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PRESENTATION

Operator

Hello, everybody, and welcome to the agilon health first-quarter 2025 earnings conference call. My name is Elliot, and I'll be your coordinator today. (Operator Instructions)

I'd now like to hand over to Evan Smith, Senior Vice President, Investor Relations. Please go ahead.

Evan Smith - *agilon health inc - Senior Vice President, Investor Relations*

Thank you, operator. Good afternoon, and welcome to the call. With me is our CEO, Steve Sell and our CFO, Jeffrey Schwaneke. Following our prepared remarks, we will conduct a Q&A session. Before we begin, I'd like to remind you that our remarks and responses to questions may include forward-looking statements.

Actual results may differ materially from those stated or implied by forward-looking statements due to risks and uncertainties associated with our business. These risks and uncertainties are discussed in our SEC filings. Please note that we assume no obligation to update any forward-looking statements. Additionally, certain financial measures we will discuss in this call are non-GAAP financial measures. We believe that providing these

measures helps investors gain a better and more complete understanding of our financial results and is consistent with how management views our financial results.

A reconciliation of these non-GAAP financial measures to the most comparable GAAP measures is available in the earnings press release and Form 8-K filed with the SEC. And with that, let me turn the call over to Steve. Steve?

Steven Sell - *agilon health inc - President, Chief Executive Officer, Director*

Thanks, Evan. Good afternoon, and thank you for joining us. We are pleased with our first quarter results, demonstrating both the resilience and growth potential of our business model. For the quarter, we reported membership, revenue, medical margin, and adjusted EBITDA in line with our Q1 guidance range, and we remain on track to deliver in line with our full-year 2025 guidance. These collective results reflect the benefit of our previously disclosed partnership and payer exits, continued execution on quality and clinical initiatives, and better payer contracting terms to reduce Medicare Part D exposure and improve percentage of premium rates.

As expected, these results were tempered by a continued elevated cost trend in the quarter. In terms of membership, I want to underscore that our Q1 membership of 491,000 is relatively flat year-over-year, and these are essentially the same members we had on the platform in '24, net of partnership and payer plan exits and irrespective of plan changes. To remind you, given underlying market dynamics, we have taken a prudent and more cautious stance to 2025 member growth with essentially no underwriting risk on a reduced class of '25 and measured same geography growth of approximately 3%.

As with prior years, we do expect some retroactive membership assignments in Q2 as we finalize contracting and attribution with payers. With these actions, essentially all of our Q1 membership, where we take financial risk, sits in year two-plus markets with a consistent and long-standing PCP patient relationship rooted in prevention, early detection, and active intervention.

While delivering results in line with expectations, we continue to make significant progress this quarter in strengthening our network and enhancing our platform through advancements in technology, clinical pathways and operating efficiency. Our partnerships with leading physician groups continue to drive value for all stakeholders while enhancing our competitive position in a Medicare Advantage and Medicare fee-for-service market that continues to migrate towards full-risk value-driven models.

As the year progresses, we expect to continue our disciplined approach to performance through reduced exposure to costs outside of our control, measured growth aligned with current market dynamics, strengthened clinical and operational capabilities to enhance quality and reduce variability, and maintained operating cost discipline. We expect these initiatives will build a stronger foundation to drive additional operating leverage and long-term performance. Looking to 2026, we are pleased to see an increase of 280 basis points in the final rate notice from CMS, which begins to meaningfully address the high cost and utilization trends experienced in recent years.

We have been encouraged by supportive comments from administration officials on the topics of value-based care and addressing the burden of chronic disease. As you will recall, early identification, diagnosis, and evidence-based treatment of chronic disease is a strong focus of our model. As we look toward the remainder of 2025, we expect to see clear signals from Congress and the administration on broader elements of Medicare policy, including Medicare Advantage.

For ACO REACH, we are encouraged that CMMI maintained the model despite efforts to narrow its portfolio. Their commentary that all remaining models are expected to produce savings and/or quality improvement aligns with our experience in the REACH program, and we continue advocating for a full risk pathway beyond 2026. We expect to learn more on this topic as we progress through the year.

Now let me provide you with our current viewpoint on underlying market trends and an update on the initiatives we are actively pursuing to reduce variability and drive improved performance. Jeff will then provide additional color on our first quarter financial results and our outlook for the second quarter. From a utilization perspective, overall market trends in 2025 remain consistent with the prior year and in line with our initial outlook of a 5.3% full-year trend. Inpatient medical admissions were up in part driven by the flu, primary care utilization, and annual wellness visit volume was flat, and overall medical cost trend was within our expected range.

In terms of growth trends, the Medicare Advantage market continues to expand, with CMS data showing trends of 3.9% year-over-year and 1.9% year-to-date. In addition, demand from payers and PCPs for full-risk value-based care partners that can deliver on quality and cost metrics is also expanding. Against this backdrop, we see growth as a controllable lever given our consistent ability to demonstrate utilization performance 20% to 30% better than the local fee-for-service benchmark and quality scores approaching or greater than 4.25 stars.

As such, our focus remains on profitable growth in current markets and new geographies. As I have stated in the past, our ability to weather this down cycle in MA and differentiate on medical cost and quality outcomes should position us well with health plans and physicians as the macro rate and cost spread ultimately corrects.

