CNC Earnings Call Transcript

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Quarter: 3

Operator: Good day, and welcome to the Centene Corporation 2025 Third Quarter Financial Results Conference Call. [Operator Instructions] Please note today's event is being recorded. I would now like to turn the conference over to Jennifer Gilligan, Senior Vice President, Investor Relations. Please go ahead, ma'am.

Jennifer Gilligan: Thank you, Rocco, and good morning, everyone. Thank you for joining us on our third quarter 2025 earnings results conference Call. Sarah London, Chief Executive Officer; and Drew Asher, Executive Vice President and Chief Financial Officer of Centene, will host this morning's call, which also can be accessed through our website at centene.com. Any remarks that Centene may make about future expectations, plans and prospects constitute forward-looking statements for the purpose of the safe harbor provision under the Private Securities Litigation Reform Act of 1995. Specifically, our discussion today of our expectations for the drivers of adjusted diluted earnings per share for 2025 and any commentary on expected adjusted diluted earnings per share for 2025 are forward-looking statements. Actual results may differ materially from those indicated by those forward-looking statements as a result of various important factors, including those discussed in our third quarter 2025 press release, Centene's most recent Form 10-Q filed this morning and its 10-K filed on February 18, 2025, Additionally, other public SEC filings, which are available on the company's website under the Investors section. Centene anticipates that subsequent events and developments may cause its estimates to change. While the company may elect to update these forward-looking statements at some point in the future, we specifically disclaim any obligation to do so. This call will also refer to certain non-GAAP measures. A reconciliation of these measures with the most directly comparable GAAP measures can be found in our third quarter 2025 press release. With that, I will turn the call over to our CEO, Sarah London. Sarah?

Sarah London: Thanks, Jen, and thanks, everyone, for joining us to review our third quarter 2025 financial results and updated full year outlook. We are driving significant progress against the milestones we provided to investors in July, yielding a better-than-expected adjusted EPS result in the period. This morning, we reported third quarter adjusted EPS of $0.50, ahead of our previous expectation. Within these results, our Medicaid business delivered anticipated HBR improvement in the period that was further aided by a positive 2025 retroactive revenue adjustment in our Florida business. SG&A; and performance within our noncore segment were both slightly favorable. Net investment income was stronger than we previously expected, and we experienced a lower effective tax rate in the quarter than originally forecasted. Marketplace experienced additional medical cost pressure in the last month of the quarter, but the segment still produced an on-track result for the period. And our Medicare segment, including MA and PDP, performed in line with expectations we shared on our second quarter call. With 3 quarters of the year complete, we are increasing our adjusted EPS forecast to at least $2, up from our previous forecast of $1.75 per share. When we came to you in July with recalibrated earnings expectations, we laid out 6 key assumptions that bridged us from our April outlook to the $1.75 per share forecast. We'd like to take a moment to update you on how those 6 factors evolved during the quarter and are now treated within our new adjusted EPS outlook of at least $2. One, relative to marketplace morbidity and its corresponding impact on risk adjustment assumptions, we received the second tranche of Wakely data in September, improving our visibility with industry-level paid claims

through July. We are pleased this data was consistent with our previous estimates, and we have, therefore, made no changes to our original full year assumption of a $2.4 billion pretax earnings impact within this new forecast. As a reminder, the next update from Wakely is expected in December. Two, also in the forecast was $200 million we added to account for additional Marketplace medical spend in the back half of the year. Marketplace delivered an in-line result for the quarter. But given the uptick in utilization we saw in September, we are holding the remaining $125 million of this provision in Q4 and are adding another $75 million given the volatility around eAPTCs. While we may not need this cover, as of now, we believe this to be a prudent posture given the landscape uncertainty that remains. Three, in July, we pointed to a 2025 Medicaid composite rate of roughly 5% based on the rates in hand at the time. With all scheduled rate adjustments now finalized, we expect the 2025 composite rate adjustment to be roughly 5.5%. Four, in July, we were targeting a second half Medicaid HBR of 93.5%. Our third quarter Medicaid HBR was 93.4%, which included $150 million in Florida Children's Medical Services program revenue, of which $90 million or 40 basis points was retro. As a result, we are now on a trajectory for a back half HBR of approximately 93.2%. Five, we continue to expect the Medicare segment to deliver $700 million of pretax favorability relative to our April full year forecast. Medicare Advantage and PDP results in the quarter were consistent with our outlook, so no change to this expectation. Six, we are also still on track to deliver $500 million in pretax benefit from SG&A.; In fact, we performed slightly better than expected with administrative expense reduction in Q3. However, given the fluid nature of marketplace open enrollment and the potential for additional enrollment activities surrounding eAPTCs decisions, we are keeping the full year SG&A; assumptions unchanged for the last quarter as of now. In addition to those items from our Q2 bridge, we want to highlight investment income and tax rate performance in the quarter and how they impact our expectations for the remainder of the year. As mentioned earlier, Q3 investment income was stronger than expected. Gains were largely driven by onetime items and therefore, not expected to recur. We believe there may be opportunity to take some investment losses in the fourth quarter to improve the trajectory of investment income in 2026, and we are providing flexibility in the guidance to do so if the opportunity arises. Tax favorability in the quarter was driven by a lower tax rate, which was purely a matter of timing. Our view of the full year tax rate remains unchanged. While we continue to track and pull levers to address Medicaid cost trend and are similarly watching marketplace utilization dynamics closely in this uncertain environment, we are pleased with the overall performance of the business in the quarter. With that, let's take a closer look at the performance and trajectory of each core business line, starting with Medicaid. We were pleased to deliver 150 basis points of sequential improvement in our Medicaid HBR this quarter. While this was aided by improved revenue from the Florida Children's Medical Services contract, it also reflects fundamental improvement that is a direct result of the actions we described on our Q2 call, including rate advocacy, program changes, clinical management, network optimization and more aggressive fraud, waste and abuse interventions, among others. Those efforts yielded tangible proof points in Q3. During our second quarter call, we identified 2 states, Florida and New York, where we were experiencing outsized Medicaid medical cost pressure. In Florida, you'll recall we saw significant trend pressure in the CMS population as members receiving ABA services were transitioned into that sole-source contract. We engaged in constructive dialogue with the state and shared real-time data throughout the summer. In September, the state moved to address the underfunding of that program going back to February 1. Additionally, the state provided a rate update for the coming year that better reflects the underlying medical demand within that population. In New York, we made real progress on the fraud, waste and abuse front, particularly in the behavioral health space. Fidelis team was able to terminate a provider group that engaged in suspicious billing practices and drove sizable excess medical costs at the expense of New York taxpayers. The state has simultaneously taken several serious actions against the same provider. It's a great example of the confidence our state partners in Albany have in Centene. Through these and other performance improvement efforts, the New York team is currently on track to deliver meaningful HBR improvement in the back half of the year compared to Q2 results. We continue to see trend in Medicaid with the same drivers we described in Q2, namely behavioral health with ABA a primary contributor, home and community-based services with home health the major driver and high-cost drugs, though high-cost drug trend did show slight moderation in the period. As you heard on the Q2 call, we have organized

