by Company, Though (2021-25)

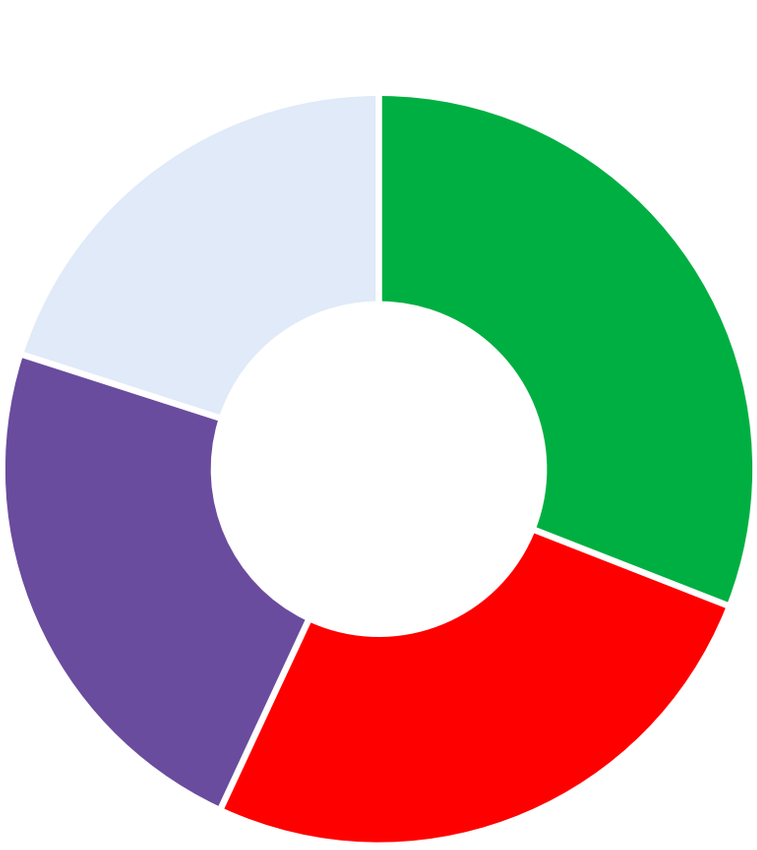


Source: Morningstar analysis of company reports as of September 2026.

Top Pharmacy Benefit Managers Help Clients Manage Biopharmaceutical-Related Risks

Cigna, CVS, and UnitedHealth Dominate the PBM Market With 80% Share

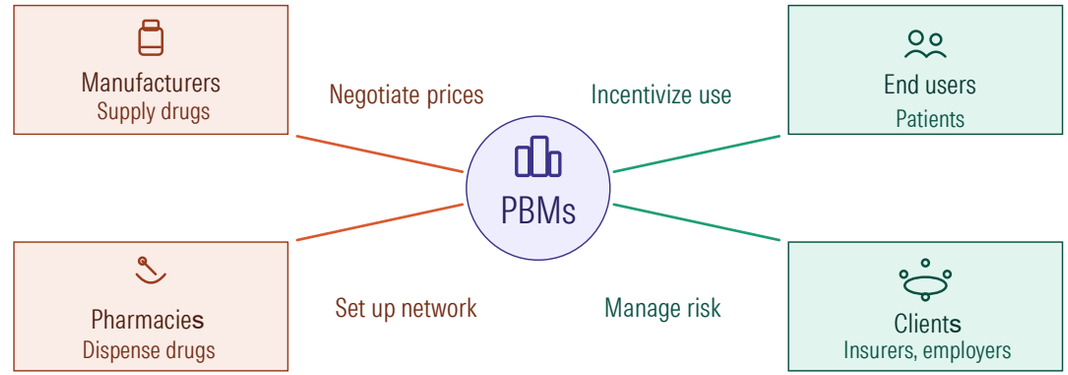
Market share by % of claims managed in 2025.



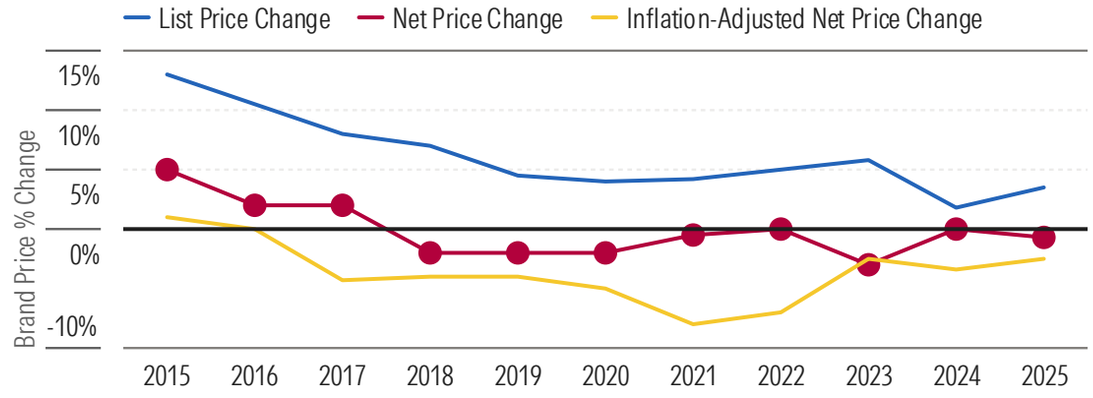
Cigna	31%
CVS	26%
UnitedHealth	23%
Other	20%

Top-Tier PBM Moats were formed by cost advantages but are maintained now by:
- Switching costs with contract lengths of at least three years with high-90s renewal rates.
- A network effect shown by increasing claims share at top-three PBMs in recent years.

PBMs Manage Risks for Clients in the Drug Supply Chain



PBMs Helped Keep Net Price Changes at or Below 0% Since 2018



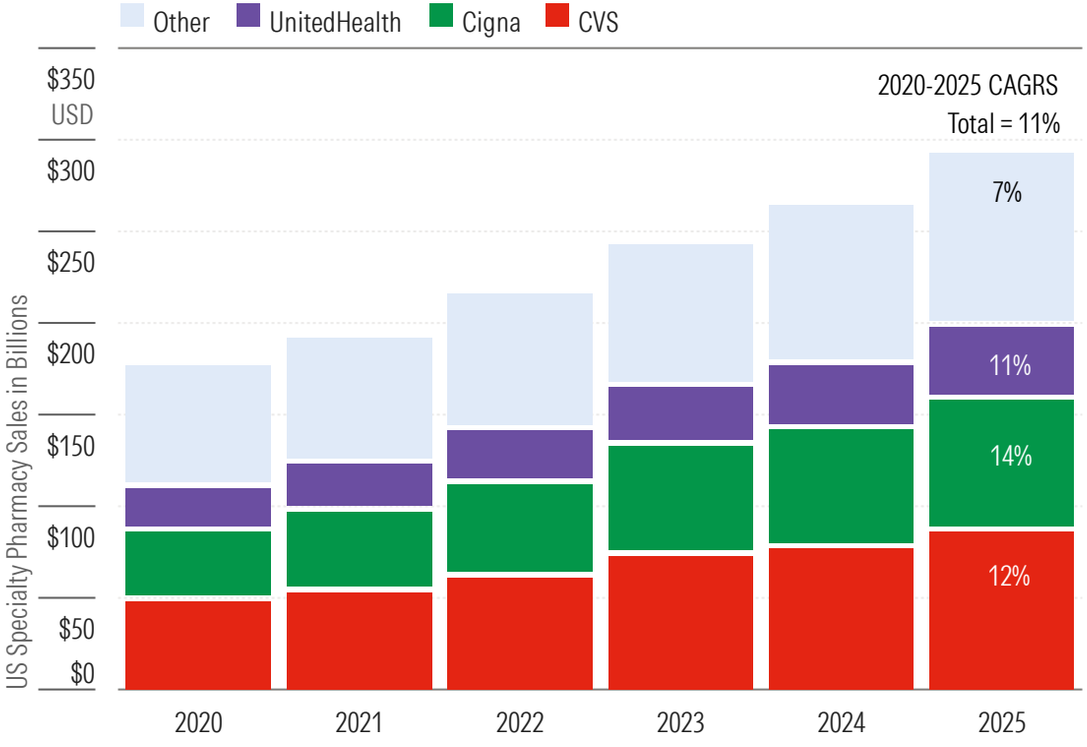
Source: Morningstar analysis of data from Drug Channels Institute as of March 2026 (left) and January 2026 (bottom right).
Top right image generated by Claude.

PBMs Also Target the Large, Fast-Growing Specialty Pharmacy Market, Which Adds Caregiving Services to the Mix

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. Biologic, or large molecule, drug growth drives this market, which expanded by 11% compounded annually since 2020. Similar to the network effects seen in the traditional PBM market, the big-3 players (CVS, Cigna, and UnitedHealth) continue to show some signs of a network effect with ongoing market share expansion versus other players.

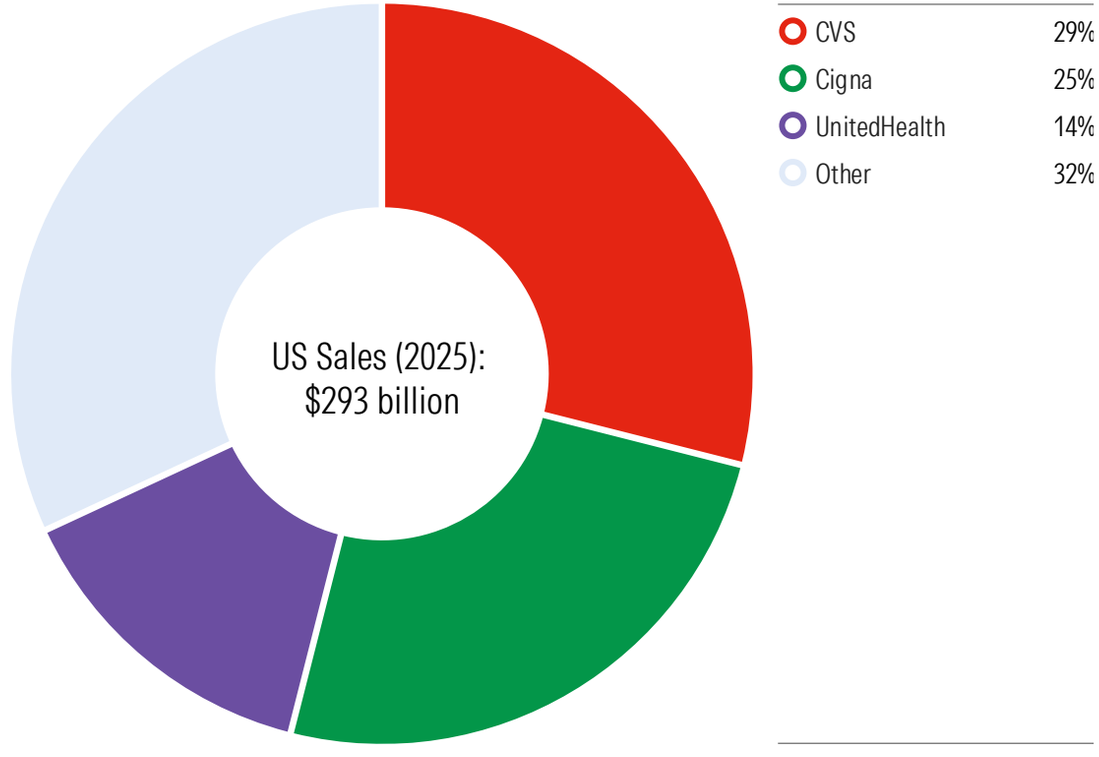
Specialty Pharmacy Market Is Growing at a Low-Double-Digit Pace

CVS, Cigna, and UnitedHealth dominate market and continue to gain share.