As a starting point, the recent favorable trends in payer bids and the 2026 final notice from CMS make us optimistic we will see a more favorable overall environment in '26 and beyond. As I outlined in our last call, we believe we have made significant progress in reducing operating variability and exposure in areas like Part D. In addition, we have negotiated improved economic terms with payers while improving our efficiency through market exits, cost discipline and advancements in technology, but there is more work to be done, and we are actively pursuing additional opportunities to strengthen performance through contracting, cost optimization and cash management.

With approximately 50% of our membership up for renewal on January 1, 2026, payer negotiations this year present a further opportunity to improve economic terms and predictability of performance. We have several focus areas, including: one, a further reduction in Part D exposure; two, an expansion of quality incentives; three, improved economic terms for Part C; and four, a continued narrowing of risk from supplemental benefits through better information and more rational payer bidding.

We expect the first three areas will have the greatest impact on our business moving forward. With respect to the fourth area, it is important to frame that our historical supplemental benefit headwind over the past two years was materially less than Part D and is anticipated to have an even lower impact in 2025 as recent payer benefit design changes reduced exposure across approximately 97% of our membership.

In addition, given our financial data pipeline is running across a majority of our payer partners as of Q1, we now have greater visibility into detailed revenue and claims information, including Part D. As renewal discussions are ongoing with payers, we will provide more detail on our progress as we move through the year. We see our investment in technology driving a key competitive advantage going forward via improved automation and efficiency, and ultimately better quality and clinical outcomes.

Our enhanced data and AI capabilities will enable us to improve our execution and day-to-day operating visibility. As an example, in 2023, we acquired mphrX, enhancing our ability to gather and process data and drive insights across health care delivery networks. Since then, we've improved integration with health information exchanges, labs, EMRs and payers to speed up onboarding of agilon partners and integrate clinical data quickly, benefiting patients and physicians.

Using AI and advanced technology, we ensure accurate identification and documentation of patients' health conditions, aiming for high-quality, cost-effective senior care. We believe our documentation practices strengthen clinical accuracy and support our value-based care model, ensuring timely care for patients.

For high-risk and chronically ill patients, we provide specialized programs for proactive coordinated care to improve health outcomes and reduce hospitalizations. Our investment in technology also allows improved efficiency, faster insights and real-time feedback for continuous improvement. Performance visibility across markets, payers and EMRs let us spot patterns and highlight best practices nationwide to facilitate PCP learning.

Technology is vital in our clinical pathways program, helping connect opportunities across our burden of illness, quality and care delivery programs to identify and manage chronic diseases like heart failure. These capabilities enable early primary care physician intervention to prevent disease progression, alleviate symptoms and avoid unnecessary ER visits and hospital stays.

Our recently launched heart failure program is a good example with two very pragmatic quality opportunities: one, to identify and diagnose the disease earlier via the primary care doctor versus later during an acute event in the ER or hospital; and two, to support our PCPs in initiating guideline-directed therapies to slow disease progression, extend survival and reduce acute exacerbations.

Many of our partnerships are in the early stages of implementing the heart failure pathway, and we look forward to reporting updates on our progress and clinical outcomes later in the year or early in 2026. With respect to our PalliUM program, we are now live across most of our markets. This program relies on the trust between a senior patient and their primary care doctor and offers significant quality of life benefits to patients and family members. For patients electing to enroll in the program, we have seen a significant reduction in hospital admissions per 1,000.

And in the first quarter, we saw a material increase in patients choosing to receive advanced illness management via our program. Given the positive clinical and business impacts to date, we're focused on additional expansion across partnerships and geographies in 2025, which we expect will create additional value in 2026. Finally, we continue to maintain cost discipline while investing in technology and clinical programs to further support medical margin and patient outcome improvements as well as strengthen our position with payers and PCPs.

In closing, we see 2025 as both a transition year financially and an inflection year in terms of quality and clinical programs, payer underwriting and cost discipline, which we expect will create a stronger foundation for growth and financial performance. As we look to 2026, we are encouraged by the recent final notice and positive comments from administration officials in support of value-based care models. As the macro shows some promising signs, our investments in technology and clinical programs are starting to bear fruit, giving us confidence in our ability to accelerate performance and speed to value for our stakeholders.

With that, let me turn the call over to Jeff.

Jeffrey Schwaneke - *agilon health inc - Chief Financial Officer*

Thanks, Steve, and good afternoon. For today's discussion, I will cover three key areas.

First, I will walk through our financial performance for the first quarter. Second, I'll provide an update on cost trends and the steps we are taking to manage risk and improve medical margin. And finally, I'll discuss our Q2 outlook and full year 2025 guidance, including our expectations for membership, revenue and adjusted EBITDA.

Starting with membership. Medicare Advantage membership at the end of Q1 2025 was 491,000 members compared to 523,000 members in Q1 2024. As we discussed last quarter, our decision to take a measured approach to membership growth has resulted in a slight year-over-year decline driven by previously disclosed partner exits in a smaller 2025 class. We continue to expect our overall same geography growth rate to be in line with the broader industry for 2025. Additionally, our first quarter membership came in at the low end of our guidance range due to the timing of contract signings for the 2025 class.

As a reminder, the 2025 class contracts are on a glide path approach and as such, are not driving a meaningful variance in our financial results. Our ACO REACH membership for Q1 was 114,000 members compared to 131,000 members in Q1 2024. This decrease primarily reflects the strategic decision to exit an underperforming MSSP partnership as we've previously discussed.