enterprise-wide to address these dynamics and saw solid momentum in the quarter on those initiatives. A few examples. We have been actively working with states on solutions to address high-cost drugs and have seen multiple states make movements over the last quarter to implement drug-specific carve-outs and revised formulary decisions, including 2 states who have reversed course on GLP-1. Additionally, our ABA task force successfully leveraged our multistate experience and unique breadth of data to drive important policy advancements with our state partners. One state established increased precision in ABA clinical service definition as well as more stringent supervisory and caregiver engagement requirements. This drove a 45% reduction to outlier payment rates, which results in tangible financial improvement for the state's program and aligns members to higher quality services. We are pleased to be making real progress on our Medicaid margin improvement agenda, but we are certainly not declaring victory. With behavioral health still driving 50% of above-baseline trend, we continue to aggressively pull levers internally to appropriately manage medical costs and advocate for rates that reflect the medical demand in the ecosystem, all part of returning Medicaid margins to a more normalized long-term levels. Despite the challenges we have navigated over the last few years, our commitment to serving low-income and underserved populations has never been stronger. We are pleased to be making progress against our financial goals and making good on our commitment to be responsible stewards of state taxpayer dollars, all while continuing to provide high-quality care and access to vital health care services for our members. Turning to Marketplace. From a membership standpoint, we ended the quarter with roughly 5.8 million members, slightly better than expectations. As you heard earlier, the business produced an in-line result inclusive of medical cost pressure in September. Given what we saw in September and the reality that we are supporting a population staring down eAPTC expiration and potentially the wholesale loss of affordable health care coverage next year, we felt it was prudent to provide for additional coverage in Q4 against a potentially more pronounced year-end utilization push. In the meantime, we have been laser-focused on positioning our marketplace book for 2026 margin expansion, and Q3 was the critical window for that effort. We were data-driven in the buildup of our revised rates, which ultimately averaged in the mid-30s, taking into account increased 2025 baseline morbidity, a prudent assumption for year-over-year trend and the combined risk pool impacts of expiring eAPTCs and program integrity measures. Consistent with what we shared in September, we were able to reprice our products for 2026 in states that cover 95% of our current membership and where we were not able to fully reflect the expected morbidity in the rates, we took additional actions to minimize margin impact for the remaining membership. Those rates have now been officially approved and absent any late-breaking policy changes will drive open enrollment as it launches this weekend. Congressional dialogue around eAPTCs has obviously gained traction in recent weeks, the outcome remains uncertain. While our products are priced to support year-over-year margin improvement in a scenario where eAPTCs expire, we believe these tax credits offer critical support for hard-working Americans, small business owners and rural health care infrastructure, and we are hopeful Congress can find a path forward. In the meantime, we are ready to open enrollment with strengthened digital tools and well-trained call center personnel to aid members during this time of uncertainty. Regardless of the outcome, we remain confident in the long-term importance and viability of the individual health insurance market as a critical coverage solution for millions of Americans. As we move beyond this moment of policy evolution, we continue to see a greater role for this platform to support a more affordable, portable individual insurance experience that we are excited to lean into and lead forward. Finally, Medicare. Both of our Medicare segment businesses performed well during the quarter, producing results consistent with our updated outlook provided this summer. Our reported Medicare segment HBR was 94.3%, reflecting typical cost of care patterns within Medicare Advantage as well as the inverted seasonality of pharmacy costs within PDP, owing largely to changes related to the IRA. Note that these dynamics are even more pronounced now that PDP is half of our Medicare segment revenue. Medicare Advantage medical cost trend remains elevated compared to historic levels, but was consistent with our expectations for the quarter. PDP performance was consistent with our previous view and is now largely contained by risk corridors, providing for increased visibility into the fourth quarter as the corridor serves to narrow the band of outcomes through downside protection for the product. AEP is live, and we are actively enrolling members in our 2026 Medicare products. Margin recovery once again took priority over membership as we constructed Medicare Advantage

