January 20, 2026

Dear Partners,

Given how much AI is dominating attention and price movements, I feel it's important to lay out to you my current thoughts and the framework we're using to invest our capital in the context of rapid AI developments.

At a high level:

- Nothing changes about our product-first approach, focusing on the creation of value for customers. Nor about our approach and innate hard-wiring toward searching for ideas on a bottom-up basis (which is how we ended up with investments in Georgia, Kazakhstan, and Brazil among other places) rather than on a top-down thematic basis. If we find a high IRR investment in a company that has seemingly nothing to do with AI (e.g., coffee or health insurance), we'll happily continue to invest in it. That said, some of these companies may eventually reap meaningful productivity benefits from AI, a speculative possibility we're keeping an eye on.
- We are of course interested in finding AI winners where we can, but only if the return profile is asymmetric. Since it's still unclear to us the *extent* to which AI developments will transform large domains outside of strong early ones like coding and customer support, we want asymmetric risk/rewards such that we still make a good return even if substantial AI benefits fail to materialize, rather than straight bets up or down on whether AI beats market expectations.
    - As product-focused investors, we are particularly interested in where AI applications can create value for users. So far, use cases for AI have lagged capex for AI, and as a result, at least in the public markets, little has been embedded in market expectations for further-down-the-line possible beneficiaries. But 2026 is a year in which that may change, and we will be watchful for signs of value creation across our portfolio.
    - Through 1) focusing on companies with the best products, which usually means having the best technology, and 2) being willing to invest broadly outside the US, we have found ourselves holding a group of companies that are far and away the technology leaders in their respective smaller countries. We've long had a thesis that these companies will be the best positioned to leverage AI in their countries. So far it's been too early, but we're excited to see what develops from this thesis during 2026.
- We are very focused on avoiding AI losers, or even perceived AI losers where shares may continue to sell off continuously until some low level of valuation support is reached.
    - As fundamental, terminal value-focused investors, we hate terminal value risk, and thus this has always been our approach since the early days of AI, and the reason we avoided investments exposed to human driving, education, IT services, legacy software rollups, vertical marketplaces, etc., even when valuations looked attractive.
    - On an exceptional basis we may try to fight the AI loser narrative in companies we believe strongly in (e.g., a few areas of software that are trading extremely cheaply but could actually turn out to be AI winners as they are best positioned to leverage their product excellence to integrate AI into already-used workflows), but we will cap our exposure there and avoid excessively averaging down (in our Q3 2023 letter, we wrote about our framework for when to average down and when not to, drawing lessons from John Hempton's classic essay on that topic).
    - In Q2 we wrote about our investment in GitLab; in Q4 we sold our investment at a small loss. The striking gains in coding abilities in the November-December models (Opus 4.5, Gemini 3, and ChatGPT 5.2) caught us by surprise and made us re-evaluate the investment and acknowledge that the level of uncertainty and downside risk has increased, especially as GitLab continues to lag on developing its own AI agent product. We still think the company will be sold, but we are no longer willing to wait around for it. While it's not ideal to sell

something shortly after we write about it, nonetheless, when the facts change, we change our minds, a characteristic that has always been our strength. We write about our ideas to share our thinking and provide transparency into what we own, but we are always mindful not to let the act of writing something down "pound it in" into our heads and prevent necessary action.

- While we're very optimistic on AI as a technology, we worry that AI capex may be in a bubble, where sky-high levels of capex investment (a classic "second derivative" type revenue where growth in capex requires ever-accelerating levels of underlying AI growth, and where the growth rate in AI usage should not be confused with growth rate in capex) are being capitalized at high multiples, embedding sustained future growth beyond just the next few years where demand signals are extremely strong. China continues to show us that, while of course they'd like to spend more on GPUs if they could, near-frontier model performance can be achieved with a fraction of US capex spending (~15% in 2025 according to some sources); these datapoints on compute efficiency are not much discussed currently but may come back to bite in the future. Accordingly, we are focused on minimizing the risks to our portfolio from a negative shock to AI capex and are being thoughtful about which of our companies may be exposed, even if only from higher multiples or sector proximity.

It's also important to reiterate what we will not do:

- We will not invest in companies we don't understand. We prioritize fully understanding our companies and their ecosystems in order to reduce the chances of being blinded by unforeseen risks.
- We will not prioritize short-term positive revisions over long-term sustainability. A common (and profitable) strategy is to buy companies with positive revisions, and let the long term (including valuation) "take care of itself" as long as revisions continue to be positive. This works very well for some investors and will likely continue to work well, but it's not for us.