Turning to revenue. Total revenue for Q1 2025 was \$1.53 billion compared to \$1.6 billion in Q1 2024. The primary drivers of year-over-year revenue decrease include the market and partnership exits we have previously discussed, partially offset by the 2025 class and premium growth. Additionally, during the first quarter of 2025, we recognized \$10 million of revenue and \$10 million of medical expense associated with retroactively assigned members from 2024.

Medical margin for Q1 2025 was \$128 million compared to \$157 million in Q1 2024. Medical costs for the first quarter of 2025 were in line with expectations and driven by continued elevated utilization, incremental flu-related costs and negative prior period development. As Steve mentioned, during the first quarter, our AWW and PCP visits were in line with expectations and medical costs continue to be driven by inpatient cases and Part B drug spend.

The first quarter 2025 results included negative prior period development of \$22 million, of which \$7 million was associated with exited markets. The remaining development was tied specifically to one payer, including \$10 million from 2023 dates of service and additional claims in the third quarter of 2024. I want to highlight that we went live on our new financial data pipeline in the first quarter that covers a significant number of our

membership. We now have greater visibility and detail for both revenue and claims as we move forward, which we expect to enhance our forecasting capabilities.

Our margin performance reflects disciplined cost management, improvements in payer terms and ongoing investments in clinical initiatives. While medical cost trends remained elevated, we are beginning to see the impact of our strategic actions to partially mitigate these pressures. Adjusted EBITDA for the quarter was \$21 million compared to \$29 million in Q1 2024. The year-over-year movement reflects continued elevated cost trends, offset by lower geography entry costs and operating cost initiatives.

Geography entry costs were lower in the first quarter of 2025, reflecting the timing of capital funding needs related to new market entries for 2026. Adjusted EBITDA related to ACO REACH was \$20 million in the first quarter of 2025. Managing medical cost trends remains a top priority.

For Q1 2025, our year two plus markets medical cost trend was 5.5% compared to 6.7% in Q1 2024. As a reminder, we expect cost trends in 2025 to run approximately 150 basis points lower than 2024 due to the effect of payer bidding and the two-midnight rule. For the first quarter of 2025, we continue to take a conservative approach in our assumptions given ongoing utilization pressures in areas such as inpatient services and Part B drugs in combination with the negative prior period development. A component of the negative prior period development was associated with the third quarter of 2024, which has an updated cost trend of 9.6% year-over-year.

As part of our strategy to manage risk, we have successfully reduced our exposure to Medicare Part D, with less than 30% of our membership carrying Part D risk in 2025. Additionally, we are working closely with our payer partners to refine benefit designs and improve alignment on medical cost management. Now I would like to provide a few highlights for our Q2 and full year 2025 guidance. Looking ahead, we remain focused on disciplined execution and financial improvement. For Q2, we expect Medicare Advantage membership in the range of 485,000 to 515,000, with ACO model membership projected to be between 105,000 to 115,000.

For the full year, our guidance for Medicare Advantage members remains unchanged at 490,000 to 520,000. For the second quarter, revenues are expected to be between \$1.44 billion to \$1.51 billion, while full-year 2025 revenue is expected to be in the range of \$5.85 billion to \$6.03 billion, reflecting the impact of membership shifts and improved revenue yield from payer contracts. The bottom end of our full-year guidance range has been increased to reflect the retroactive membership assignment and corresponding revenue recognized in the first quarter.

For the second quarter, medical margin is expected to be between \$50 million and \$70 million and full year medical margins are projected to be between \$275 million to \$325 million, driven by targeted initiatives in our BOI program, clinical initiatives, and operating performance. As a reminder, the class of 2025 will have a lower revenue and margin PMPM due to our measured glide path approach mentioned last quarter. Second quarter 2025 adjusted EBITDA is expected to be between negative \$35 million to negative \$20 million.

Our full year 2025 adjusted EBITDA guidance range remains unchanged at negative \$95 million to negative \$55 million, consistent with our plan to achieve financial stability while investing in long-term growth. On the balance sheet, we ended the quarter with \$369 million in cash and marketable securities and another \$25 million of off-balance sheet cash held by our ACO entities. We expect to use approximately \$110 million of cash in 2025, and we continue to maintain a disciplined approach to capital allocation, ensuring we have the resources needed to support our business objectives while progressing toward our goal of cash flow breakeven in 2027.

In summary, while we continue to operate in a challenging environment, the actions we are taking to refine our strategy, improve operational execution and financial visibility, and strengthen our financial position are evident in our first quarter performance. We remain confident in our ability to navigate the near-term headwinds and to position agilon for long-term success.

With that, operator, let's move to the Q&A portion of the call.

QUESTIONS AND ANSWERS

Operator

(Operator Instructions)

Stephen Baxter, Wells Fargo.

Stephen Baxter - Wells Fargo Securities, LLC - Analyst

I guess maybe starting with a bigger picture one. Obviously, there's been a lot of focus on the impact of the V28 risk model transition on value-based care companies for this quarter, in particular, and whether there's anything about the transition that's proving potentially more difficult than might have been expected for various reasons. So I think it'd probably be helpful if you could just give us a quick update, I guess, on the company's thinking around V28, the impact specifically on 2025, and whether there's anything different to consider relative to the impact you faced in 2024?