Major PBMs Lead Specialty Pharmacy Market With 68% Cumulative Share

2025 market share as a % of US specialty drug revenue.



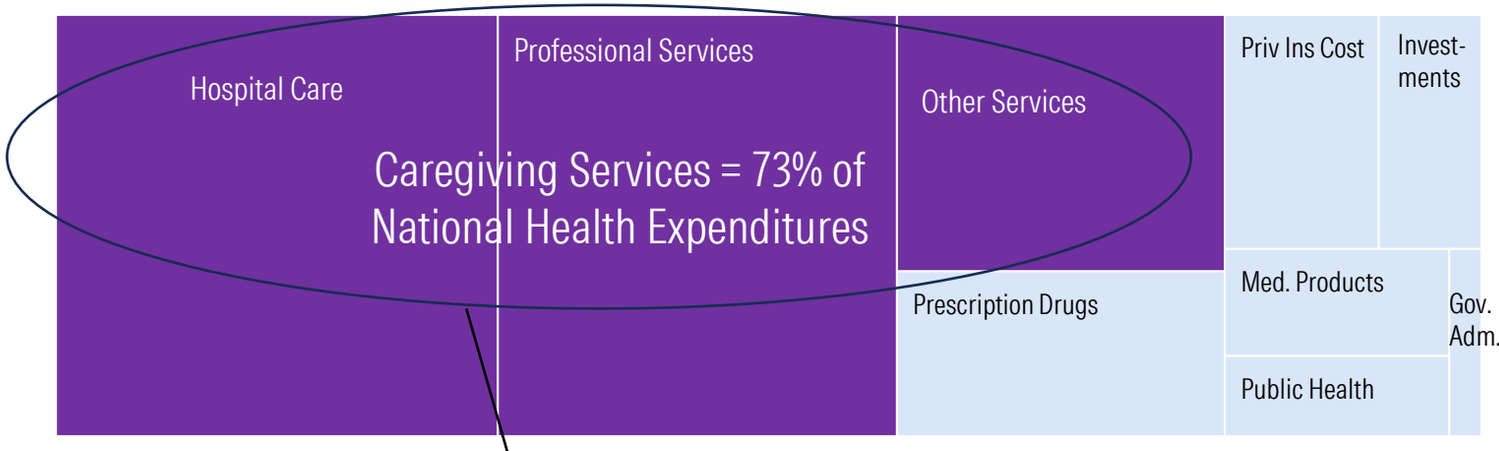
Sources: Morningstar analysis of Drug Channels Institute estimates as of September 2026.

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

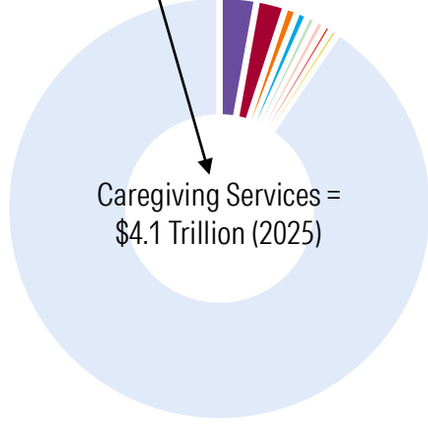
Caregiving services represent about three-quarters of US national health expenditures, However, providing care directly to patients remains a highly fragmented business typically served by locally focused caregivers, including hospitals, primary-care physicians, home healthcare providers, outpatient clinics, and others.

For perspective, we cover eight companies that provide at least some healthcare services in the US, but even these large publicly traded companies only account for about 6% of the US market, cumulatively. While this high fragmentation suggests further consolidation is possible by the MCOs, consolidation has slowed, as value-based care economics have slipped, similar to medical insurance margins, and as regulators have been investigating combined insurers and caregivers on antitrust concerns. Regulatory action to reverse this vertical integration in the MCO industry even appears possible.

Caregiving Services Account for Nearly Three-Quarters of National Health Expenditures in the US



The Provider Market Remains Highly Fragmented and Locally Focused



UnitedHealth	2%
HCA	2%
Tenet	1%
Universal Health	0%
Fresenius	0%
DaVita	0%
CVS	0%
Humana	0%
Other	94%

Source: Morningstar analysis of company reports Centers for Medicare & Medicaid Services data as of September 2026.

Outlook

Mid-single-digit market growth and margin improvement should boost MCO profits.

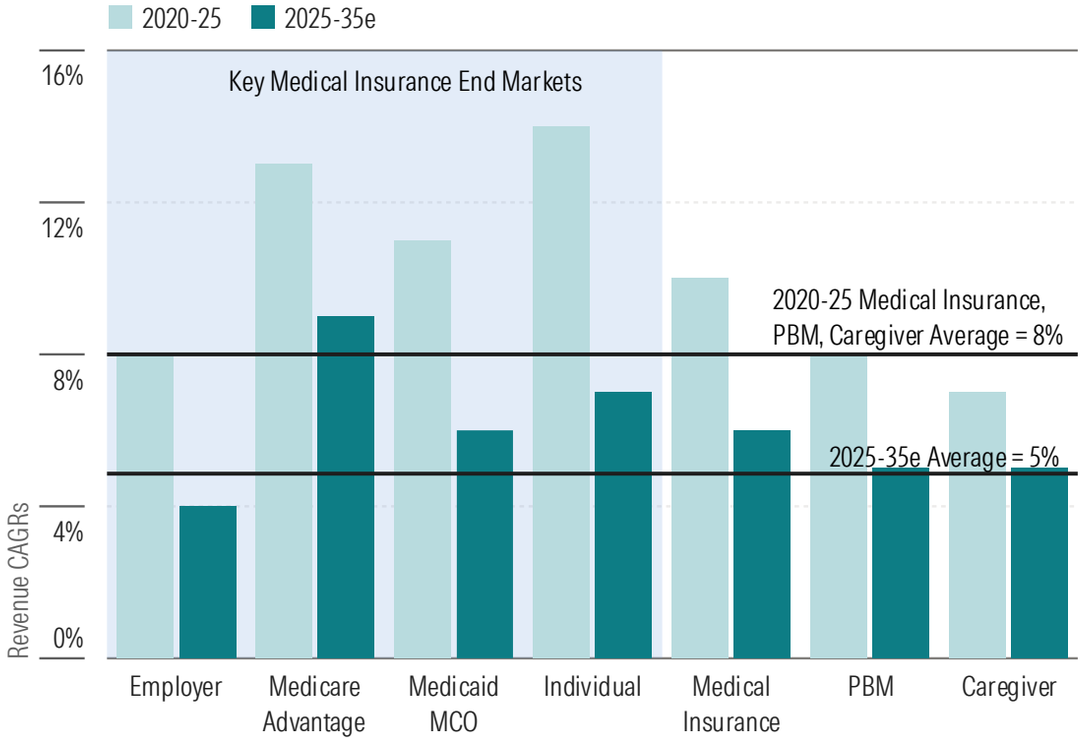
Government Budget Cuts and a Focus on Margins, Not Market Share, May Decelerate MCO Revenue Growth

End market deceleration, including government budget cuts in Medicaid, Medicare, and the individual markets, look likely to decelerate the MCO market's total growth opportunity by about 300 basis points during the next decade versus the past five years.

Broad market growth deceleration and an intense focus on margin improvement rather than market share may materially weigh on top-line growth in the industry. We expect 6% compound annual revenue growth at covered MCOs through 2035.

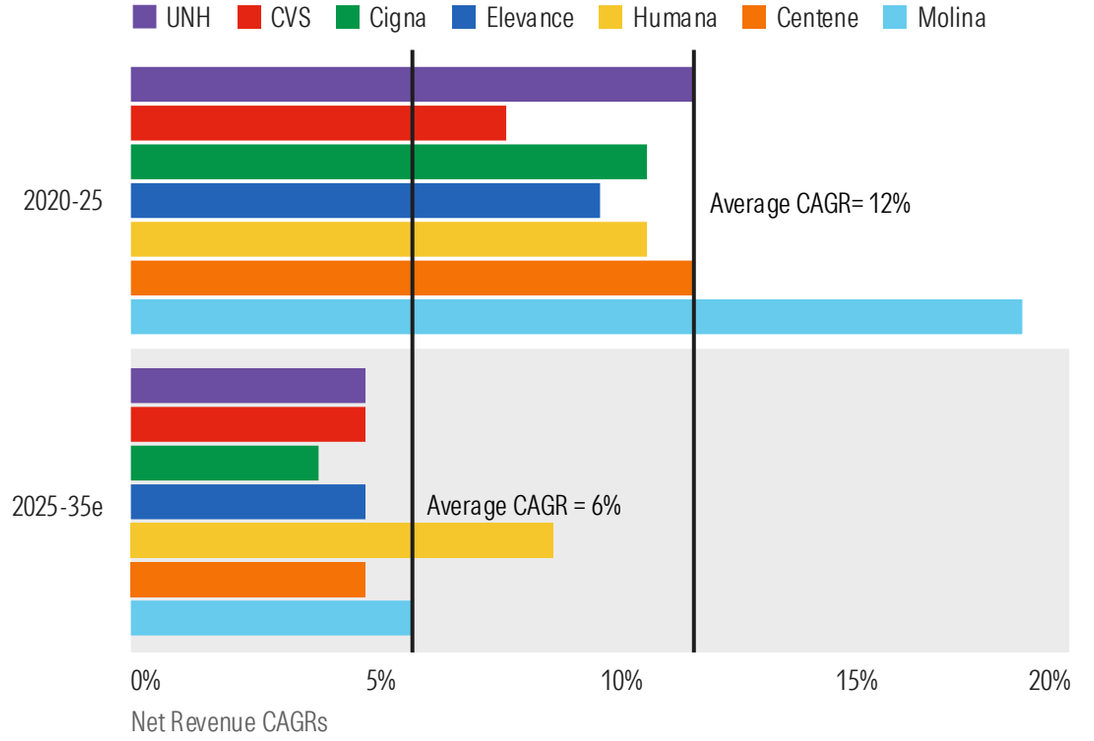
Key Market Growth Deceleration Could Eat Into MCO Growth Opportunities

We expect a 5% total MCO market CAGR through 2035 versus 8% since 2020.