We will analyze AI products just like we analyze regular products – from the perspective of looking for value creation for users, "management with the dog in them" leaders working hard to break tough tradeoffs, and raving customer reviews. If anything, in the age of AI that feels more important than ever. So far, applications have lagged capex, and it has not been our time yet to benefit from AI. But when it is, I want us to be well positioned to capture it.

Health insurance – Elevance Health and Molina Healthcare

Over the summer, as health insurance stocks cratered amidst guide-downs from UnitedHealth, Centene, and others, we bought a large position in Elevance Health, a diversified health insurer known for its portfolio of Anthem Blue Cross Blue Shield plans. Toward the end of the year we added to our health insurance investment with a purchase of Molina Healthcare, a Medicaid specialist.

First, to state the obvious, we are not healthcare experts; our stated industry focus areas are tech, tech-enabled consumer, and financials/fintech, and as mentioned earlier we place utmost importance on fully understanding what we own. But health insurance/managed care in the US is far more of a financial product by nature than a healthcare product. I've also had a long fascination with the sector. I first did a deep dive on the industry (particularly focused on Wellpoint, which later renamed to Anthem and then Elevance) back in 2012 in the early days of Obamacare, was struck by the nature of their business models (benefiting from continual above-inflation growth of healthcare costs while earning high returns on tangible equity, leaving insurers free to use generated earnings to acquire smaller companies and return capital to shareholders), and have followed the industry on and off since, including with an occasional short during my past life as an active short seller.

These companies write short-tail insurance policies of one year in duration. The industry is an oligopoly, barriers to entry are enormous (think about what happened with the Berkshire-JPM-Amazon joint venture,

or Oscar Health struggling to gain scale more than 13 years after launch), and pricing is rational (and in government programs, effectively controlled by the government), leaving insurers with a low-single digit underwriting margin before investment income from float (thus, mechanically, insurance company profits cannot be the reason why healthcare costs so much in the US – a hugely complex topic that points mostly to prices paid for care). If, during the one-year insurance policy, insurers price health insurance more or less accurately vs. cost trends, they earn a normal margin. In occasional years, an unforeseen cost driver surprises to the upside, and in response insurers raise prices the following year to recapture their normal margin (in practice, especially for government programs, this mechanism may lag, and this lag program by program is the key focus for our research). This is the beauty of short-tail insurance. Thus, it makes no sense to value health insurance companies by placing a trough multiple (~10x at our purchase price, ~13x now vs. normal multiples of 15x+) on trough earnings (currently 33-45% below normal earnings depending on the company), when we *know* that the earnings will eventually reprice. Yet this is what the market is doing, and what creates our opportunity. In the meantime, these companies are using cash flow to acquire struggling companies and aggressively buy back stock (Molina repurchased 5% of its total shares outstanding in Q3 2025 alone), setting the stage for explosive growth of earnings per share and total return potential over time.

Why is the market pricing these companies this way? We think it comes down to the short-term nature of markets:

- Uncertainty over *when* repricing happens – due to various lags, does full recovery of margins happen in 2027, 2028, or 2029? To a fundamental investor focused on terminal value, this doesn't really matter. But to most buy-side participants with one-year performance cycles, this matters hugely. Sell side also doesn't want to get caught defending a "speculative" repricing potentially years into the future, and as a result they largely flatten their future earnings estimates for these health insurance stocks vs. the current trough level.
- Fear of things "getting worse before they get better" – i.e., further negative revisions. As mentioned earlier in our discussion of AI, market structure has evolved to a point, driven by multi-manager pods, where stock returns are driven disproportionately by earnings revisions, to levels far above and below what seems to us as fair value. Most pods will simply refuse to invest in a stock ahead of negative revisions. Our specialty is in threading the needle through estimate blowups, with a conservative view of valuation as our guide – respecting the power of revisions, staying clear when prospective returns don't justify the risk, but then buying at a level with solid valuation support and IRR upside, before all the clouds are clear at which point the opportunity will have faded.

Elevance and Molina

Elevance Health is a diversified health insurer with businesses in Medicaid (28% of total revenue before investment income), Medicare (22%), group commercial business (21%), insurance for federal employees (8%), individual ACA marketplace (5%), and pharmacy and directly providing care (16% of revenue after eliminations for services provided internally). Elevance operates in 14 states with the "Anthem Blue Cross Blue Shield" brand, a blue-chip brand that carries a halo, provides differentiated nationwide coverage across sister Blue Cross Blue Shield plans, and drives a jewel of a commercial business. Elevance trades at ~13x 2026 earnings (we estimate the entire government business including ACA marketplace, which comprises more than half of all revenues before investment income, together delivers very little margin today, with nearly all current earnings coming from the commercial and pharmacy/direct care segments) and ~7x our estimate of 2030 earnings. We estimate that Elevance's adj. net margin will recover from 3.0% in 2026 to 4.3% in 2030 (vs. 4.7% in 2019; the company since 2019 has more than doubled in scale and mix-shifted into higher margin pharmacy and direct care businesses) and that Elevance will buy back ~3% of shares annually while spending the rest of free cash on acquisitions and dividends. Assuming an exit at the end of 2029 at 15x forward earnings, plus interim dividends, this drives a ~25% 4-year IRR.