bids, but we are pleased with both the value proposition we are offering beneficiaries as well as our competitive positioning. We continue to invest in our member experience, providing enhanced digital tools and resources for members and prospective members. Dual eligible populations are a strategic focus for Centene, and we recently launched the first phase of our enhanced integrated duals model across 8 states as part of the broader transition of MMPs to integrated D-SNPs effective January 1, 2026. We look forward to the opportunity to serve these beneficiaries as their needs and our capabilities continue to align and evolve. Earlier this month, CMS released 2026 Star ratings that impact 2027 financial results, and we are pleased to have generated another year of progress. During this cycle, we elevated our performance despite continued cut point headwinds to 60% of members in plans at or above 3.5 stars versus 55% from the prior year with roughly 20% of members in 4-star plans. These results demonstrate a true One CenTeam effort with the initiatives being planned and executed at every level of the organization and provide us with increased confidence in our ability to achieve breakeven pretax margin in 2027. We are proud of the Medicare Advantage Star score advancements we have achieved over the last 3 years, but remain focused on the opportunity for continued improvement. In the near term, we are leaning into provider interoperability, multimodal member engagement and advanced VBC partnerships as levers for the future. Overall, we are pleased to have maintained strong Medicare segment results, including positioning PDP well to achieve results better than the 1% pretax margin guidance we began the year with and putting Medicare Advantage on an even stronger path to achieve breakeven in 2027. As we reflect on the quarter, we are pleased to have made material and necessary progress on Medicaid profitability and delivered solid results across the balance of the business. It is a testament to the resilience and discipline of this entire organization that we are able to raise the outlook today. And while a tremendous amount of work remains ahead of us, we intend to harness the positive momentum we have generated here in the third quarter to help power the balance of the year. Looking ahead, given that we will not be hosting an Investor Day in December, our plan is to provide detailed 2026 guidance on our Q4 earnings call in early February. In the meantime, we wanted to offer some initial comments on the major building blocks of our 2026 plan. In Marketplace, as we've shared, we were able to successfully take actions to account for baseline morbidity, trend, eAPTC expiry and program integrity impacts for 2026 across 95% or more of our membership. While the policy landscape remains uncertain, based on what we know today, we believe we have positioned the portfolio well for meaningful margin improvement in 2026. As a result of thoughtful bid construction and disciplined management, we believe our Medicare Advantage business is also well positioned for margin improvement in 2026. CP continues to outperform in 2025, but you can assume we would not guide to a similar level of outperformance as we step into 2026, making this a year-over-year headwind as we set initial guidance. In Medicaid, in light of our now better-than-expected full year trajectory, we believe a prudent posture for 2026 is profitability consistent with our current full year outlook in 2025. Additionally, you should assume that a lower tax rate environment makes net investment income a headwind and that our tax rate increases. Overall, we remain focused on driving margin improvement across the enterprise and delivering EPS growth in 2026. The current dynamic policy landscape has presented significant challenges in 2025, but also offers meaningful opportunity in the months and years to come. We have incredible runway ahead of us in the form of operational improvements, efficiency gains and margin expansion, all in service of our dual mandate to ensure quality health outcomes and serve as responsible stewards of taxpayer dollars. None of this would be possible without the tireless work of more than 60,000 Centeneers across the nation, serving and supporting our nearly 28 million members. Thank you once again for showing up day in and day out in service of our mission. With that, I'll turn it over to Drew.

Andrew Asher: Thank you, Sarah. Today, we reported third quarter 2025 results, including $44.9 billion in premium and service revenue and adjusted diluted earnings per share of $0.50. The GAAP loss per share of $13.50 was the direct result of a $6.7 billion non-cash goodwill impairment charge recorded in the quarter. More on that in a minute. Within the $0.50 of adjusted EPS, we had a temporarily low adjusted effective tax rate in the quarter, which contributed about $0.10 compared to an expected full year 2025 adjusted tax rate of 20% to 21%. Let's go through the drivers for the quarter and then map that to the full year. Starting with Medicaid. We are pleased to report a Q3 HBR of 93.4%, better than we expected for the quarter and heading in the right direction. Of the 3 previously discussed high