Covered MCO Revenue Growth Rates Expected To Fall by Half Overall Through 2035

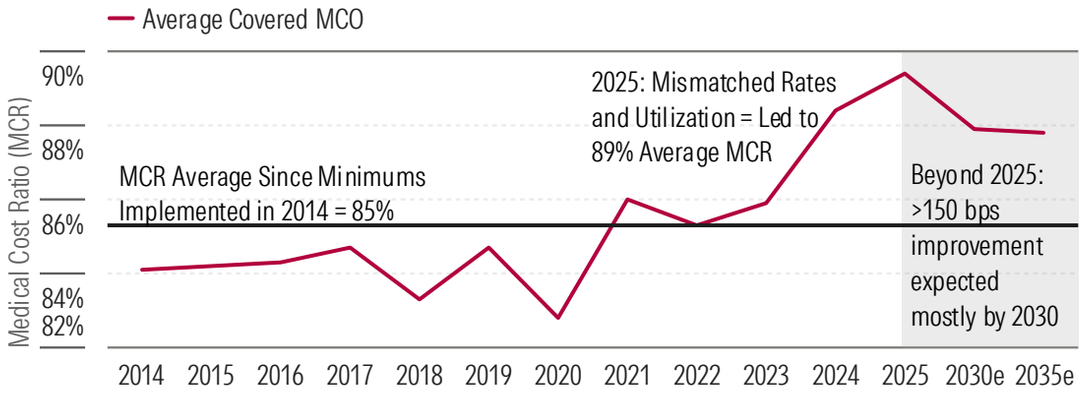
We expect 6% revenue growth from covered MCOs through 2035 versus 12% since 2020.



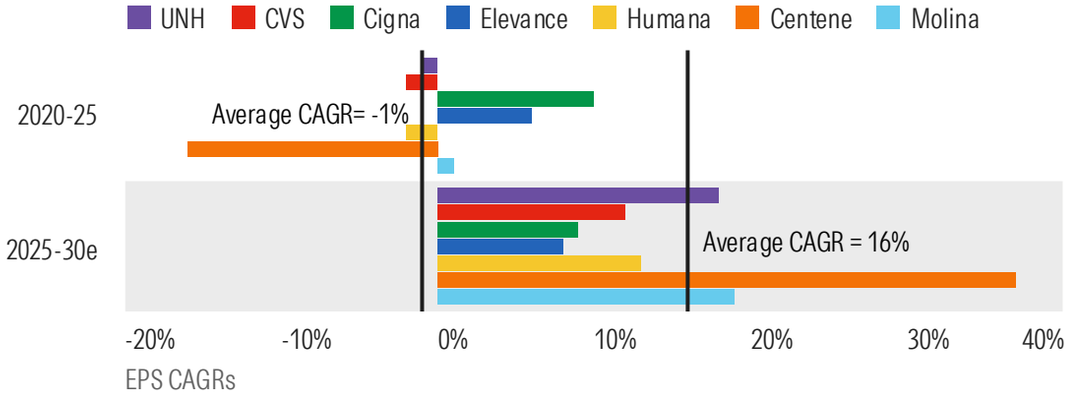
Sources: Morningstar estimates and analysis of company reports, US Census Bureau, Centers for Medicare & Medicaid Services, Congressional Budget Office , and KFF data and estimates as of September 2026. CAGR = compound annual growth rate.

From Recent Troughs, MCO Margins May Rebound and Boost Profit Growth Well Above Norms Through 2030

MCOs Are Pulling Levers To Improve Medical Cost Ratios and Margins Over Time

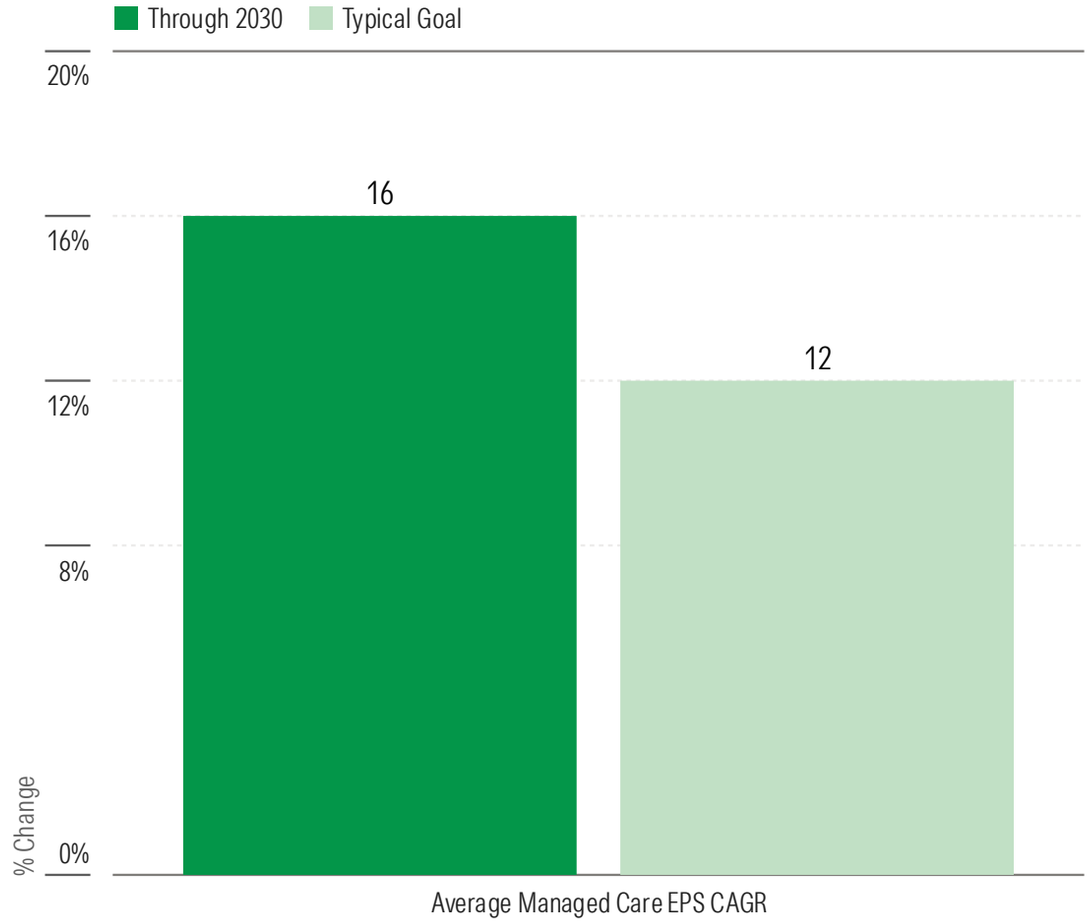


Improving Margins Should Boost MCO Profits Materially From Recent Troughs



Margin Improvement Should Boosts EPS Growth Above Norms Through 2030

Expect 16% EPS CAGR through 2030 at covered MCOs, versus low-double-digit norm.



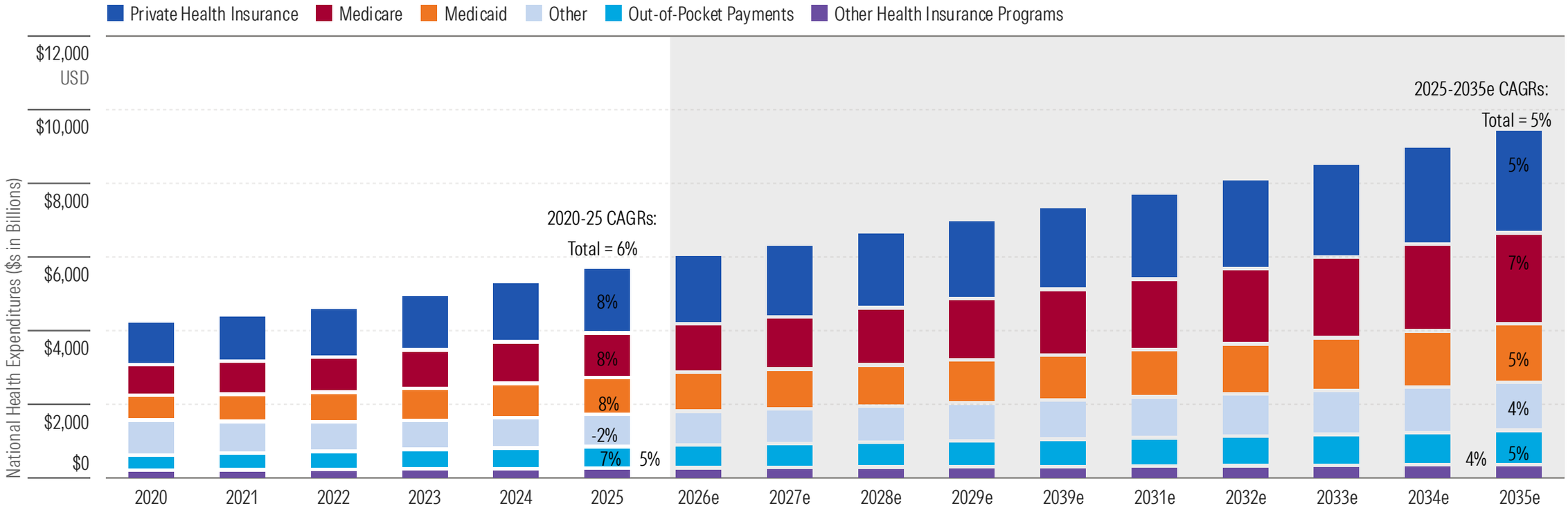
Sources: Company reports and Morningstar estimates as of September 2026.
CAGR = compound annual growth rate

Medical Insurance Revenue Growth Supported by US Healthcare Spending Growth of 5% Through 2035

We expect the medical insurance market to grow at a similar pace as US healthcare spending, which looks likely to grow about 5% compounded annually for the next decade including expected Medicaid budget cuts starting in 2027. With the aging of the US population, the Medicare market looks likely to lead national health expenditure growth, with 7% annualized growth expected during the next decade while the other markets grow closer to 5%.

US Healthcare Spending (5% CAGR) Will Likely Be Led by Medicare (7% CAGR), Offset Somewhat by a Medicaid Deceleration (5% CAGR) Through 2035

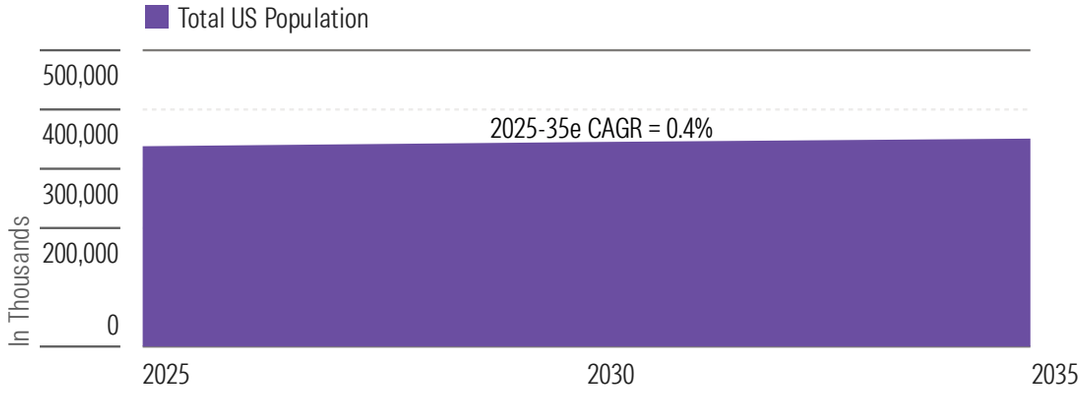
$ in billions.