Molina by contrast is a specialty insurer focused on Medicaid; 75% of premium revenue comes from Medicaid, 14% from Medicare which is largely linked to serving older Medicaid-eligible patients via integrated Medicare-Medicaid plans, and 11% from individual ACA marketplace which aims to capture lower-income individuals with incomes slightly above Medicaid eligibility levels. Since each state sets the same per-person rate for every insurer in its program, Medicaid is about operating with the lowest cost; and as a focused scaled player Molina has excelled at this, using disciplined execution and cost management to consistently achieve lower costs and thus higher margins than peers while maintaining good quality scores and using those scores to win new RFPs and gain market share at a best-in-the-market type rate (~71% success rate on RFPs in new territories, ~83% success rate in retaining existing contracts when they come up for RFP). In a year where industry Medicaid profitability is estimated to be -2%, Molina's Medicaid business is still making a +2.3% after-tax margin, a 4-point spread. Molina trades at ~13x 2026 earnings and ~4x our estimate of 2030 earnings. We estimate that Molina's overall adj. net margin will recover from 1.5% in 2026 to 2.9% in 2030 (vs. 4.4% in 2019). Assuming an exit at the end of 2029 at 14x forward earnings, with no dividends since all free cash goes to acquisitions and buybacks, this drives a ~34% 4-year IRR.

Why did we pick Elevance and Molina? We felt strongly about the "margin normalization after cost overrun" thesis and studied every insurer in the space.

- Elevance has a fantastic brand and commercial business and is fairly valued on that alone, with almost no contribution needed from the government business (of course, margins have to normalize there to get us our expected return).
- We are very impressed with what Molina's management team (in place since late 2017, replacing two Molina brothers who had inherited the business from their father) has accomplished in turning Molina into a low-cost, focused share gainer in Medicaid. Our checks on CEO Joe Zubretsky and the management team he's put in place are very positive. We think Molina has a long runway in both organically continuing to gain market share through winning RFPs as well as in acquiring struggling Medicaid plans. Ironically, the longer this Medicaid downturn lasts, the better positioned Molina may be longer term, as they continue to acquire. We've spoken to smaller Medicaid insurers running at -3% negative margins in this environment while Molina is solidly profitable.
- Our favorite businesses in this category are Commercial (oligopoly business with freedom to price to target margins) and Medicaid (clearest upside to normalized margins, diversification via exposure to multiple states), and we looked for companies with more exposure there. We worry more about Medicare, where pricing is set annually by the federal government via opaque formulas and where competition dynamics are harder to figure out.
- We applied our usual analysis to this industry of "who delivers the best product?" which led us to prefer Elevance over UnitedHealth. We are worried about United's seemingly excessive cultural focus on profits (reinforced by conversations with industry participants, vs. Elevance's higher relative focus on patients and providers), which has led to widely reported allegations around over-billing Medicare via targeting high-value diagnoses and being too aggressive in denying care. We also prefer Elevance's higher relative mix of Commercial and Medicaid vs. Medicare.

Cost overrun in 2025

What happened in 2025 is that healthcare costs unexpectedly blew out for a few reasons, mainly a mix of underlying cost increase itself on top of "adverse selection" type risk shifts:

- Underlying costs increased (which hurts in the current year but ironically leads to higher revenues and profits in future years as insurers will get a percentage margin on the higher costs):