And then whether there's anything to think about from here in terms of expectations for the pacing of the remainder of the V28 phase-in.

Steven Sell - agilon health inc - President, Chief Executive Officer, Director

Sure, Stephen. Thanks for the question. I think the headline is that from a risk adjustment perspective in '25, we're in line with our expectations, 2% net increase year-over-year, inclusive of about a 3% headwind from V28. I think a couple of things to consider as you think about our model is, one, the continuity that our primary care physicians have with their patients.

Our patients have been with their PCPs on average for 10-plus years. Each year, they're doing annual wellness visit assessments with them. And so we were able to really do that work in 2024, that's reflected in what we're expecting for '25 paid.

The second is that, as I called out in my prepared remarks, our membership in '25 is essentially the membership we had in '24. It's really part of our disciplined growth. It obviously is net of those payer and partnership exits that we've talked about previously. And so I think the takeaway overall it's in line with our expectation. We did the work last year to really reflect that. It's early, but we're encouraged by what we're seeing.

Jeff, anything you'd add to that?

Jeffrey Schwaneke - agilon health inc - Chief Financial Officer

No. That is good.

Operator

Elizabeth Anderson, Evercore ISI.

Elizabeth Anderson - Evercore ISI - Analyst

I was wondering if you could talk a little bit more about anything in terms of contribution from previously exited areas or other sort of lingering impacts that you're sort of at least aware of now or sort of expecting for the rest of the year, just to sort of help us clean out the like current run rate performance of the business versus some of those legacy issues that you've dealt with.

Jeffrey Schwaneke - *agilon health inc - Chief Financial Officer*

Yes. This is Jeff. I mean, certainly, the \$7 million that we called out for unfavorable development for the exited markets would be something that kind of stays in 2024 and doesn't have an impact on 2025. Obviously, we still have some IBNR left for those days of service. But to this point, it's pretty minimal. So that would be the only thing that I think I would highlight. Steve, anything else?

Steven Sell - *agilon health inc - President, Chief Executive Officer, Director*

Yes. I think just Elizabeth, we talked about the step-up last year from exiting those markets, which was reflected in our bridge that we shared with you on a previous call. But outside of that, no, I don't have anything else.

Operator

Jailendra Singh, Truist Securities.

Jailendra Singh - *Truist Securities - Analyst*

So, following up on your comments on 2026 MA final rate notice, which came in better than advanced notice. Can you help us understand how we should think about this flowing through agilon? You guys have previously talked about 40% membership being repriced for Jan 1, '25. Do those contracts get any sort of guaranteed flow-through from CMS rate update? Or are they completely dependent on how payers approach their bidding process?

And related to that, at what point will you have clarity on your rates for 2026?

Steven Sell - *agilon health inc - President, Chief Executive Officer, Director*

Yes. Thanks for the question, Jailendra. So you are correct. We repriced 40% of our membership for January 1 of '25. Those are percentage of premium increases.

So if you talk about an average 9% increase across the network or nationally, that would flow through on that baseline that you're going to take a percentage of premium on. So that, we will get the benefit of that. Obviously, there's the impact from risk adjustment in Stars quality on that. As it relates to the '26 renewals, as I called out in my prepared remarks, we've got 50% of our membership up for renewal. So between the 2 years, you're talking about the vast majority of membership being repriced.

We are just starting through that progress right now. There's a set of priorities that we've got against that. The first is reducing Part D exposure. We talked to you for '25, getting that below 30%. While it's early, we already have one small regional payer for '26 that is going to carve that out.

So, further progress on Part D. Additional quality incentives is a key focus for us. That's half of our programs or initiatives that are loaded in our plan for this year. We see an opportunity to increase that because we're consistently above that or a 4.25-star performance perspective. So those are really big ones.

Further economic terms that we've got on that. And then supplemental benefits is kind of fourth in our list. We've got a lot of work going on with payers in terms of improving our information around that and reducing our risk overall through their payer bidding. But those are the areas that we'll work through. That will run our normal cycle.

So we'll be updating you on future calls in terms of our overall progress.

Operator

Justin Lake, Wolfe Research.

Justin Lake - Wolfe Research - Analyst

I wanted to follow up on the questions around risk scores. Two things. One, you mentioned previously you're talking about pricing up 2%. I want to make sure, is that on a same patient basis? It just seems like given V28 plus some pretty mediocre rate increases, I think a lot of people think of them in the 1% range, give or take, for 2025.

That number stands out as being pretty strong. So I just want to make sure it's same member. And then secondly, one of your peers mentioned seeing a bunch of new patients bouncing around because of all the disruption talked about a bunch of the new members that they got being uncoated versus 2024. Just curious if you saw any of that.

Steven Sell - agilon health inc - President, Chief Executive Officer, Director

Yes, Justin, thanks for both of those questions. So in terms of year-over-year improvement from a risk adjustment perspective, that is on a same member basis, members that we had last year that get -- that are continued this year that the net 2% increase is the effect of that. It's 5% gross, it's 2% net from a risk adjustment perspective on that. I think I'd just remind you that we've gone into markets that historically have been heavy fee-for-service. We start from a lower risk score.

And so the ability to get a larger lift over year-over-year is sort of part of our approach and what we expect to see in the early years in these markets. And if you remember, 50% or nearly 50% of our membership sits in the class of '23 and '24. So we're very early in that cycle. On your second question in terms of disruption and a lot of movement, there was more movement between payers in '25 in some of our markets than we have seen in past years, but not necessarily everywhere. But as I sort of shared in response to Stephen's question, I think the distinction here is the primary care physician stays with that patient all along.