trending areas, Medicaid high-cost drug trends settled a little in the quarter, and we successfully advocated for much improved revenue in our Florida Children's Medical Services or CMS business, where we've seen very high ABA costs. As Sarah covered, we received a net $150 million positive revenue adjustment in Q3 for the Florida CMS program for the 21 February 1 to September 30, 2025 period, of which about $90 million was retro to Q1 and Q2 2025. Retro piece was worth about 40 basis points on the Q3 Medicaid HBR. We also made some progress in New York, but there is more work to do to further improve performance. Overall, given the Q3 result and momentum we are seeing from actions we have taken in 2025, we're a little ahead of our back half Medicaid HBR goal. On the rate front, the 9/1 to 10/1 cohort that represents about 28% of annualized premium averaged in the mid-5s, consistent with the full year 2025 composite rate. We are focused on 1/1 and 4/1 rates, representing about half of our 2026 annualized premium revenue, and that advocacy is in process. Medicaid membership is at $12.7 million, and we would expect slight attrition over the next few quarters. Stepping back, we are pleased with the sequential progress in Medicaid with opportunity for improvement ahead. In our Commercial segment, our HBR was on track for Q3 at 89.9% Sarah indicated, in September, we received and evaluated the second run of marketplace weekly data, which represents updated claims through July. Our review of this data is consistent with the $2.4 billion forecast change we described on the Q2 call. Recall also, our previous guidance had accounted for a pickup in marketplace trend in the back half of the year, especially given the level of public discourse around the eAPTCs. We did see a pickup in utilization in September, including ER. And as we assess risks and opportunities for Q4, we added another $75 million to our prior marketplace medical expense forecast. The more critical activity during Q3 was focused on 2026 rate filings and eAPTC education and advocacy. We sit here today based upon our rate filings in 29 states, we have priced for our estimates of: one, 2025 baseline correction; plus two, 2026 forecasted trend; plus three, the impact of program integrity rules implemented in 2025 and those announced for 2026; and four, the sunset of eAPTCs. Unlike 2025, which is expected to run at a slight loss, we expect these pricing actions to support margin expansion in our Marketplace business in 2026. Our Medicare segment was also on track in the quarter. Medicare Advantage continues to show progress toward our 2027 goal of breakeven, and we were pleased with the progress with the October Stars announcement, as Sarah covered. Within PDP, while trends are still high in the non-low-income PDP population, they weren't as high as we had planned for in Q3. That's good for cash flow and forward forecasting, but is largely offset against the risk corridor receivable for current earnings purposes. As we discussed at a webcast conference during Q3, we are pleased with our 2026 PDP product positioning relative to the relevant benchmarks and direct subsidy estimates. More to come on the Medicare segment after AEP. Our adjusted SG&A; expense ratio continues to be strong at 7.0% in the third quarter compared to 8.3% last year and 7.3% year-to-date compared to 8.3% year-to-date last year. This is largely due to growth in 2025 PDP revenue and continued leveraging of expenses over higher revenues, coupled with good discipline. Given the amount of activity expected in Q4 with open enrollments and member communications, we are assuming for now that we will spend any remaining Q3 SG&A; outperformance in Q4. You will notice investment and other income is up $79 million in Q3 compared to Q2. We had a few gains in the quarter, plus temporarily higher cash balances than expected. As we think about Q4, we may harvest some unrealized losses like we did a couple of years ago in Q4. as we think about reinvesting in higher-yielding instruments for 2026 and beyond. So for now, we are assuming that Q3 investment and other income outperformance will be earmarked for that purpose. Overall, the fundamental business performance was good in Q3 relative to our July forecast. Our GAAP results, you can see a reduction or write-down of about 38% of our goodwill during Q3. As we covered on the Q2 call, the drop in market cap required us to accelerate our annual goodwill evaluation into Q3. After going through an accounting promulgated and detailed review of our goodwill, we took a onetime non-cash charge of $6.7 billion in our GAAP results. This has no impact on statutory capital, cash or adjusted EPS results. Our sole credit facility financial covenant is a debt-to-cap limit at 60%, and we sit at 45.5% on 9/30/25 after this write-down. The topic of the balance sheet, we had 0 drawn on our $4 billion revolver that has a duration until 2030. We also had a strong cash quarter with cash flow provided by operations of $1.4 billion in Q3, primarily driven by net earnings and the net timing of pass-through and other payments. Unregulated cash on hand at quarter end was $357 million. As you

can see in the 10-Q, we expect to receive net $200 million in dividends from subsidiaries in Q4. Medical claims liability totaled $21.5 billion and represents 48 days in claims payable, an increase of 1 day as compared to the second quarter of 2025. We look at the full year 2025, we are increasing our 2025 adjusted EPS forecast from the previous $1.75 to at least $2, driven by early execution on the improved Florida CMS revenue. 2026. We look forward to providing 2026 guidance on our next quarterly call in early February once we have closed out 2025. But as you heard from Sarah, we look forward to growing adjusted EPS in 2026. Thank you for your interest in Centene, and we can -- Rocco, we can open it up for questions.

Operator: [Operator Instructions] And today's first question comes from Josh Raskin with Nephron Research.

Joshua Raskin: I guess my question really would be, how do you get comfortable that you are getting ahead of trend in the exchanges? And do competitor exits make the pool less stable for 2026? And is there a point where this adverse selection spiral causes you to rethink certain markets or maybe even the segment entirely?

Sarah London: Josh, thanks for the question. Let me hit utilization and trend in marketplace both as we think about the back half of 2025 and then how we've thought about it for 2026. So as we said, we saw a slight uptick in utilization in September, primarily outpatient ED. It correlated from a time standpoint with the direct uptick in dialogue nationally around both rate increases for 2026 and the eAPTC discussion at the congressional level. So not a perfect correlation or causation, I guess, but sort of correlation there. And as we thought about Q4 and thought about sort of that $200 million provision, pushing the remainder of the $125 million into Q4 and then adding another $75 million was really based on taking what we saw in September, extrapolating that out and assuming that given just the volatility in the landscape and the fact that some folks are going to be concerned about their ability to access health care next year, we may see more of an uptick than we normally do in terms of that Q4 utilization. So we feel like we've put prudent coverage in Q4 as we run out the year. Relative to 2026, we obviously did a lot of work and just want to call out again the marketplace team jumping on top of the weekly data in July really through that and understanding the drivers of what we were seeing and the fact that there were indicators in that data of what the extrapolated morbidity shifts would be above and beyond what we're seeing in '25 or '26. So what we built into the revised rates that we talked about filing across 95% of membership were 4 major components. One was that adjusted 2025 baseline morbidity. And obviously, the fact that the September weekly data came in consistent with our extrapolation of the July data is a strong reinforcing data point. So that's one. Two is a healthy provision for trend as we step in -- year-over-year trend as we step into 2026. Three is the assumption of the expiration of eAPTCs because that is current law of the land and what that will do to risk pool shifts. And then the last is a sort of composite view of the additional risk pool shifts that would be driven by both the continuation of the 2025 program integrity measures and sort of enrollment hurdles that were put in place as well as those hurdles that are -- were in the final rule and also in OB-3. And so all of that was loaded as part of that revised rate. And that gives us confidence that an average step-up, as I mentioned, in the 30s, really with a focus on margin over membership sets us up well for meaningful margin recovery in '26. Now there are multiple pieces that are still moving, right? Obviously, we don't know where eAPTCs will land. The payment program integrity measures that were in the final rule have been stayed in the courts. And our view is it's unlikely that those move ahead of Saturday and possibly not even through at least the original planned open enrollment period. And so we need to see where those land, but the bottom line is that our pricing took into account sort of all of those actually being in place during the open enrollment period. Lastly, just relative to your comment on overall stability, we do feel like there is still a competitive market. We feel like peers were thoughtful about '26 in terms of understanding the risk pool shifts. And we do think that sort of the fundamental construction of the market with those advanced premium tax credits prevents any kind of sort of death spiral, but we've been cautious as we constructed our view of 2026.