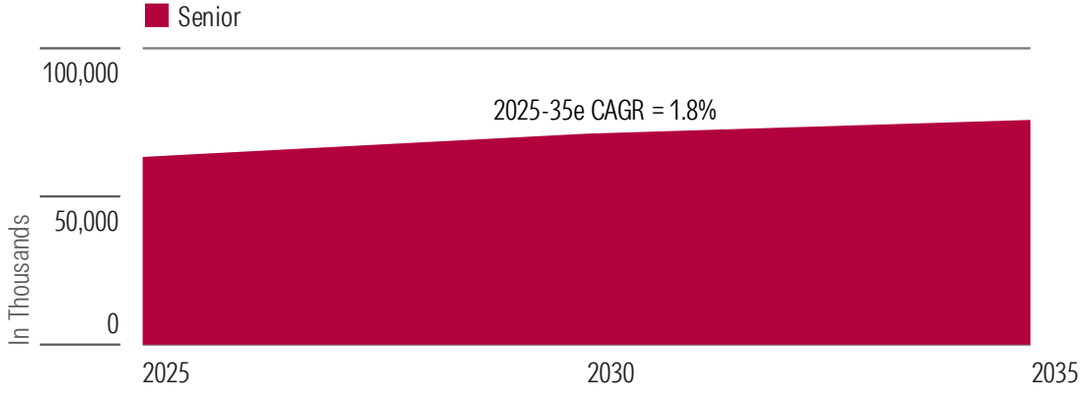
Source: Morningstar analysis of Centers for Medicare & Medicaid Services estimates as of September 2026.
CAGR = compound annual growth rate.

Population Growth Looks Meager Except Seniors, So 5% Per Capita Growth Will Likely Remain Key Spending Driver

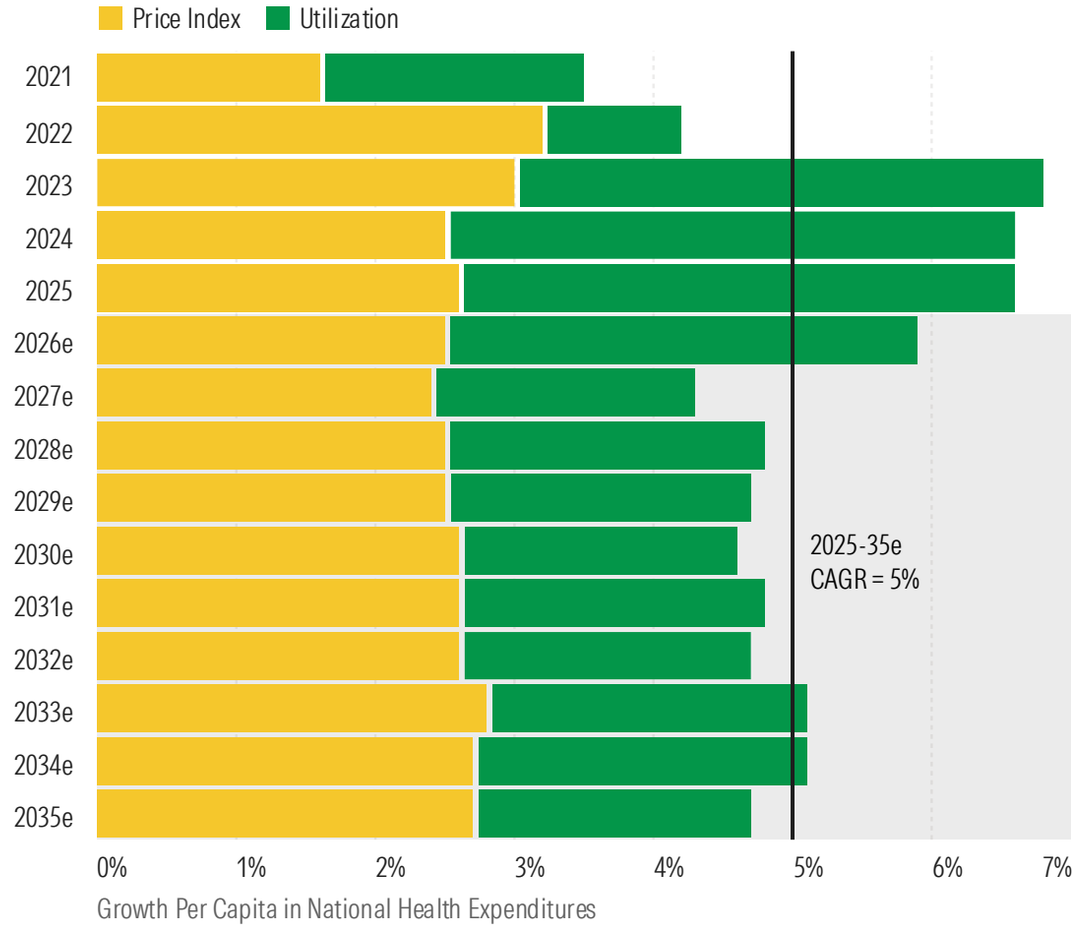
US Population Is Expected to Grow Below 0.5% CAGR for the Next Decade



Senior Population (65+) Still Growing at Just Under 2% CAGR Through 2035



Price and Utilization Likely To Boost Spending Per Capita at 5% CAGR Through 2035



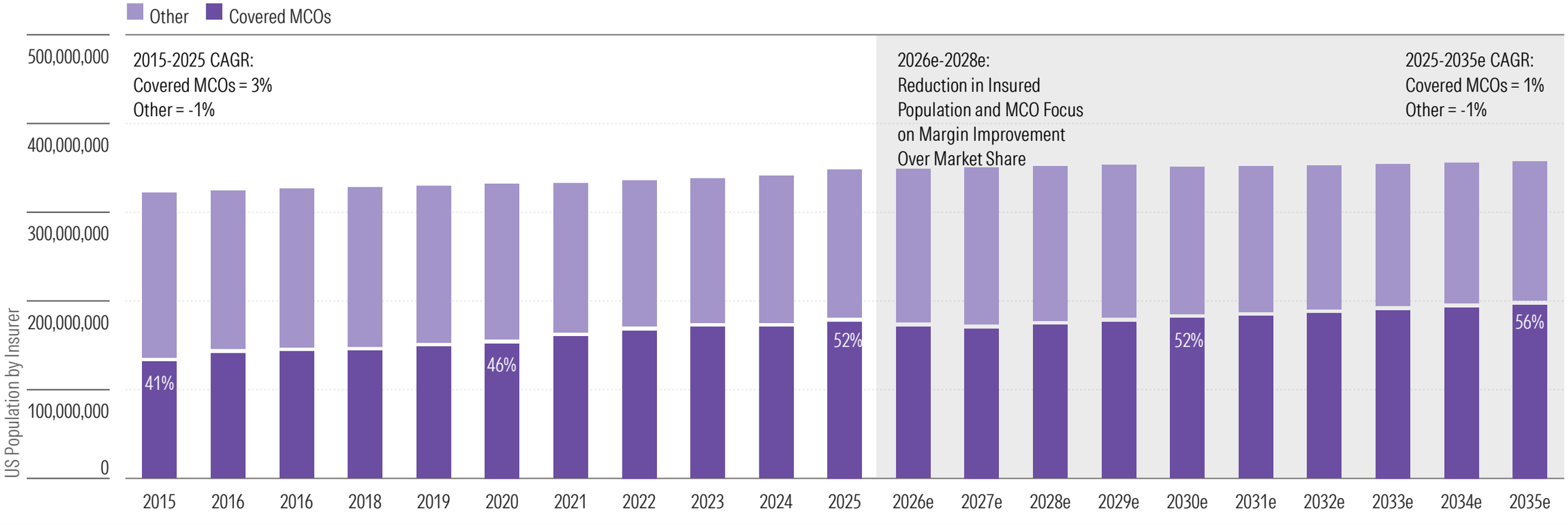
Source: Morningstar analysis of US Census Bureau estimates and Centers for Medicare & Medicaid Services estimates as of September 2026.
CAGR = compound annual growth rate.

Following Near-Term Margin Improvement Focus, Covered MCOs May Eventually Return to Share Gains

Although membership share may decline in the near-term due to the industry's focus on margin improvement and due to regulatory changes that reduce the insured population, covered MCOs look likely to eventually expand their share of the US population by 2035, given their advantaged competitive positions and continued outsourcing of government programs to MCOs. Through 2035, we expect these MCOs to cumulatively grow membership around 1% compounded annually while the remainder of the US population declines 1%.

After a Brief Near-Term Dip As the Insured Population Declines and MCOs Prioritize Margins, the Top-Tier MCOs Look Likely To Boost Market Share Through 2035

We expect covered MCO share of the US population to grow to 56% by 2035, up from 52% in 2025 and 42% in 2015.

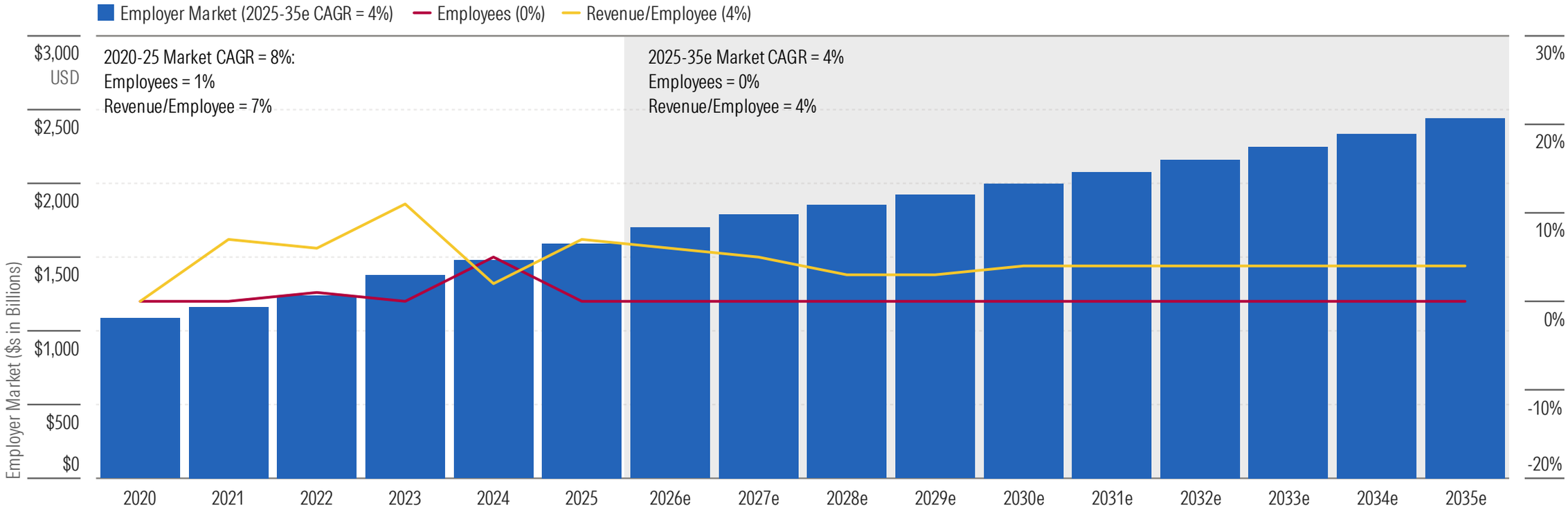


Source: Morningstar analysis of company reports and population data from the US Census Bureau as of September 2026.