If you move from health plan A to health plan B, it doesn't change anything in the total care model. And so the prevention, the early detection, the assessments that went on in '24, well, they were with health plan A, that gets reflected as they carry into '25. And so that's just a function of the model that we've built around. Then there's the choices that we've made on disciplined growth. And so our membership is essentially flat year-over-year.

And those members that we had in '24, we've got in '25. The members that we did add in the class of '25, as Jeff called out, it's 20,000 in total as we get them on the platform, smallest class we've had in a while. There's no underwriting risk on those members because they're care coordination, no downside contracts for 2025. So that's, I think, some of the distinctions and what we're seeing year-over-year.

Operator

Amir Farahani, Bernstein.

Amir Farahani - Bernstein - Analyst

I was thinking if you can talk a little bit about your expectations for the '26 bid cycle in terms of pricing benefits and potential impact on your business. And a quick follow-up, if I may, about your EBITDA guide. I believe it incorporates a \$50 million lift from operating initiatives and clinical expense management we call that. I guess it would be great to get some update how that's tracking and how much of that do you estimate you achieved in Q1?

Steven Sell - *agilon health inc - President, Chief Executive Officer, Director*

Yes. Thanks, Amir. Good question. So I think as we said in our prepared remarks, we're optimistic about '26. We're obviously encouraged by the final rate notice.

We're encouraged by the bids that payers submitted for '25. And I think our commentary or our discussions with them and their public commentary reinforces that they're going to be pretty measured as they go into '26. But we're right in that cycle right now, and they would be putting sort of the finishing touches on those bids here in the next couple of weeks. So we can update more as we get to the next call. Your second question was \$50 million in our operating initiatives.

It's \$25 million in terms of those quality incentives, and it's \$25 million in terms of clinical cost-saving initiatives. Let me take the second one first. The biggest part of the clinical initiatives is our palliative program. I highlighted that in my prepared remarks. We saw an acceleration in enrollment in Q1.

Most of the savings this year is going to come from people who were enrolled last year and were enrolled in Q1 just because of the nature of the cycle and what happens across the last 12 months of end of life. And so that's sort of where we're at. We're tracking well on that. And then the second piece is in-year incentives around quality scores, delivering depending upon the payer 4 or 4.25 and even some upside if you get to 4.5%. And we are tracking well on that.

We -- our docs do an excellent job in terms of managing quality, in terms of closing their care gaps. The technology that I talked about is very focused on getting them the information around that. And so while it's early in the year, we feel like we're off to a good start and tracking well across both our quality initiatives and our clinical initiatives.

Operator

Lisa Gill, JPMorgan.

Lisa Gill - *JPMorgan - Analyst*

Just want to follow up, Steve, on the comments that were made around the medical cost trends, obviously coming in higher than expected in this quarter. And I think you called out inpatient as well as Part B. Can you maybe just talk about a couple of things? One, the level of visibility you currently have for completed claims? And then secondly, how are these trends progressing as you were exiting the quarter?

And then just lastly, I know Part D, you said is less than 30% of your book. But with the changes to Part D, I'm curious if you're seeing an increase in utilization there with the maximum out-of-pocket cost shifting pretty materially.

Steven Sell - *agilon health inc - President, Chief Executive Officer, Director*

Sure. There's a lot in that question, Lisa. So let's see. So medical cost trends in the quarter, maybe just to reset, were in line with our expectations. Our expectations were that they were going to be at elevated levels, and they came in at that level.

So we had guided and forecasted at plus 5%, as Jeff called out, and they came in at that level within the quarter. In terms of visibility, we've worked really hard over the past few calls, we've updated you on our financial pipeline. We brought that live this quarter. That is a big milestone for us. It gives us detailed member level revenue and claims data that really allows us to better understand the total revenue and cost profile of those members.

And so that's encouraging as a step further to go, but a big milestone for us. You asked about the quarterly progression, I think. I think exiting the quarter, so the census data, well, two areas that drove the elevated levels of utilization in line with our expectation was inpatient and Part B as in

boy. Inpatient, our census data says January and February were higher, came down in March as we move through the quarter. And so that's sort of tracking in line overall.

Flu, as I said in my prepared remarks, had an impact on those inpatient admissions. And then finally, in terms of Part D, I think we're down to 30%. I called out we've got another payer that's going to carve it out for '26, smaller regional payers, so not a huge impact in terms of our overall total, but a good trend line for us. And Jeff, you can talk a little bit about utilization there.

Jeffrey Schwaneke - *agilon health inc - Chief Financial Officer*

Yes. As far as Part D is concerned, just a reminder that we record that net in our financial statements in the revenue line. And so -- and then given the magnitude, as Steve mentioned, below 30%, it's really not having a significant, I would say, driver as far as the shifting in the utilization pattern on our financial statements.

Operator

Ryan Langston, TD Securities.

Ryan Langston - *TD Cowen - Analyst*

Maybe on Part D, I guess just bigger picture, if you're unable to kind of carve out maybe the rest of that past the regional payer that you mentioned, I mean, Steve, I know you said 50% of your membership is up for renewal. I guess is there a potential we could see sort of more material membership reduction into '26 if you just can't see sort of a longer-term acceptable margin profile?