Operator: And our next question comes from A.J. Rice at UBS.

Albert Rice: Maybe just a follow-up on that and then maybe ask you something on Medicaid as well. On -- so presumably, the open enrollment people -- the open enrollment that enrollees are going to see will reflect the loss of these tax credits, and there may well be a move by Congress to extend them in some

form or fashion. Do you have the ability to quickly reengage people to get them to sign up? I assume the people that are sicker and dealing with the health system through their providers will get prompted to resign, but I'm thinking about those that are younger, healthier and have less frequent contacts, many of those still using the exchanges. How easy is it to notify them that now it may make sense to re-sign up? And what efforts do you have in place for that? And then just quickly on your comment about stable margins or stable contribution in Medicaid next year. There's a lot of discussion about some states trying to adopt work rules early and also putting in place program integrity measures on that side of the business. How are you thinking about that when you think about your outlook for Medicaid next year? And is that a meaningful swing factor?

Sarah London: Yes. Thanks, A.J. Great questions, easy question. So let me hit marketplace first. And you're right. So what we are navigating through is the idea that traditional open enrollment launches on Saturday. The eAPTC discussion is, we assume live as we speak with the possibility that there may be action before the end of the year. And so I think what you're really asking about is sort of breakage. So even if we got eAPTC extension, are we able to go and recapture folks who maybe got an initial letter, made a decision about the affordability of their insurance based on that data point and don't actually reengage or return of their own volition to understand how that landscape may change. So that is something that we are paying a lot of attention to. And in fact, if you think about our commentary about rolling forward some of the SG&A; favorability that we saw in Q3 because of this idea that we may be going through sort of a multilayered enrollment process. We may find ourselves with a special enrollment period or an extension. We may want to be putting forward additional marketing efforts, obviously, mobilizing our broker relationships to go and find those members if and as the landscape changes midstream. Our view is that there will still be some degree of breakage. And so even if the eAPTCs are extended in the middle of the cycle and you go forward, for example, with an additional 60-day special enrollment period, our view of market contraction for 2026 is in the high teens to mid-30s range. So again, that's based on sort of all of the different factors that could be at play. But it tells you that even that bottom end where, for example, the program integrity rules remain stayed and eAPTCs are extended that there is going to be some degree of market contraction. And again, some of that is the roll-through of '25 program integrity enrollment hurdles, but also a view that there will be some abrasion and breakage on members who get that initial letter and don't come back. But we are certainly prepared to do everything we can to go find those members and help them understand in the event of an extension that they do have access to affordable insurance and certainly have done all of the work kind of both mathematically and administratively to be prepared, frankly, for any of these scenarios. so that we can help be a good partner both to the administration as they navigate through this, but also supportive of our member base. So that's Marketplace. Medicaid, so a couple of things embedded there. Relative to work requirements, we saw some movement over the summer for states that were putting in waivers and thinking about potential early start, call it, 7/1/26 implementation of work requirements. As of now, those states that were sort of early in that have all moved back to a 1/1/27 start date. So we don't have any firm data points of states that have our intent or have explicitly pinned 7/1/26 start date. There's also quite a bit of important guidance that is still to come from CMS that is not scheduled to come down in rule-making until the summer. And those are really important provisions relative to state flexibility, how to define able bodied what additional population states may be able to carve out what the data capture and reporting requirements are going to be, what the frequency is of all of this. So states can certainly and it should be, and we are working very closely with them to plan ahead, but there's a lot about what this is actually going to look like that is not even scheduled to become clear until the summer, which means that 2027 and for some states beyond that is going to be the more rational sort of implementation time frame of that. And then what, therefore, is the impact as we think about '26, we don't see a huge impact in '26 relative to work requirements as we think about the the overall sort of margin profile and our ability to retain, as we said, sort of initial view of '26 sort of consistent profitability. And then the program integrity measures, similarly, we are expecting some degree of membership attrition next year just as we're seeing states get better at the reverification process, but we don't see that as a huge swing factor.

Operator: And our next question today comes from Justin Lake at Wolfe Research.

Justin Lake: First, just a quick follow-up on the exchanges. I appreciate you sharing your thoughts on

the market contraction potential. I wanted to hear your view on competitive positioning for '26 versus '25. And would you expect your growth overall to be in line with that market [SAR] or better or worse and by how much? And then maybe, Drew, any color you could share with us in terms of how much of that $700 million of Part D upside we should think about unwinding next year?

Sarah London: Yes. Thanks, Justin. So a little bit about market competitive position. So again, sort of a slightly refined view of overall market contraction in that sort of high teens to mid-30s. Obviously, it depends on sort of which scenario lands, and we need to see how open enrollment, which may be extra complex plays out. But it's possible that we end up slightly on the higher end of that range. However, relative to our competitive positioning and sort of the landscape, relativity, we had 55% of our portfolio in the low-cost silver positions in '25 and 42% in '26. So not a huge change, but a change that I think reflects the fact that we were very focused on margin recovery over membership as we stepped into those 2026 pricing decisions. And then I'll kick it over to Drew on PDP.

Andrew Asher: Yes. PDP, good question, Justin. So as Sarah said in her remarks, PDP is now about half of our $37 billion of full year '25 Medicare segment revenue. So you can keep that in mind on the impact on the full segment. And then underneath that, PDP, think about it this way. We're running -- we expect to run in the 3s in terms of pretax margin in 2025. And while we're still constructing all the elements of the plan, and we need to see how open enrollment plays out, we would probably come out of the gate something less than that as we think about initial guidance that we will give in February for 2026.