Insurers Need To Look Beyond Employer Market's Projected 4% CAGR Through 2035 for Growth

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 growth near 0% for the next decade. We continue to expect mid-single-digit growth in medical spending per insured person for the next decade, though, which could help this MCO stronghold grow.

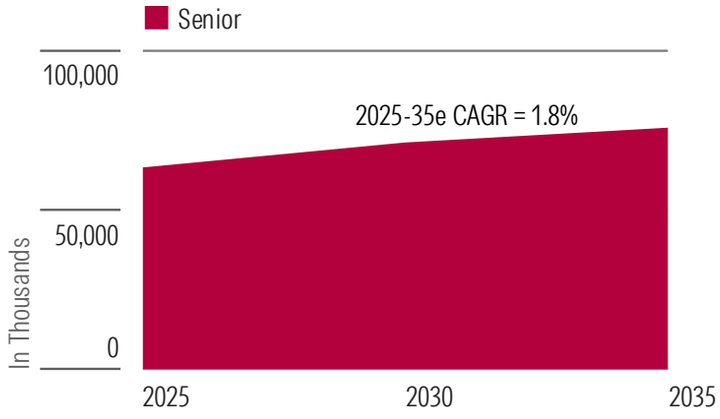
Insurers May Have To Depend on Mid-Single-Digit Spending per Member Growth Through 2035, Due to the Limited Growth Expected in the Employment-Age Population



Source: Morningstar estimates and analysis of KFF and Centers of Medicare and Medicaid Services data as of September 2026.
CAGR = compound annual growth rate.

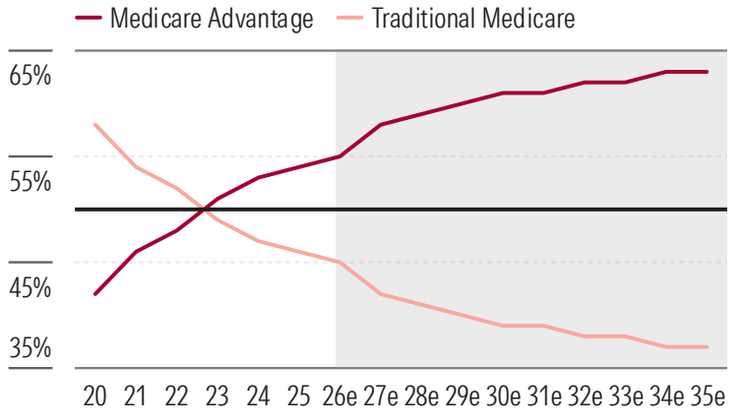
Medicare Advantage Remains the Fastest Growth Opportunity With a Potential 9% CAGR Through 2035

Senior Population = +1.8% CAGR Through 2035e



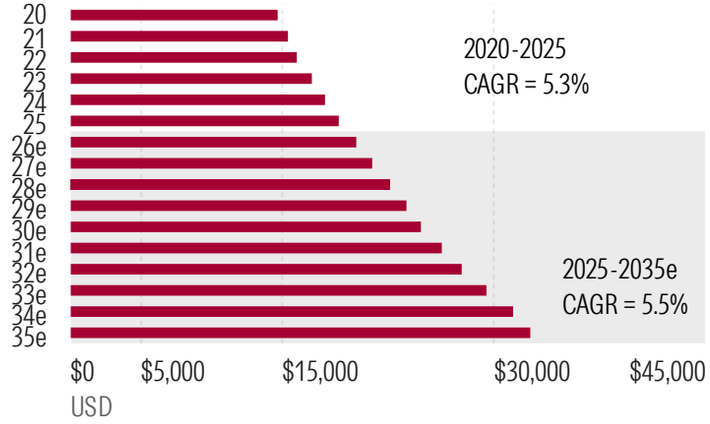
The total Medicare population (age 65 and older) looks set to grow nearly 2% compounded annually over the next decade, or well above the rest of the US population.

Increasing MA Popularity = +1.6% CAGR Through 2035e



Extra benefits and lower potential out-of-pocket payments should help Medicare Advantage plans continue stealing market share from traditional Medicare plans, adding over 150 basis points to the Medicare Advantage population's growth prospects over the next decade.

Spending per Member = +5.5% CAGR Through 2035e



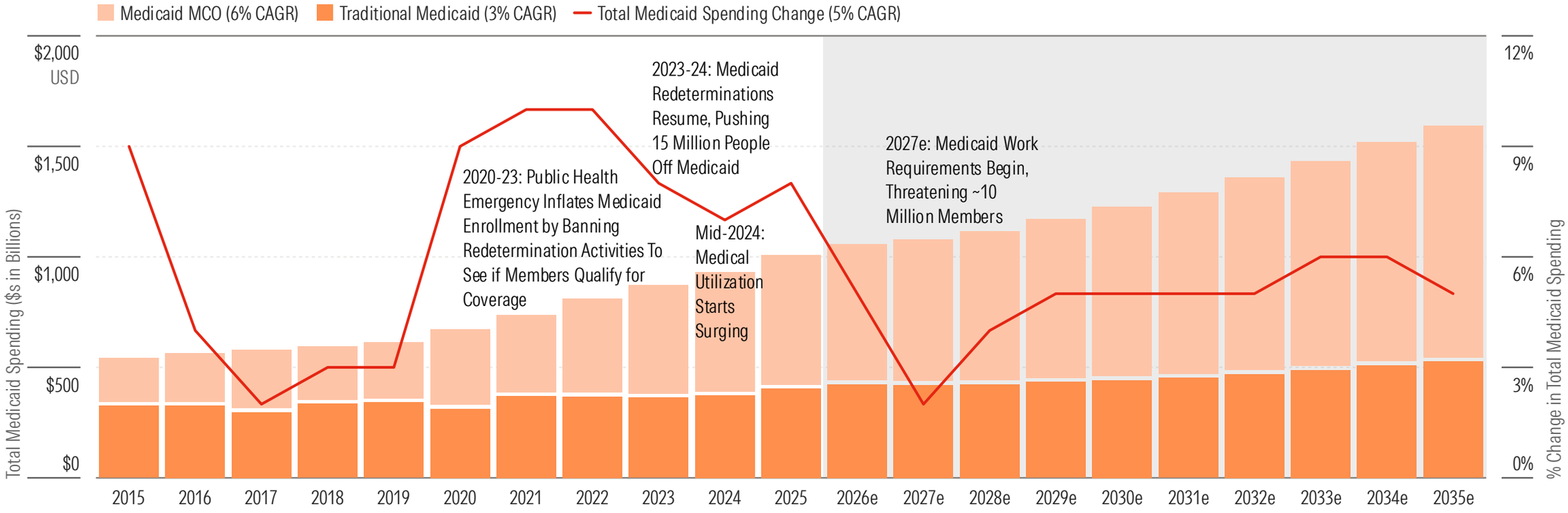
With higher rates and rising utilization as seniors enter their high spending years, Medicare spending per member is expected to grow about 5.5% compounded annually through 2035. However, given the potential for slower rate increases for Medicare Advantage insurers due to the ongoing risk assessment controversy, we see that 5.5% potential increase in spending per member as a ceiling for MA insurers rather than what may be realized by the MCOs.

Sources: Morningstar analysis of US Census Bureau, Centers for Medicare & Medicaid Services, and KFF data and estimates as of September 2026.
CAGR = compound annual growth rate.

Medicaid MCO Outlook (6% CAGR) Hurt by Regulatory Changes but Helped by Rates and Outsourcing

The federal government aims to reduce its Medicaid (low-income) spending budget by implementing work requirements and other administrative hurdles by the end of 2027. According to Congressional budget estimates, these changes could cut into Medicaid membership by 10 million people. Including rate increases to catchup to elevated utilization levels though, Medicaid spending is expected to grow at a 5% CAGR through 2035 with Medicaid MCO spending growing a bit faster at 6%, as states increasingly outsource to insurers to save money.

With Federal Budget Cuts Looming in 2027 but Rates Projected To Rise, Medicaid Spending Managed by MCOs Is Projected to Grow at a 6% CAGR Through 2035
2025-35e CAGRs.