And just real quick, can you remind us what your membership proportion is from group MA? I know in the past, you referenced it, but having a little trouble finding a recent reference to that.

Steven Sell - *agilon health inc - President, Chief Executive Officer, Director*

Yes. Thanks, Ryan. Two good questions. I think Part B, one, we continue to make progress. Reducing that remaining 30% is at the top of our list, and we're off to a good start, as I called out.

If you're not able to carve it out, you can corridor it. You also can be reflected in increased percentage of premium. Basically, you can pay for it more. And so I think as we go through these renewals on 50% of the membership, there's a lot of ways to get there. But I don't think that element would necessarily lead to a reduction in membership for 2026.

I think we're going to be disciplined and measured on our growth. Market growth sort of as our target this year, and we'll see as we go to next year and what things look like overall. But I don't think that would necessarily drive a reduction in membership. Your second question was on group. Our group MA penetration is really in line with the overall industry average nationally.

We said about 18%, so like 17%, 18% is industry average. In the markets we serve, we're actually underweight. So those markets have a little bit higher percentage in terms of group, but we come in at 18%. So we're about 3% under the market average there. Our trends -- you didn't ask this, but our trends in group are in line with what we see in individual.

So not material changes there. And I think maybe a key part of it is sort of what I said in response to Justin and Stephen is we've got the same members on the platform in '25 that we had in '24. That's true for group. That's true for individual. But specifically on group, the trend and the utilization that was experienced in '24, that's in our baseline.

So we're not seeing a big movement in utilization, and they're with the same primary care physician that they had last year.

Operator

Joanna Gajuk, Bank of America.

Joanna Gajuk - *BofA Global Research - Analyst*

So I guess a big picture question, a follow-up, I guess, to the comments on 2026 rate notice, which came in better. So your comments when we had the preliminary rate notice, right, was that you guided to breakeven free cash flow in '27. So now with the final rate notice being better, how much of this additional, call it, 200 basis points or so improvement in the final versus preliminary, how much of that is fair to assume that would kind of fall to that improvement in free cash flow, say?

Steven Sell - *agilon health inc - President, Chief Executive Officer, Director*

Yes. Thanks for the question, Joanna. I mean, as we said, listen, we're encouraged by the final rate notice. I think it starts to catch up on a period of higher utilization that we've seen for a while, but doesn't get us all of the way there. As we think about 2026, we're not giving guidance on that today, but that final notice is clearly a tailwind.

I think our disciplined growth is another tailwind that we see around that. The potential for additional quality incentives and our BOI and our clinical work is material. V28, last year, a full implementation, I mean, that's going to be a headwind. So there's going to be another step up of another 3% or so on that. And then the big question is kind of macro utilization, what happens as you move into 2026.

And so conceptually, if you hold everything constant, the incremental 280 basis points, that should flow through, but that's a big if. So you got to work through those other elements. And as we get better visibility on payer bids, as we progress through the year and see what utilization of other things look like, I think we'll be able to inform that more.

Operator

Ryan Daniels, William Blair.

Ryan Daniels - *William Blair & Company - Analyst*

Maybe another big picture one for you, Steve. As we think about the dynamics of the marketplace, kind of a hangover with higher utilization and some pressures, but then better rates in '26 and kind of a new revenue model where you have less risk and more visibility, both with your data and with the care coordination fees, how are you thinking about the pipeline and partnership growth as we think of '26, '27 and beyond and what the balance there might look like?

Steven Sell - *agilon health inc - President, Chief Executive Officer, Director*

Thanks, Ryan. Great questions. So for '26, I think we're in line with what we said on our last call. We think we're going to be in that 30,000 to 45,000 members. We'll probably weight a little bit more to existing geography or same geography growth within that just because the beta on that is lower.

And we've got the opportunity to sort of increase that if we want to. But most of the focus right now, Ryan, is on '27. And so that class of '27, it's a rich pipeline. As I said in my prepared remarks, the demand from groups that are looking for partners that are experienced in moving them to value, taking on global risk, doing the basics around risk adjustment and utilization clinical programs is highly strong. And so that's reflected.

And I think you could see that across basically all types of groups, primary care only, multi-specialty, health systems, et cetera. And so I think it's pretty robust. We still are being pretty disciplined and measured as we wait to see how this shapes overall. But I think as the macro starts to correct, there's an opportunity to lean into that demand and increase that growth but that would probably be more for '27 than it would be for '26.

Ryan Daniels - *William Blair & Company - Analyst*

And if I could squeeze in one quick financial one for Jeff. I just saw in the footnote, there was a negative \$1.2 million charge for implementing in new geographies. Did you get a payment from a payer or reverse something that caused that?

Jeffrey Schwaneke - *agilon health inc - Chief Financial Officer*

Yes. Yes. It's a true-up of some of our annual wellness visits. So it was a reversal of an accrual. So yes, that happened in the quarter.

Operator

Michael Ha, Baird.

Michael Ha - *Baird - Analyst*

So I understand you expect a more favorable '26 environment, especially with the final rate notice being so strong. And if you were to hold everything constant, things should go well. But with one of your largest payers, Humana facing potentially very material star ratings decline next year. I was wondering if you could speak to how you're thinking about the directional net impact of both factors to agilon. How are you thinking about the benefit of the rate notice netted against this potential decline in both member growth, financial flow-through and the loss of quality bonus and rebates?