  - Spending spiked in specific areas such as behavioral health (including ABA treatment for autism), high-cost drugs (GLP-1s as well as new cancer treatments and gene therapies), and long-term support services for disabled individuals.
  - Providers (e.g., hospitals and clinics) increased their use of AI tools for coding and denials management, which drove an increase in billing that the insurance companies are now racing to build tools to match.
- Several markets suffered from unanticipated "adverse selection" type shifts:
  - Medicaid had several good years during and post-covid as the federal government disallowed states from removing members from Medicaid rolls for reasons of ineligibility until the end of the Public Health Emergency (PHE), which was ended in May 2023. After the end of the PHE, states progressively moved to re-certify members and kick off ineligible members, a process that continued through mid-2024. However, proving eligibility required paperwork, and healthy members disproportionately didn't make the effort to stay enrolled, leaving a sicker population behind with higher costs per patient. The health insurance companies and state actuaries mismodeled the extent of this mix shift, resulting in rates that were inadequate and sending the entire industry to a loss in 2024 (-0.3%), which substantially deepened in 2025 (-2%).
  - The individual ACA marketplace experienced a similar negative mix shift, though with a different driver; new rules put in place by the Centers for Medicare and Medicaid Services (CMS) increased the verification burden for consumers to enroll in ACA plans at the start of 2025, a new hurdle that disproportionately caused healthy members to drop out of the annual enrollment process, leaving a sicker population behind. Even more so than in the Medicaid market, the negative mix effect led to significantly worse-than-modeled results for the insurers.

These cost increases hurt so much in 2025 because they were largely unanticipated (though in hindsight you could argue that the insurance companies with all their actuaries should have anticipated them more). Once they're out in the open, though, the forward path is clear – because the insurers will use everything in their power to get back to adequate rates (for commercial and ACA exchange, setting the price themselves the following year; for Medicaid, a multi-quarter/multi-year process of advocating for sufficient rates with each state regulator).

In Medicaid, our thesis rests on a federal law that specifies that states must provide insurers with "actuarially sound" rates – which means rates that cover costs and leave enough for a small margin for the average insurer (a price umbrella that Molina, operating at lower costs than the average insurer, benefits from). While "actuarially sound" in practice means a band centered around a median and in certain years states can push for the lower end of the band, over the medium term states are required to give rates that cover increased costs and leave insurer profitability in the black. This is also a practical matter – states need the insurers to manage Medicaid for them in order to provide administrative services impractical for the states to do themselves and to provide care at lower cost (accordingly, the percentage of all Medicaid lives managed by managed care companies has increased from 10% in 1990 to 56% in 2000 and 75% in 2024), and sustained negative profitability will lead to plan exits. From a risk perspective, Medicaid is a nice business because it is diversified – each state has different rules and will set rates differently, leaving a diversified insurer less exposed to risk from one or two capricious states.

"One Big Beautiful Bill"

President Trump's "One Big Beautiful Bill" budget reconciliation passed in July 2025, and it used federal cuts in Medicaid spending (alongside student loan support and SNAP benefits) to fund tax cuts and military/border spending. This bill reduces federal funding to state Medicaid agencies, but in a back-loaded fashion, with most of the funding impact hitting in 2028-2032 and especially 2030-2032. In 2030,

for example, the total cut from the OBBB to combined federal and state Medicaid spending vs. baseline is ~8%.

The bill's Medicaid provisions can be grouped into two broad sections:

- Starting in 2027, states will begin implementing 80 hours/month work requirements for Medicaid expansion adults (~20 million members out of 77 million total Medicaid members), verified biannually. Medicaid expansion is a subset of the broader Medicaid program and refers to low-income adults that were previously not eligible for Medicaid until the ACA, subject to state-by-state decisions on whether to "expand" Medicaid (all blue states did, 10 red states did not). Our research suggests that, after excluding members that fall under exclusions (such as caregiver of a child or medically frail), most of the remaining affected adults (~2/3) already work in some capacity, but like with redeterminations (the process of removing ineligible members from Medicaid rolls post the Public Health Emergency), some healthier members may not make the effort to submit paperwork, leading to drop-offs.
- Starting in 2028, federal funding for Medicaid will progressively ramp down each year, structured in a way that will hit blue states most (those that have the highest health insurance taxes and special funding to hospitals, spending which then attracts a federal match).

In 2027, one risk is that work requirement rules will lead to another mismodeled mix shift in the remaining Medicaid pool, leaving plans to again try to push for higher rates to catch up in 2028 and 2029. Our research suggests however that the impact will be much less than with redeterminations in 2023-2024; that round involved a cumulative 20% loss in members, whereas this round is estimated to be ~6-9% (starting with the 26% of Medicaid members that are in the adult expansion population, assuming ~65% of those do not fall under exclusions, ~2/3 of those remaining already work but some don't fill out the paperwork, etc.). Additionally, the work requirement rules will be phased in over time starting from 2027 through to 2029, leaving enough time for plans and regulators to react.