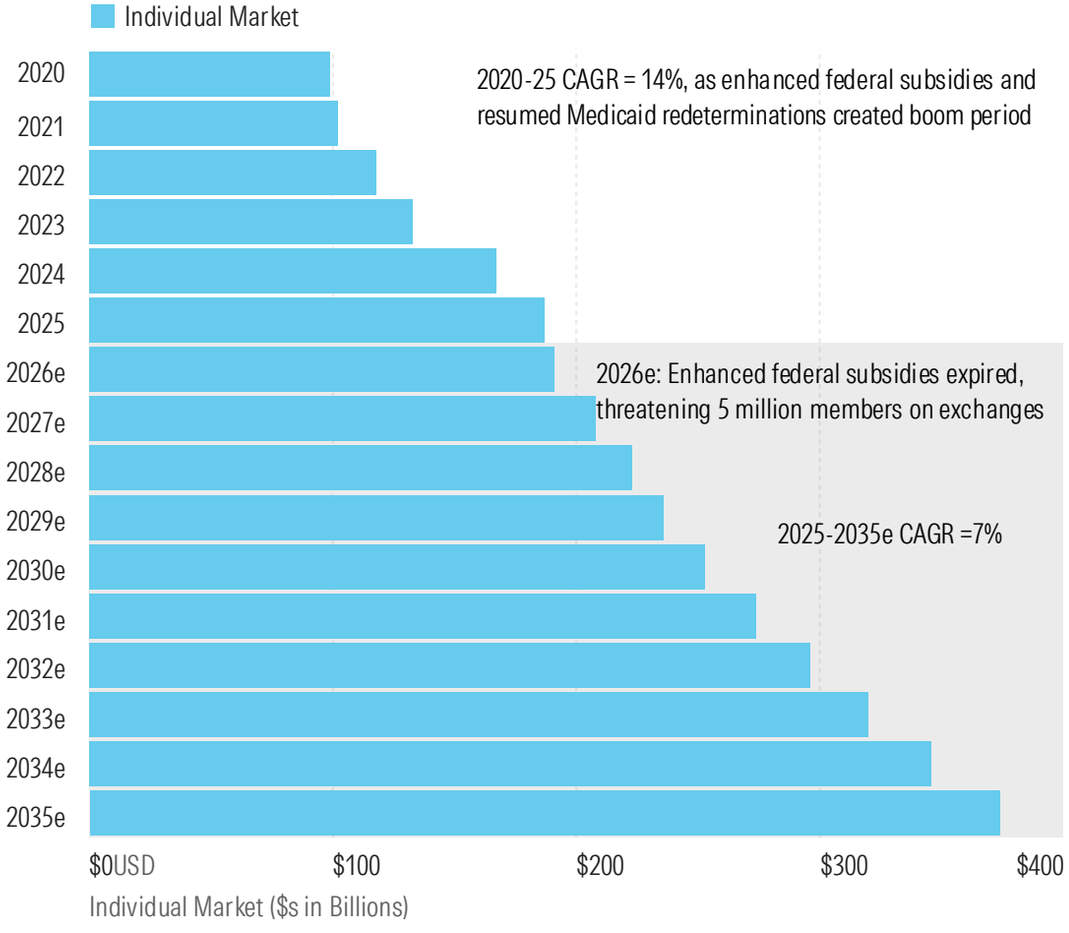


Source: Morningstar estimates and analysis of Centers for Medicare & Medicaid Services and Congressional Budget Office estimates as of September 2026.
CAGR = compound annual growth rate.

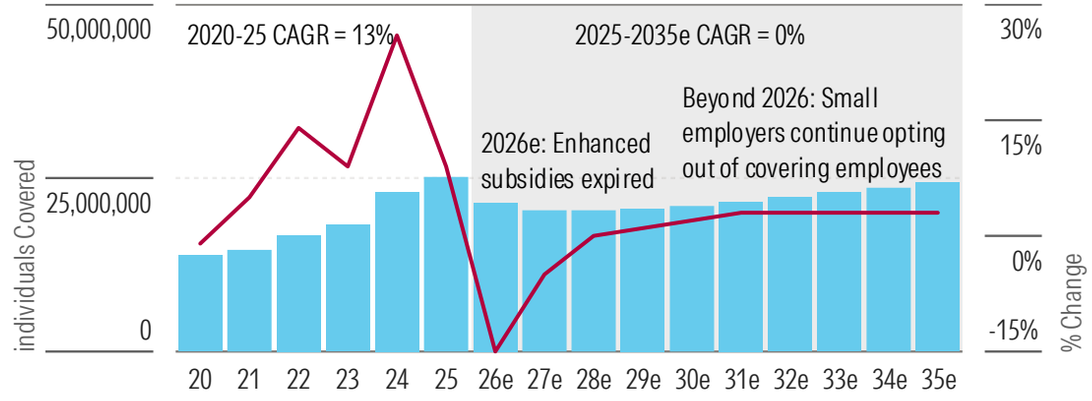
Expired Subsidies Are Constraining the Individual Market Now, but 7% CAGR Expected in Long Run

Big Growth Hurdle in 2026 Being Offset by Rate Increases

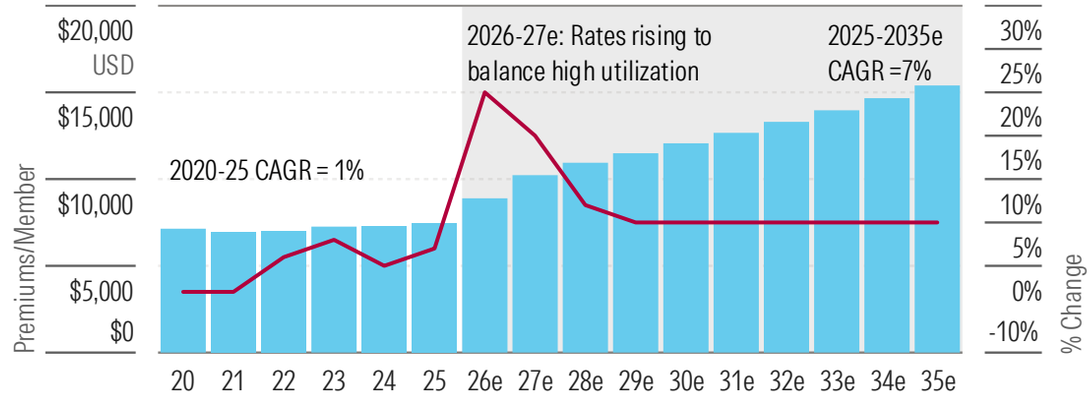
Individual market 10-Year CAGR = 7% on rate increases.



Expired Subsidies Threaten 5 Million Individual Members Starting in 2026



Rate Increases Offsetting Individual Market Utilization Spike That Started in 2025



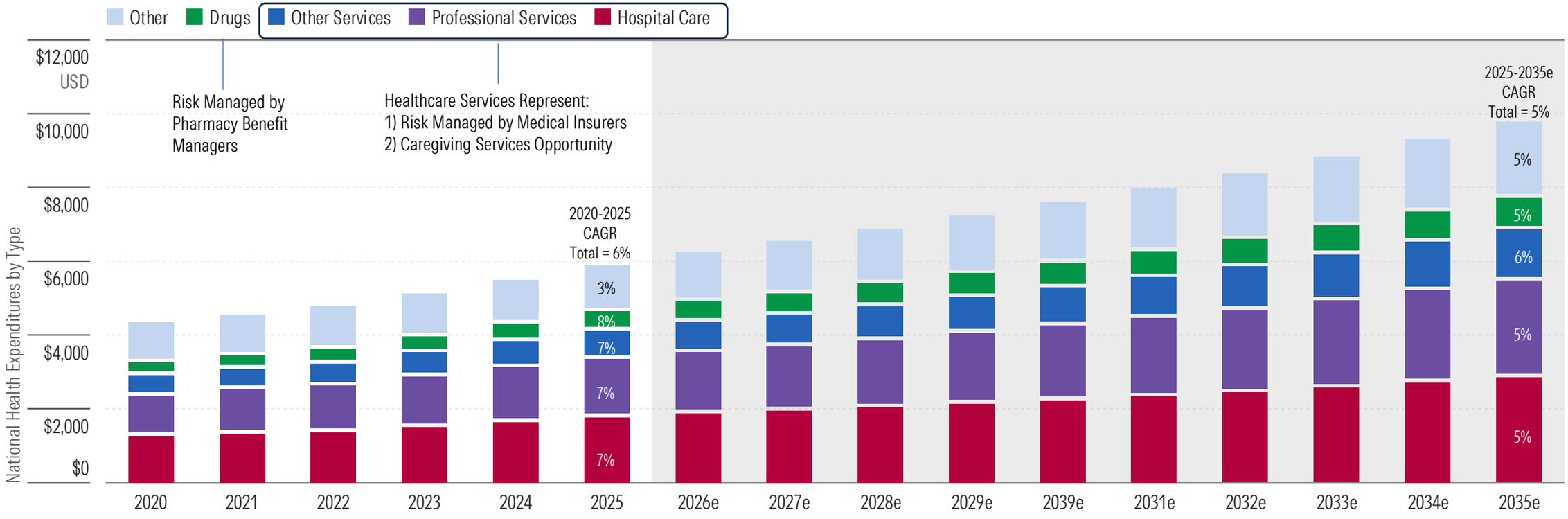
Source: Morningstar estimates and analysis of KFF data and Congressional Budget Office estimates as of September 2026.

Beyond Medical Insurance, the MCOs Target 5% CAGR Opportunities in Healthcare Services and Drug Spending

Many MCOs provide healthcare services and pharmacy benefit-related services, although big acquisitions in these areas now appear unlikely and regulator-forced reversals of this vertical integration may even be possible eventually. Healthcare services (5% CAGR through 2035) represent both the risks that medical insurers manage and direct caregiving opportunities. Prescription drug spending (5% CAGR expected through 2035) represents the risk handled by the PBM arms of the MCOs.

Some Managed Care Organizations Manage or Target Health Services (5% Growth Expected) and Prescription Drug Spending (5% Growth Expected)

$s in billions.

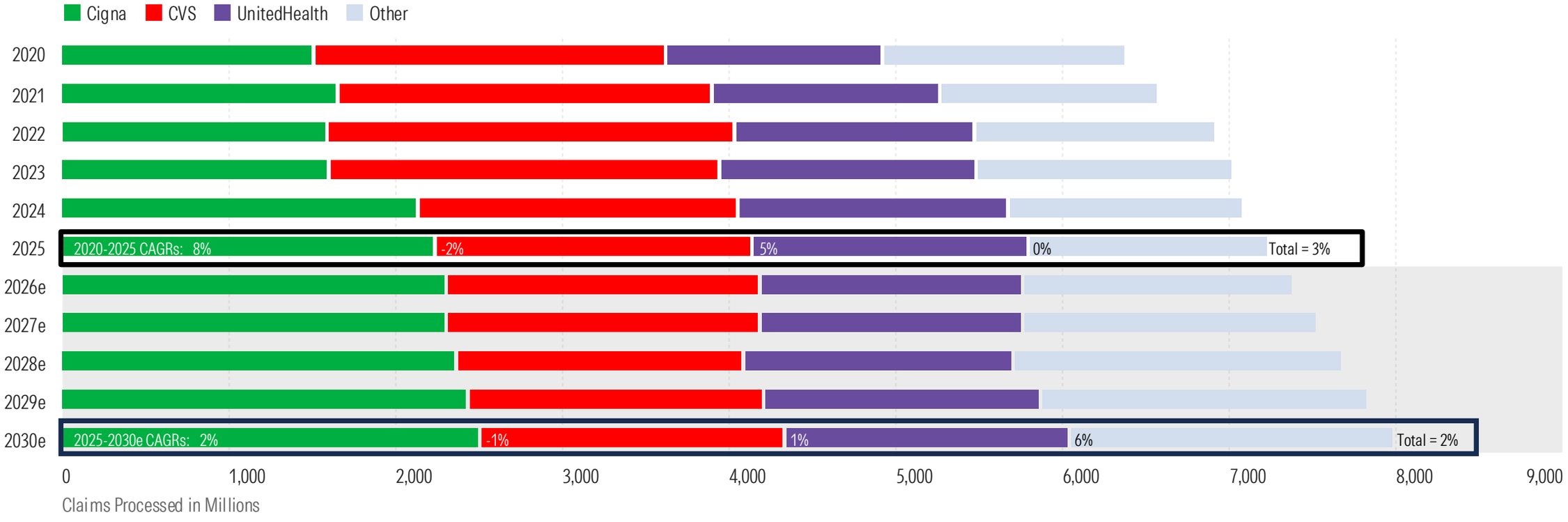


Source: Morningstar estimates (2035e) and analysis of Centers for Medicare & Medicaid Services and projections (through 2034e) as of September 2026.
CAGR = compound annual growth rate.