Operator: And our next question today comes from Andrew Mok at Barclays.

Andrew Mok: Last quarter, you expressed confidence in margin improvement across all business lines, including Medicaid. Now it sounds like you're not expecting much improvement in Medicaid profitability. First, was that comment framed through the lens of earnings dollars or margins? Because I think there might be some pressure on the revenue line from disenrollment and contract losses. And second, was there a change in underlying performance across the broader portfolio when excluding some of the idiosyncratic events in Florida?

Sarah London: Yes. So let me sort of step through Medicaid, and I'll take your last question or last piece of the question first and just reinforce that, first, obviously, very pleased to be delivering sequential HBR improvement quarter-over-quarter. And the fact that what we delivered is reflective of the improvement that we were expecting in the July guidance. It was further aided by the $150 million in Florida, which actually, I think, is a great proof point of the fact that rate advocacy is an important lever. And that while in Medicaid, we don't set the rates, we can influence the rates and those rates are ultimately data-driven. So what influences our view of '26 now versus July, the biggest shift is really that we're on a better-than-expected trajectory than we were in July. But a couple of factors as you think about how we're looking at progression and important to note that regardless, we are not taking our foot off the gas on HBR improvement overall as an organizational focus. But we were jumping off a very high starting point in Q2 and a first half HBR of 94.2%. So we're going -- we're expecting to have a lower HBR in Q4 even than Q3, which was lower than Q2. We have the benefit of solid rates at 5.5% composite, which is sitting in that sort of back half cohort annualizing into 2026. We'll also have -- be lapping the acceleration of trend. And so does trend step up at the same accelerated rate? Our belief is that it is more likely to moderate to some degree, but that is also something that we are very focused on controlling where we can. And so a big proof point for us in Q3 was the fact that we were able to put points on the board against every one of those major levers that we talked about. So rate advocacy, not just in Florida, but the fact that the 10/1 rates materialized better than expected, clinical policy design in states. And I talked about a couple of those examples where we are influencing states to change their approach to high-cost drugs. And in fact, some of those changes that I described are effective 1/1/26. So we have hard data points about how states are making changes. We've got another great example of states that are adding CCBHCs to their program and the fact that we have experienced where that can drive unintended high costs in states from other parts of our portfolio have been able to inform states about what could happen if you don't put those in place with the right guardrails. And so they're stepping into those program changes in the right way in the first instance. Network optimization, I talked about some examples of that, not just from a fraud waste and abuse perspective, but we have a great program called Partnerships in Care when we go out to outlier providers and provide them with data

and really talk about -- sometimes it's just a question of education about a better path of care for members. And then, of course, stamping out fraud waste and abuse. So really strong proof points of that work in the quarter and the fact that we've been at this now for almost a year. So good visibility into additional opportunities and additional tactical efforts that are out there and ahead and will manifest in '26. We also have almost 40% of the membership that re-rates in the 1/1 cohort. So our view, as we stand here today, sitting on a better-than-expected trajectory with important dates in 2025 still to play out, which will tell us a lot about Q4 trends, will tell us about sort of the right jump-off point for next year. We only have about visibility into 50% of 1/1 rates, and those are only draft. So if asked what jump-off point for '26, we believe it's prudent to say consistent profitability and margin as we go from '25 to '26. I will tell you that I will be disappointed if that's all we can deliver. But we think that, that is a prudent assumption at this time, given where we stand and what we know and also what we don't yet know. But we absolutely look forward to giving much more detailed perspective and formal guidance on the Q4 call.

Operator: And our next question today comes from Ann Hynes with Mizuho.

Ann Hynes: Just in your main businesses, Medicaid, Medicare health exchanges, can you tell us what -- you had that initial 2026 outlook, what you're assuming the trend is in each segment? And then with Medicaid, can you tell us what your initial thoughts are for the composite rate increase?

Andrew Asher: Yes. So thanks, Ann. Let's start with Medicare. Medicare trend has been running high single digit to even maybe 10 plus for the last couple of years. And so we're assuming that, that continues. If you compose it with respect to our bids and what's baked into that progression towards breakeven, that would be low double digits. And at some point, that's going to start being reflected in the fee-for-service rates that we all get as an industry. So we look forward to getting an advanced notice in February and seeing what that looks like. In Marketplace, you have to think of the 4 buckets that I laid out in my remarks because they foot to like a mid-30s average rate increase. And certainly, fundamental trend is a component of that, but probably even more important than trend in Marketplace is the expected risk pool shift. And we learned -- and back to an earlier question, we learned a lot in 2025, which we talked about in the Q2 call, like what happens to risk pools when program integrity measures are put in place. And it was fortuitous that we were able to see that and learn that before we undertook the repricing effort that was largely successful, as Sarah indicated. So you've got to add a bunch of things up to get to that mid-30s, but that would include 1 of the 4 pieces is the fundamental trend. And then in Medicaid, -- if you think about this year, our HBR is up probably 120 basis points from 2024, and we got mid-5s rates. And as Sarah said, 30% of that will roll into next year and 2026 in terms of the annualization of what we got in 7/1 and 9/1 and 10/1. And then we have a little bit of the visibility into the 1/1 cohort. And jumping off of a high baseline, including, as Sarah said, like a 94.9% in Q2, a 94.2% for the first half of the year. And then with the levers we've been able to pull a couple of things Sarah mentioned in her script, the 2, maybe even 3 states rolling back on GLP-1s for weight loss, high-cost drug pools being formed, carve-outs of high-cost drugs like Zolgensma, Elevidys, Lyfgenia. And so examples of where we're able to pull levers impacting the trajectory of even then home health with private duty nursing management and behavioral health with the -- what we're being able to do with the task force, we think we're taking sort of a bite out of forward trends. So we'll give more details on the components. But all of that goes into the formula where we can sit here today, once again, with the visibility we have and the visibility we don't have about 2026 and feel like stability in that HBR relative to 93.7%, if you do the math on 2025, expecting to be able to maintain that in 2026 is the starting point of our forecasting for 2026.