And I know in prior years, you've mentioned you've gotten relief through incremental premium and other forms of premium. But just given the sheer magnitude of the decline with Humana Stars, how confident are you in being able to avoid this sort of headwind flow through?

Steven Sell - *agilon health inc - President, Chief Executive Officer, Director*

Yes. Thanks for the question, Michael. I mean I think as we look at '26 and we net everything, we are optimistic. We see this opportunity for improvement coming off this transition year of '25. The final notice is materially better.

As you called out, we have one payer who's got a material step down in terms of their star ratings. This is something that we've gotten used to. We've gone through this with multiple payers. And so there are multiple mechanisms to correct for that. It can be increased percentage of premium.

It can be lump sum. I mean there's just a variety of ways that you can get there. I think what we are seeing more is the value that we provide to these health plans around our quality scores. So the ability for us to deliver at 4.25 or move towards 4.5 could be really material in their overall network score and getting them above that four. And so we like the concept of incentives that reward us for that in addition to some of the offsets or compensations for the step down overall in terms of 5% from Stars.

So I think it's a combination, Michael. I think we have to go through and work that. But what we're hearing today from all of our payers is our strong quality performance is a real differentiator. They'd like us to lean into it more.

We're working closely with them on that last mile and how we make sure that we get quality or credit for all of that. But that's sort of how we think about quality for 2026 and how we would manage that headwind.

Operator

Matthew Shea, Needham.

Matthew Shea - *Needham & Company Inc. - Analyst*

The development of clinical programs seems to be a rising theme that's getting more attention. You called out heart health, I think dementia and COPD are areas of interest as well. Would love to hear how those programs have gone collectively or individually relative to expectations. And then if my understanding is correct, this year is more of an investment year for those newer programs and you expect to reap more of the benefits next year. Do I have that correct?

And if so, how big of a factor are these programs in improving the medical margin in 2026 just versus the broader improvement in the MA environment that you called out?

Steven Sell - *agilon health inc - President, Chief Executive Officer, Director*

Yes. Thanks, Matthew. I mean great question. So you are right. I mean we are very focused on managing these high acuity chronic diseases.

And the majority of our costs come from patients with multiple chronic diseases. So doing this well is critical not just for patient health and quality outcomes, but for having a successful risk business and risk partnership. So we are very focused on that. It is early in the day. In my prepared remarks, I talked about the rollout of heart failure, which is across the majority of our markets in that clinical pathway.

The focus there is around early detection and preventing disease progression across time and preventing people unnecessarily from ending up in the ER or for an inpatient admission. The early returns on that, given the technology investments we've made and the ability to provide that information for that primary care physician in the office is going pretty well. The ability to identify a patient early through a PCP versus later through an acute event in the ER and inpatient is pretty material. Now there's a lag. You identify that early.

There's actually a cost around identifying it early, which is reflected in '25. But the benefit will progress across time as you step into '26 and '27. We're not dimensioning what the magnitude of that lift is. But again, just like we think doing well on quality is a differentiator for us with payers and with CMS, we believe the same thing on managing chronic disease. And so heart failure is up and running.

We'll work on these other conditions, COPD, dementia, et cetera, as we progress, and we'll update you on that. I think it's going to be a little while for us to talk about the results. I did call out palliative. You didn't ask about that, but palliative is one that's been rolling for a while, and you're starting to see the impact. It's the biggest dollar impact in '25, again, because there's a lag between when a patient enrolls and the impact overall.

So that's sort of the progression that we're thinking about. We think we're on the right path, and it should be a nice tailwind for us as we step into '26 to get some improvement from these chronic programs.

Operator

Daniel Grosslight, Citi.

Daniel Grosslight - Citi - Analyst

I was wondering if the better-than-expected funnel rate in '26 is informing or how it's informing your growth for the class of '26. You mentioned 30,000 to 45,000 new member adds. Do you think those folks will be on the glide path like the class of '25? And then as we think about the class of '25 graduating into '26, do you -- are you going to be more receptive to moving those members off of the glide path?

And then lastly, I just wanted to confirm, you still expect to exit 29,000 members at the end of '25?

Steven Sell - agilon health inc - President, Chief Executive Officer, Director

Yes. Good question. So let me start with the last one. Yes, we plan to exit the 29,000 members at the end of the year. For the class of '26, I mean, I guess I'd back up and say the headline is we'd like to get to risk as rapidly as possible, assuming we have appropriate economic terms.

And so the final rate notice is material across all of our markets. As it looks towards the class of '26, it's too early for us to say what that distribution would be, but the final rate notice does obviously improve the economics overall around that. So we can update you on the next call. On the class of '25, similarly, those that are on the no downside care coordination fee this year in this difficult financial transition year, same thing with the rate notice that improved the overall economics as we would look towards '26. We'll update you on that in terms of what that looks like.

Anything on that?

Operator

David Lawson, BTIG.

Jenny Shen - BTIG - Analyst

This is Jenny Shen on for Dave. For the members that you're still taking drug trend risk on, can you speak to some dynamics going on in drug pricing, what your views on drug pricing are? We saw the recent executive order that was signed on April 15. And our thought is that some of those initiatives could be favorable and a tailwind to the industry and agilon. Just any of your thoughts on drug pricing would be helpful.