We will be watching to see how states react to broader Medicaid funding cuts in 2028 and beyond. States will likely deal with cuts through a combination of 1) increasing the share of state budgets that go toward funding Medicaid, 2) reducing Medicaid member rolls through increased requirements as well as cutting certain covered services, and 3) letting hospitals/providers take the hit through a natural decrease in funding to those entities as a result of the federal cuts from OBBB, which are targeted there. Medicaid providers like Elevance and Molina may take a hit as well, which is why we model ending margins lower than historical averages – but due to 1) the requirement of giving actuarially sound rates by federal law as discussed above, and 2) low-single digit margins across the industry as current practice (~1-2% in the pre-covid period), there is only so much that can be squeezed there, and whatever new normalized margin rate we end up with necessarily *must* be higher than the current industry average Medicaid profitability of -2%.

Regulatory risk

Talking about health insurance in the US inevitably brings up a discussion of broader regulatory risk. We agree that healthcare in the US costs too much and leaves too many people uninsured or under-insured. Yet good solutions to this issue without enormous downsides/tradeoffs are few, and the US health insurance industry is one that has stood the test of time, including major change brought by the ACA.

We think the industry is unlikely to significantly change in a way that would disrupt the insurance companies:

- Large changes in healthcare policy (OBBB was a reduction in federal funding but did not change how the system works) cannot be done through reconciliation and must pass as regular bills, which require a 60-vote Senate majority.

- The majority of Americans, especially those in employer-sponsored plans (160 million people), are happy with their personal health insurance while expressing concerns about the system overall. Support for "Medicare for All" plummets from ~55% to ~36% when surveys clarify in follow-up questions that the plan would eliminate private health insurance companies and employer-sponsored plans.
- A single-payer, "Medicare for All" type system would represent a drastic re-ordering of the current system with many losers – requiring massive increases in overall government spending and taxes, people on employer-sponsored coverage would lose their current plan and likely see a downgrade in experience, provider/hospital revenues would take big hits and doctor and nurse pay would likely be forced down (the current Medicare system works because it is subsidized by commercial insurance that pays providers ~150-250% of Medicare rates), increased utilization of services would result in longer wait times, etc.
- Health insurance companies play an important role in the ecosystem by using their scale to negotiate lower prices with providers and managing appropriate care utilization to reduce system costs.
- In Medicaid specifically, Medicaid managed by private insurers delivers lower costs and better outcomes than state-driven fee-for-service Medicaid, which is the reason why Managed Medicaid as a % of Medicaid lives has steadily increased over time (as mentioned earlier, from 56% in 2000 to 75% in 2024).

Recession resilience & possible AI benefits

In addition to the high IRRs, we like these health insurance investments because they are recession-resistant, rare in a troubled world. They are effectively utilities with regulated margins but unregulated return on equity. This type of exposure provides nice diversification to our portfolio.

Additionally, not discussed much today is the extent to which these health insurance companies can be AI beneficiaries. AI-driven productivity improvement has the most potential financial impact on businesses with thin margins and high administrative costs; health insurance certainly fits this bill, with low-to-mid single digit operating margins before investment income, meaning a small improvement in administrative costs (7-8% of revenue) and/or benefits costs (89% of revenue, but a share of savings there will be returned to members/government) can drive large increases in operating profit. There are big buckets of costs in areas such as claims processing, prior authorizations, provider network management, call center, care coordination, etc. that are mostly manual today but could become more automated with AI. Our research here indicates that it's too early to see benefits and that Elevance and Molina need to make large investments into unifying systems, data stores, and IT processes before AI can be widely deployed, and accordingly we are not modeling AI productivity in our base case. But the companies are focused on this (Elevance is investing an incremental >$100 million into AI initiatives in 2026), and if we're thinking long term, this is an exciting source of potential upside that we will follow closely.

In summary, we are very excited about these investments and, as mentioned earlier, we see 25% and 34% 4-year IRR for Elevance and Molina respectively.

Business

As the fund continues to grow, we are looking to hire an analyst. The role will be remote and we are searching globally for the best analyst that we can find. While we prefer some level of buy-side experience (2+ years), we are more focused on talent and personality traits (conscientiousness, curiosity, etc.) than on any particular set of experience. If you have any candidates in mind who you think could be a good fit, please reach out to me.

Conclusion

AI has massively accelerated our research process, especially as a single-investor firm. Yet despite AI, I feel there is a certain beauty and depth in still doing some tasks manually. We build every model by hand, typing in each historical number cell by cell to internalize each datapoint; we read hundreds of user and employee reviews manually, looking for signs of an amazing product while seeking to understand nuance; and we listen to recorded audio (not transcripts or summaries) of historical earnings calls, listening for management personality and emphasis. Those are tasks that I feel (or hope) that AI will not replace.

As always, I am immensely grateful for the opportunity to manage our capital and am hard at work trying to compound it at the highest rate that I can.

Yours,
Tim Liu

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