Operator: And our next question comes from Kevin Fischbeck at Bank of America.

Kevin Fischbeck: I was wondering if you could talk a little bit about Medicaid margins, obviously, flat next year. Are you guys expecting that 2026 is going to be basically more of a trough year and that you should be expecting to build on that in '27? It sounds like you're assuming work requirements more of an issue in '27. Is that enough of a risk pool shift to offset the catch-up of prior rates? Or is it clear from this point that probably '26 is where you think the low point will be?

Sarah London: Yes. Thanks, Kevin. It's a fair question. And as we look out over the next couple of years, our goal continues to be to drive back to more normalized Medicaid margins. As Drew walked through and I referenced, I think we've got a lot of momentum as we think about stepping into 2026 and

our view of flat profitability, again, is sort of a prudent posture. As I said, I will be disappointed if we don't do better than that because I think that the enterprise is really organized around pulling the levers that we are in control of and those that we can influence. 2027 and 2028, to your point, is where we will start to see, I think, the real introduction of impacts of [OB3] and what that means for work requirements within the expansion population there is a lot, as I mentioned, a lot still there to play out, including how much of that programmatic change actually takes root and how it manifests state by state. And so the way that we're approaching that is really leveraging lessons learned from the redeterminations process, leaning into state conversations. We've got a formal team that has already been organized around this over the last 6 months and starting to plan, again, at the enterprise level, coordinating with each one of our boots on the ground health plan teams to understand how the states are thinking about this, where we can step in and leverage the data that we have as an MCO and the expertise to help make sure that every member who is eligible and who is contributing to their community and who is working has access coverage. So we feel like we are preparing very well for that. We also feel like we have the precedent now of states incorporating more recent data and also understanding that as there are seminal program shifts, they need to make different decisions in terms of how the risk pools are going to shift prospectively. And so bringing forward a very concrete view of the expansion population, the specific rate that they're getting, what we think the shift is going to be so the states think about the '27 rate setting process as early as 2026, back half of '26 that we're having those conversations as well. So we obviously can't guarantee that states are going to perfectly nail the rate relative to what that shift will be. And so we're thinking about how that will play through in '27 and '28, but doing everything we can to set up the organization to continue to drive consistent margin improvement over the next couple of years to get to a place where we're back at long-term margins in Medicaid.

Operator: Our next question today comes from George Hill at Deutsche Bank.

George Hill: I guess this is more for Drew. I guess, Drew, can you talk about any of the assumptions that underpin the margin stability for Medicaid in '26? In particular, does that include the Florida retro and what's changed in New York. And I'd be interested if you'd be able to talk about the contribution of benefit cuts or benefit design changes you called out the high-cost drug carve-outs as it relates to margin stability in '26.

Andrew Asher: Yes, George, thanks for the question. So if you think about -- you asked about the retro, that's actually not retro to a prior year. It's just retro. The Florida retro was retro to Q1 and Q2. So when you look at the full year, once again, around 93.7%, you guys could do the math, some I will tell you, 93.7% is sort of what we're forecasting for 2025 and stability, the goal of stability in that. And I agree with Sarah, like that's our initial goal, but we'd be disappointed if we don't move that down a little. But 93.7%, some of the things I covered with Ann, including the levers that we're pulling, you mentioned high-cost drugs. And so yes, those would get -- in one case, in one large state, they're going to do a carve-out. In another state, there's a kick pool, kick payment pool for those payers that have those encounters. And there's other examples of well-run reinsurance pools that other states are considering because of the lumpiness of some of those high-cost drugs. So that's just -- that's one example of sort of the hand-to-hand combat we have to go through in terms of managing care and creating affordability for our state partners and our members. So I won't repeat everything I went over with Ann, but those were some of the levers we thought about when we contemplate being able to have stability as we go into 2026.

Operator: Our next question for today comes from Erin Wright at Morgan Stanley.

Erin Wilson Wright: So you're still very committed to the business. And I know last week, I think, Sarah, you were at an industry conference talking about ICHRA still being a compelling area. But how do you just think about some of the longer-term dynamics across the exchange business, the longer-term margin targets and growth profile of that business? I guess a lot is dependent on the regulatory changes, right? But just given your level of commitment, how confident are you in some of those targets? And then -- and just what would potentially make you change your commitment to that as well?

Sarah London: Yes. Thanks, Erin. So we haven't changed our commitment, obviously, to this product and not -- we haven't really changed our view of what philosophically we should be able to price for long term. And as we said, the work that we did for 2026 was really designed with the intention to make