Steven Sell - agilon health inc - President, Chief Executive Officer, Director

I think our headline overall is that we don't believe that we can materially manage Part D risk because the majority of those prescriptions are not written by our primary care physicians, and we obviously don't have control over formulary or visibility to manufacturer rebates. And that's why we have chosen to reduce that as much as possible. We're below 30%. We've got one payer that has agreed to carve it out for 26 smaller payer, but that would reduce that number. And our goal is to take that ultimately all the way down.

I don't know that we have tremendous insight on the recent policy that you talked about and how that would impact us overall. But our focus is on reducing that risk overall.

Operator

George Hill, Deutsche Bank.

George Hill - Deutsche Bank - Analyst

Two quick on, Steve. Number one, I'd love to hear you talk about your conversations on the provider side. One of your big peers talked about having to convert a sizable piece of business from risk back to fee-for-service. So I'd love to hear you talk about the comments like the appetite of providers and whether or not you feel like that's stable? And do you see any impact of the class of '26 or '27 on the provider side?

And then just as it relates to Part B drug risk, do you guys feel like there's anything you can do to mitigate that or kind of improve outcomes? Or are we talking about disease states like in oncology where the providers are kind of -- they have to deliver the care, they have to deliver in cost -- what it costs. I love comments on those two areas, please.

Steven Sell - agilon health inc - President, Chief Executive Officer, Director

Yes. Thanks, George. Good question. So I think what I said overall in terms of the total addressable market and the interest in physician groups is there is a strong demand to move to value overall. Is there -- given what's happened overall in the market, obviously, a discussion about help me understand what the economics look like in my market, walk me through a pro forma, if I execute in line with your early markets around the basics of burden of illness, quality, clinical programs, yes.

And so it is a more elongated discussion than it has been historically. But the challenge is the alternative of fee-for-service is not getting a whole lot better. And this final rate notice, a very big change. So that has changed the underwriting assumptions that you use within the model, and that's made some of those questions or conversations a whole lot easier.

On Part B as in boy drug, it is -- the biggest driver, Jeff called this out in his script, is around oncology. It is a challenging one to manage. We do have some early initiatives that we're probably not ready to talk about that are focused on that. And it is a big area for us to manage as we go forward.

We kind of look at oncology as a very deep area and an opportunity for our primary care physicians to work more closely with the oncologists in their communities. So more to come on that one, George.

Operator

Whit Mayo, Leerink Partners.

Whit Mayo - Leerink Partners - Analyst

Any color on the negative PYD that you took for 2023 in the quarter? It sounded like it was maybe one payer, but was that something specific around supplemental benefits, OTC Flex or anything? And then if you could just remind us what your estimated completion factor for 2024 is now?

Steven Sell - agilon health inc - President, Chief Executive Officer, Director

Let me start and Jeff can kind of give you the details. So, what we've tried to call out a couple of times is, we've talked a lot about on these calls, the work we've done over the last year to improve our visibility. Our financial data pipeline just went live in Q1. We're using it for the first time with the majority of our payers on that. So that's a big step forward, very detailed member level revenue and cost information that we weren't able to see a year ago.

And that includes the detail on what Jeff will walk you through around this. But that is a very big step forward. I think that addresses the majority of this issue. If we had this a year ago, we would have seen this and been able to identify it. But Jeff, do you want to fill in?

Jeffrey Schwaneke - *agilon health inc - Chief Financial Officer*

Yes. Just to fill in the numbers, right? So we mentioned the \$7 million really from exited markets, total of \$22 million. \$10 million was from '23 in prior days of service. And I think as Steve mentioned, this financial data pipeline on a going-forward basis kind of solves the visibility to that and then really a small amount related to 2024 dates of service.

And we're roughly, I would say, 90% complete on 2024 date of service at this point.

Operator

Andrew Mok, Barclays.

Thomas Walsh - *Barclays - Analyst*

This is Thomas Walsh on for Andrew. Looking at your second quarter guidance, EBITDA seasonality appears a bit lower than prior years. Hoping you could provide any color on discrete items or expectations for 2Q and how you see the trajectory of medical margin and EBITDA across the year?

Jeffrey Schwaneke - *agilon health inc - Chief Financial Officer*

Yes, certainly. This is Jeff. I think one of the hard parts about comparing to prior years is there was a substantial amount of development in the third quarter. As we prepare our budget for the next year, we use an incurred basis. So, we put all that development in the dates of service where it belongs.

And so it's kind of hard to get the quarterly trajectory. I wouldn't call out anything specific other than we're using kind of a restated income statement on an incurred basis to develop our seasonality here, and that's really what we're [targeting of]. So nothing unusual. And I would think you would see a normal progression that you've seen in the past with higher profitability in the earlier quarters and obviously, Q4 generally being the highest amount of medical costs.

Operator

This concludes our Q&A. I'll now hand back to Steve Sell for any final remarks.

Steven Sell - *agilon health inc - President, Chief Executive Officer, Director*

All right. Thanks everyone for a good call. In summary, I think we're pleased with our first quarter results. I think they reflect: one, the resilience of our business model; and two, the solid progress that we've made on the action plan areas that we've called out to you towards the back half of last year. There's more for us to do, and we look forward to updating you on that on the next call.

Thanks, everybody.

Operator

Ladies and gentlemen, today's call has now concluded. We'd like to thank you for your participation. You may now disconnect your lines.

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