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



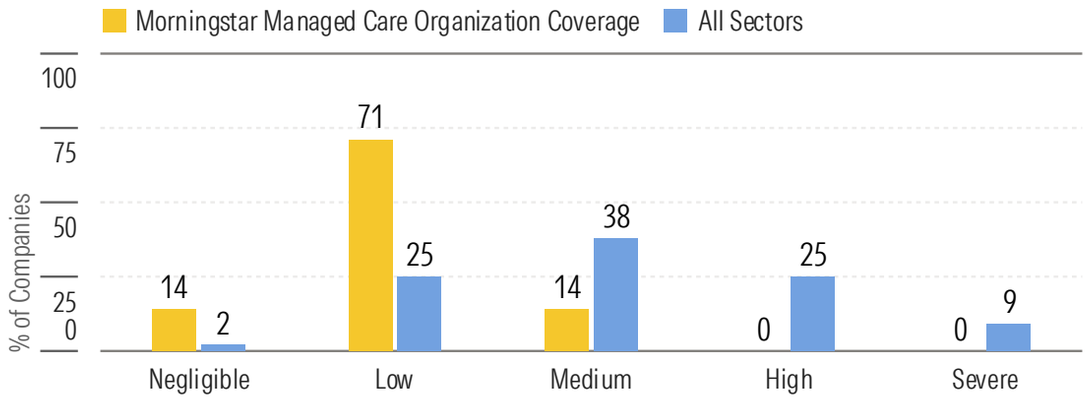
Source: Morningstar estimates and analysis of company and Drug Channel Institute reports as of September 2026.

ESG Snapshot

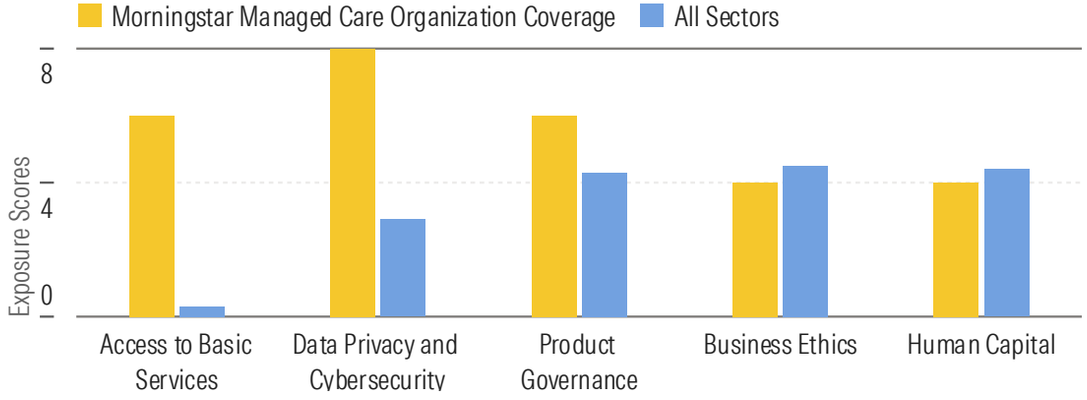
The MCOs face significant regulatory scrutiny.

Summary of Sustainalytics ESG Risk Ratings and Exposure Scores

Distribution of Sustainalytics ESG Risk Ratings for MCOs and All Sectors



Material ESG Issue Exposure Scores



Potential Regulations To Solve ESG Issues Create Some Risks for the MCOs

Sustainalytics assigns Negligible (14%), Low (71%), and Medium (14%) ESG Risk Ratings to the managed care organizations we cover. However, investors should know that the top environmental, social, and governance risks surrounding how the US achieves more universal, affordable coverage may continue to roil MCO shares and constrain some of the industry's moat and uncertainty ratings.

The biggest ESG issues that MCOs face include:

- Access to basic services: We think investors should recognize that how the US eventually achieves universal, affordable coverage may come at the expense of MCO industry 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 for that company.
- Product governance: Regulatory oversight, especially in government-sponsored plans, can result in lawsuits, fines, margin constraints, and antitrust actions for the MCOs. For example, CMS aims to rein in overpayments from aggressive risk assessments in the Medicare Advantage program, which could result in fines and lower potential MA margins, going forward. Regulators also appear concerned about vertical integration in the industry, which may eventually lead to reversals of previous combinations.

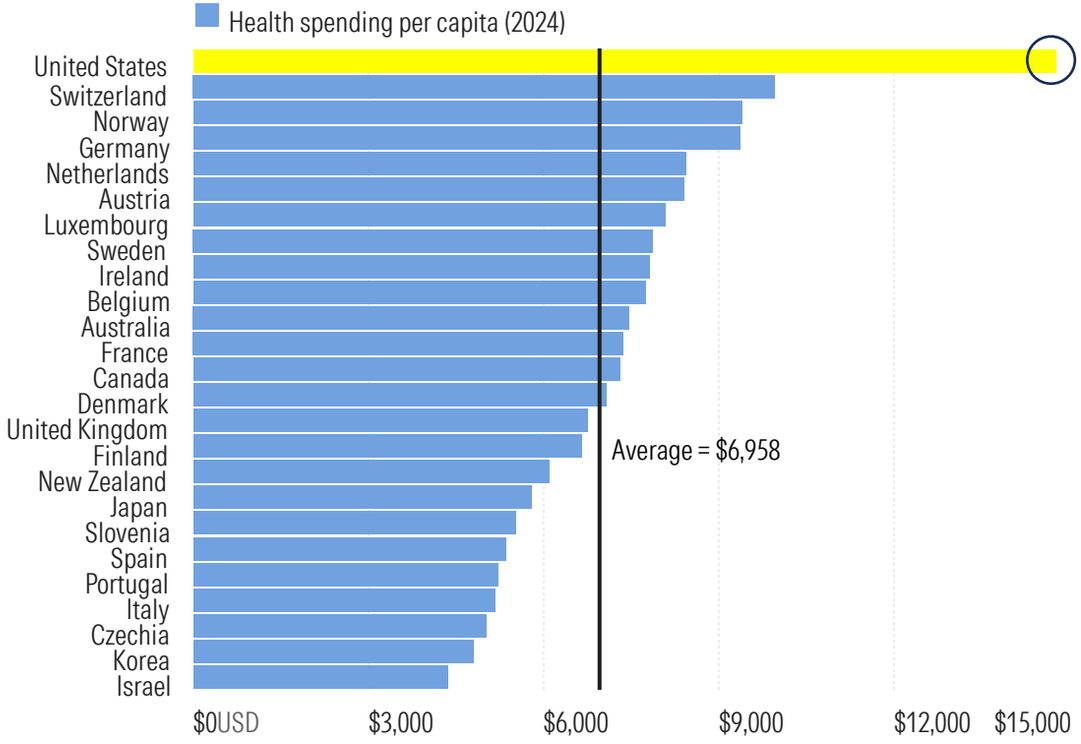
Source: Morningstar analysis of Sustainalytics data as of July 2026.

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 (79 years in 2024) on its "healthcare spending" investments of nearly $15,000 per capita in 2024 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. These potential changes could eventually cut into MCO profitability.

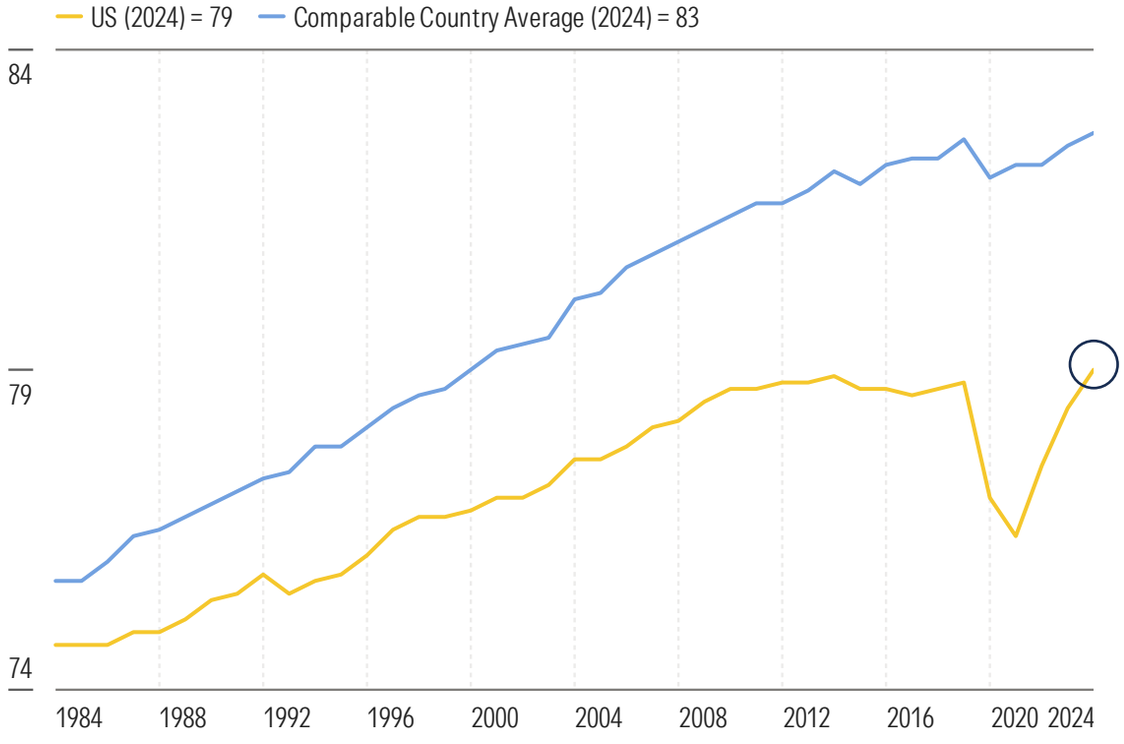
US Healthcare Spending Per Capita Far Exceeds Other Countries

The US spends about $15,000 per capita annually, more than double the average below.



US Life Expectancy at Birth (79) Trails Comparable Countries (83)

Measured in years as of 2024.