a meaningful step forward in margin recovery in 2026. But I think to your point, sort of longer-term stability, you're absolutely right. First of all, a fair amount depends, although not ultimately, but some short term certainly depends on what plays out relative to policy changes. eAPTCs, I think, is probably the biggest swing factor just in terms of getting to a really, really stable base so that we can think about building on the platform. There are still millions and millions of Americans even if eAPTCs go away that rely on the individual marketplace for coverage that have the backstop of the eAPTCs. And so we believe that this product stabilizes, we still think there is growth or millions of Americans who are still uninsured. And actually, I think the way that this administration is thinking about, at least in conversations, the possibility of getting creative about different product design and different ways to drive affordability in this market is really encouraging. We obviously think that the individual market is a compelling chassis as we consider the future of insurance and a view that individuals are going to want more agency. They're going to want more affordability. And as I mentioned last week in the conference, it's really hard to take a small number of benefit options across for Centene's 60,000 employees and feel like you're really customizing to each individual's needs. I use the example of the fact that I'm a 45-year-old healthy woman, and I didn't go to the doctor until last Saturday. And so I am definitely paying more for health insurance at Centene than I need. And so we continue to be excited and lean into ICHRA. We're hopeful that this administration is also very interested in ICHRA because it is -- a lot of the legislation is a legacy of Trump's first term, and we have leaders in the administration who have spent careers thinking about how this could be a way to sort of reinvent individual coverage. So we are going through a policy transition on the base, and we feel very confident that we will get through that. We're thinking about ways to drive additional transparency and stability in the core business. And so how can we partner with CMS, how can we partner with the DOIs, how can we partner with our peer set and actually do a better job of sharing data as we step through each year so that the risk adjustment conversation itself is sort of incrementally derisked. But we're not backing off sort of the view that we can design benefits that drive value and price for that value on the exchange and that this is a platform for future individual growth that I think we are investing in and positioned well to help capture.

Operator: Our next question today comes from Stephen Baxter at Wells Fargo.

Stephen Baxter: I just wanted to ask about the kind of the rate mechanics in Florida. It's obviously good to hear that CMS, the population there, Florida saw reason on the rates. But just in terms of the cadence, it looks like in the third quarter, obviously, you got trued up on your performance there. So if we're thinking about the Florida rate update, does Florida actually improve sequentially in the fourth quarter now, which is normally what you would expect when you see those rate updates come in? Or should we think about the Q3 performance effectively showing that you've got the rate year-to-date rather than getting it in Q4? Hopefully, that makes sense.

Andrew Asher: Yes. No, good question on the progression. And so the way I'd probably look at it is we put up a 93.4% in the quarter. And the $150 million, if you sort of take that out and you want to sort of judge the progression into Q4, that's 60 bps, the full $150 million, of which [40] of that related to prior periods. So you're jumping off a 94.0%. And then, yes, you can evaluate, call it, mid-5s in terms of the 9/1, 10/1 cohort and Florida was slightly above that in terms of the mix between CMS, MMA and the long-term care population. And so yes, we expect a sequential lift going from Q3 to Q4 given the cohort of 9/1 and 10/1 rates, and that will be a contributor to the improvement that we expect in Q4. And then obviously, we have trend as well as a pretty soft November in terms of the day count. If you look at November, it looks more like a February in terms of the number of business days and the holidays. So that all goes in the formula of how we can get -- how we expect to get to around 93% for Q4, which then when you add to all the other numbers you know would get us to the 93.7% for the full year that we would jump off of and seek to maintain for 2026.

Operator: And our final question today comes from Lance Wilkes of Bernstein.

Lance Wilkes: Great. Yes. Could you give some maybe additional color on the resetting environment at the states? And what I was interested in is what sort of variability are you seeing across states in rates? And then as you're looking at the budget outlook for fiscal '26, '27, how is that budget, the '25, '26 fiscal year and then the '26, '27 kind of conversations that you're seeing impacting the potential for future rate increases? And as a result of these things, are you seeing any smaller competitors that are looking to either exit contracts or not rebidding in any of the states you participate in?

Sarah London: Yes. Thanks, Lance. So every state is a little bit different. So there's certainly variability in the actual absolute rates. But I would say that what we have seen consistent across the states and consistently now for more than 18 months is very constructive collaborative dialogue around rates. The integration of more recent data. We've obviously now got for the 1/1 rates, the benefit of a full 12 months with sort of the step-up in trend drivers that we're seeing and then 18 months with the acuity impacts from redeterminations. And again, I think this increased sort of cadence and reflex around leveraging more recent data, both at sort of a baseline period, but also being able to better anticipate what inflation may be prospectively into the future period. Obviously, Florida is a great example of that because they had to use '25 rates to make the '25 adjustment. But again, that has become sort of normal course, and it's how we think about what we expect to see in the 1/1 cohort and going forward. The budget outlook for the states, there are obviously concerns that with the changes in legislation, there will start to be budget impacts in '26 as states need to balance their budgets and go through those legislative sessions. one of the things that I would point to, and we've said this before, but I think this is really a moment where we will start potentially to see this play out because we're seeing it play out from a program design standpoint is this is a moment where we -- our partnership with the states can really drive value. And they're coming to us and saying, we've got a balanced budget. We've got tighter sort of guardrails, how can we think about continuing to deliver the core benefits that we want to and continuing to drive health outcomes, but make adjustments where we can to optimize the program. And Drew and I have both given a bunch of examples of that. But we think there are -- there's definitely runway on that front. But then also states thinking about carving in fee-for-service populations where if you have a state that has ABA and a fee-for-service disposition over the last 12 months, they are struggling right now. And so there's opportunity as they go through upcoming procurement cycles to think about aligning some of those fee-for-service populations into kind of the core procurement. We started to see some opportunity for net new program adds in the RFP pipeline in '26. And so yes, we do expect there will be budget pressures. But in our world, that's actually an opportunity to help them think about managing care and therefore, managing taxpayer dollars. And that's really kind of the business that we're in.

Operator: Thank you. This concludes our question-and-answer session. I'd like to turn the conference back over to Sarah London for closing remarks.

Sarah London: Thanks, Rocco. Thanks, everyone, for the questions and for your time and interest in Centene this morning. 2025 has definitely been a challenging year, but I firmly believe that the Centene is stronger for it. And I just want to take a moment to thank my teammates for being unwavering in your focus on and commitment to our mission. We look forward to continuing to provide updates on these key inputs and milestones and then obviously provide formal guidance for 2026 on our Q4 call. Thanks, everybody.

Operator: Thank you. This concludes today's conference call. We thank you all for attending today's presentation. You may now disconnect your lines, and have a wonderful day.