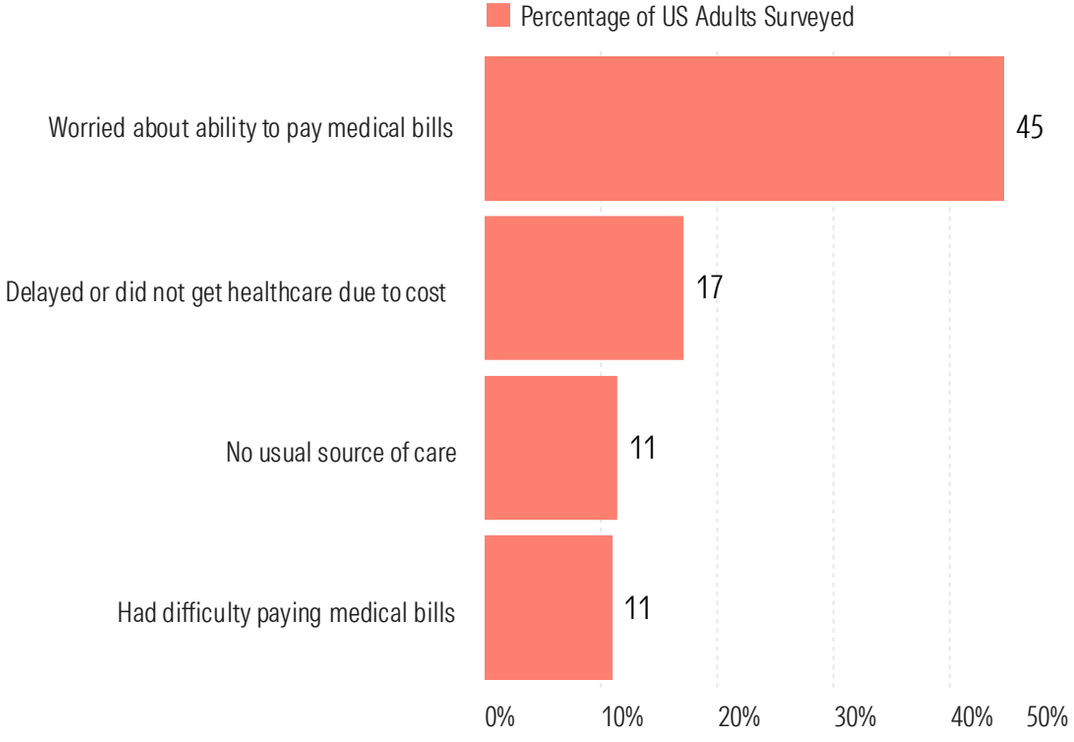
Source: Morningstar review of Peterson-KFF analysis as of March 2026. Left; Right
Comparable Countries include Australia, Austria, Belgium, Canada, France, Germany, Japan, the Netherlands, Sweden, Switzerland, and the UK.

Even Before Projected Fall in Insured Rates, Affordability Has Challenged Americans

Even with insured rates near recent peaks, healthcare affordability remains a big problem for Americans, and that problem looks likely to get worse with new regulatory changes. Specifically, with expired subsidies on the individual exchanges (2026) and new Medicaid work requirements and other points of friction (2027) cutting into key safety net programs, about 4% of the US population may lose coverage by the end of 2027.

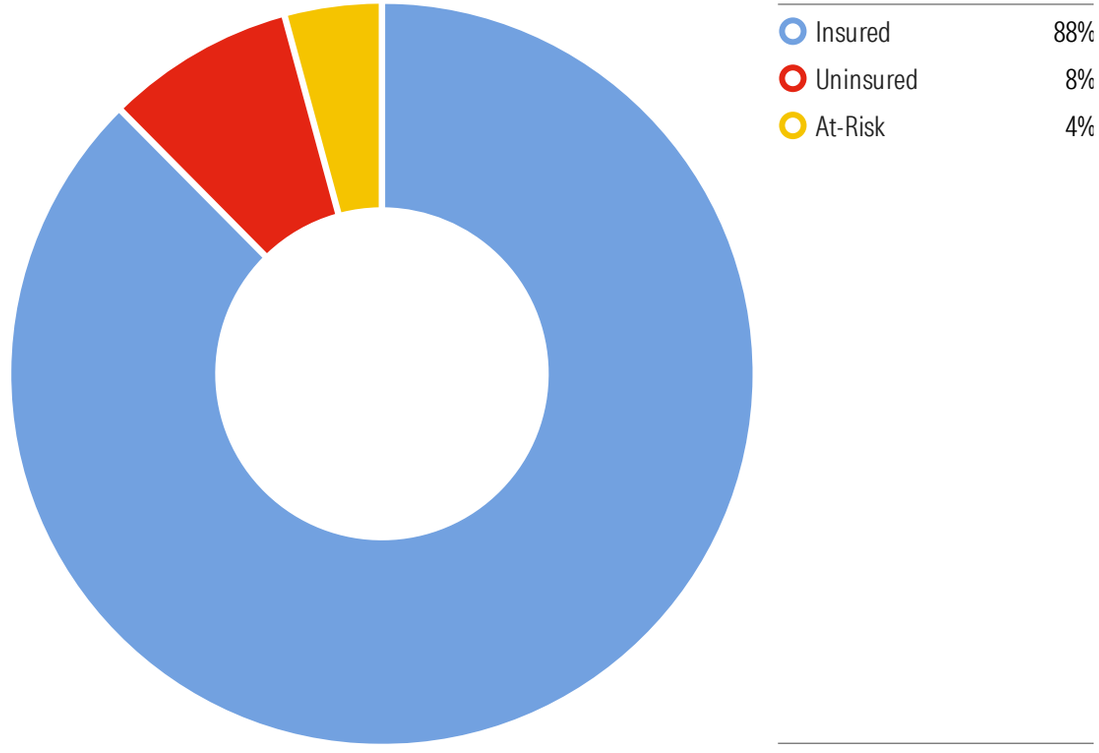
Affordability of Care Remains a Key Concern of Americans

KFF analysis of National Health Interview Survey data (2024).



The US Insured Rate Is Falling From Recent Peaks

% of US population.



Source: Morningstar analysis of data from KFF, Peterson-KFF, and Congressional Budget Office estimates as of September 2026.

Regulators Aim To Reform the MCOs, With Medicare Advantage and Vertical Integration in Focus

In mid-2025, we started incorporating lower Medicare Advantage margin targets and potential fines related to aggressive risk assessments from 2018-24 in our base-case scenarios. So far, though:

- CVS has settled for much lower than anticipated.
- Elevance estimates about $1 billion in a settlement versus our previous estimate around $2 billion.

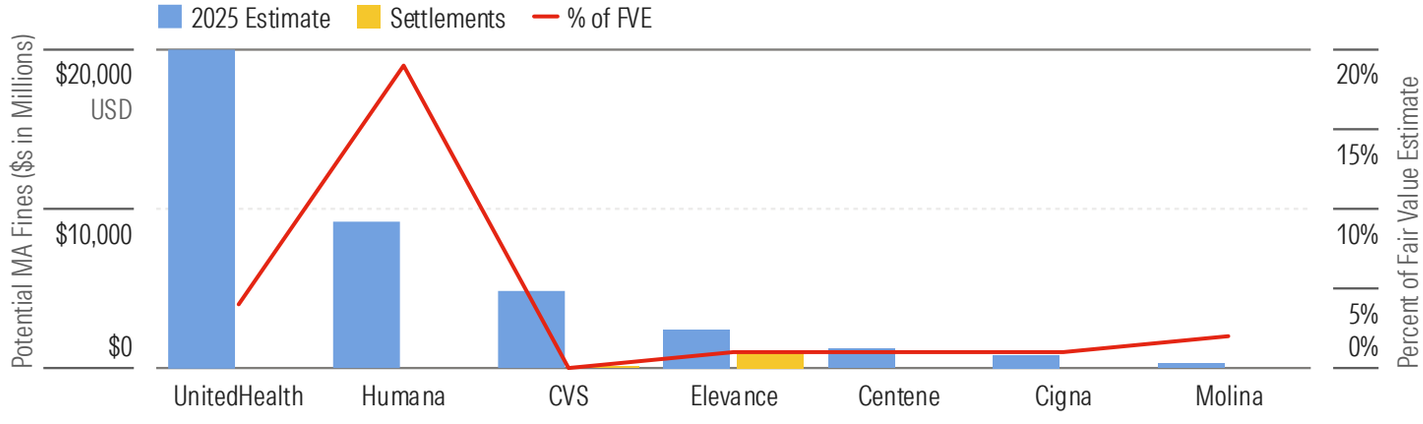
If the other fines come in much less than anticipated, fair value estimates could rise, with Humana potentially gaining the most since our fair value estimate is constrained nearly 20% by potential MA risk assessment fines.

Vertical integration is coming under fire at the MCOs with the potential for lost synergies, new corporate standup costs, and other financial consequences if the following occurs:

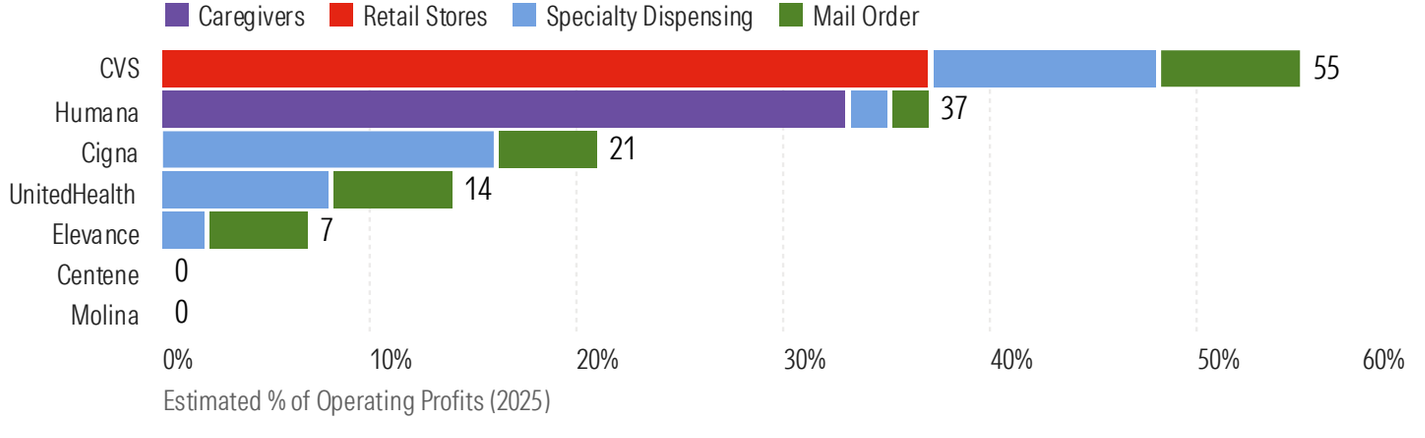
- The PBMs and drug dispensers (retail stores, specialty infusion clinics, and mail order operations) may be split.
- Medical insurers and caregivers may be forced to separate.
- Group purchasing organizations at the top-tier PBMs appear under investigation, which could lead to further financial fallout, although difficult to quantify.

CVS, Humana, Cigna, and UnitedHealth face the most financial risk if the above occur.

Medicare Advantage Settlements Coming in Under Our Estimates, Creating Most Upside for Humana FVE



Uncertainty Surrounds Further Regulatory Fallout Around This Vertically Integrated Industry



Source: Morningstar analysis of company reports and Office of Inspector General report from October 2024.

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 primarily 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 to those entities.

Medical Cost Ratio or Medical Loss Ratio (MCR or MLR) – The cost of caring for members as a percentage of premiums generated by a health 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 cap 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 by reducing membership through new work requirements and administrative processes in 2027 and does not continue the federal subsidies on the individual exchange plans 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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