CENTENE CORP
Form 10-K
February 19, 2019

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549
Form 10-K
(Mark One)
x ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the fiscal year ended December 31, 2018
or
o TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the transition period from to
Commission file number: 001-31826
Centene Corporation
(Exact name of registrant as specified in its charter)

Delaware	42-1406317
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification Number)
7700 Forsyth Boulevard	
St. Louis, Missouri	63105
(Address of principal executive offices)	(Zip Code)

Registrant's telephone number, including area code: (314) 725-4477
Securities registered pursuant to Section 12(b) of the Act:

Common Stock, $0.001 Par Value	New York Stock Exchange
Title of Each Class	Name of Each Exchange on Which Registered

Securities registered pursuant to Section 12(g) of the Act:
None
(Title of Each Class)
Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes x No o
Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes o No x
Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes x No o
Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit such files).
Yes x No o
Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. x
Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or smaller reporting company, or an emerging growth company. See the definitions of “large accelerated filer”, “accelerated filer”, “small reporting company”, and "emerging growth company" in Rule 12b-2 of the Exchange Act.
Large accelerated filer x Accelerated filer o
Non-accelerated filer o Smaller reporting company o

Emerging growth company o

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. o

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). Yes o No x

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant, based upon the last reported sale price of the common stock on the New York Stock Exchange on June 30, 2018, was $25.3 billion.

As of February 15, 2019, the registrant had 413,170,382 shares of common stock issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Proxy Statement for the registrant's 2019 annual meeting of stockholders are incorporated by reference in Part III, Items 10, 11, 12, 13 and 14.

CENTENE CORPORATION
ANNUAL REPORT ON FORM 10-K
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CAUTIONARY STATEMENT ON FORWARD-LOOKING STATEMENTS

All statements, other than statements of current or historical fact, contained in this filing are forward-looking statements. Without limiting the foregoing, forward-looking statements often use words such as “believe,” “anticipate,” “plan,” “expect,” “estimate,” “intend,” “seek,” “target,” “goal,” “may,” “will,” “would,” “could,” “should,” “can,” “continue” a words or expressions (and the negative thereof). We intend such forward-looking statements to be covered by the safe-harbor provisions for forward-looking statements contained in the Private Securities Litigation Reform Act of 1995, and we are including this statement for purposes of complying with these safe-harbor provisions. In particular, these statements include, without limitation, statements about our future operating or financial performance, market opportunity, growth strategy, competition, expected activities in completed and future acquisitions, including statements about the impact of our recent acquisition (Fidelis Care Acquisition) of substantially all the assets of New York State Catholic Health Plan, Inc., d/b/a Fidelis Care New York (Fidelis Care), investments and the adequacy of our available cash resources. These statements may be found in the various sections of this filing, such as Part II, Item 7. “Management's Discussion and Analysis of Financial Condition and Results of Operations,” Part I, Item 3. “Legal Proceedings,” and Part I, Item 1A. “Risk Factors.”

These forward-looking statements reflect our current views with respect to future events and are based on numerous assumptions and assessments made by us in light of our experience and perception of historical trends, current conditions, business strategies, operating environments, future developments and other factors we believe appropriate. By their nature, forward-looking statements involve known and unknown risks and uncertainties and are subject to change because they relate to events and depend on circumstances that will occur in the future, including economic, regulatory, competitive and other factors that may cause our or our industry’s actual results, levels of activity, performance or achievements to be materially different from any future results, levels of activity, performance or achievements expressed or implied by these forward-looking statements. These statements are not guarantees of future performance and are subject to risks, uncertainties and assumptions.

All forward-looking statements included in this filing are based on information available to us on the date of this filing. Except as may be otherwise required by law, we undertake no obligation to update or revise the forward-looking statements included in this filing, whether as a result of new information, future events or otherwise, after the date of this filing. You should not place undue reliance on any forward-looking statements, as actual results may differ materially from projections, estimates, or other forward-looking statements due to a variety of important factors, variables and events including but not limited to:

- our ability to accurately predict and effectively manage health benefits and other operating expenses and reserves;
- competition;
- membership and revenue declines or unexpected trends;
- changes in healthcare practices, new technologies, and advances in medicine;
- increased healthcare costs;
- changes in economic, political or market conditions;
- changes in federal or state laws or regulations, including changes with respect to income tax reform or government healthcare programs as well as changes with respect to the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act , collectively referred to as the Affordable Care Act (ACA) and any regulations enacted thereunder that may result from changing political conditions or judicial actions, including the ultimate outcome of the District Court decision in “Texas v. United States of America” regarding the constitutionality of the ACA;
- rate cuts or other payment reductions or delays by governmental payors and other risks and uncertainties affecting our government businesses;

- our ability to adequately price products on federally facilitated and state-based Health Insurance Marketplaces;
- tax matters;
- disasters or major epidemics;
- the outcome of legal and regulatory proceedings;
- changes in expected contract start dates;
- provider, state, federal and other contract changes and timing of regulatory approval of contracts;
- the expiration, suspension, or termination of our contracts with federal or state governments (including but not limited to Medicaid, Medicare, TRICARE or other customers);
- the difficulty of predicting the timing or outcome of pending or future litigation or government investigations;
- challenges to our contract awards;
- cyber-attacks or other privacy or data security incidents;
- the possibility that the expected synergies and value creation from acquired businesses, including, without limitation, the Fidelis Care Acquisition, will not be realized, or will not be realized within the expected time period;

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- the exertion of management's time and our resources, and other expenses incurred and business changes required in connection with complying with the undertakings in connection with any regulatory, governmental or third party consents or approvals for acquisitions, including the Fidelis Care Acquisition;
- disruption caused by significant completed and pending acquisitions, including, among others, the Fidelis Care Acquisition, making it more difficult to maintain business and operational relationships;
- the risk that unexpected costs will be incurred in connection with the completion and/or integration of acquisition transactions, including, among others, the Fidelis Care Acquisition;
- changes in expected closing dates, estimated purchase price and accretion for acquisitions;
- the risk that acquired businesses, including Fidelis Care, will not be integrated successfully;
- the risk that, following the Fidelis Care Acquisition, we may not be able to effectively manage our expanded operations;
- restrictions and limitations in connection with our indebtedness;
- our ability to maintain the Centers for Medicare and Medicaid Services (CMS) Star ratings and maintain or achieve improvement in other quality scores in each case that can impact revenue and future growth;
- availability of debt and equity financing, on terms that are favorable to us;
- inflation; and
- foreign currency fluctuations.

This list of important factors is not intended to be exhaustive. We discuss certain of these matters more fully, as well as certain other factors that may affect our business operations, financial condition and results of operations, in our filings with the Securities and Exchange Commission, including our annual report on Form 10-K, quarterly reports on Form 10-Q and current reports on Form 8-K. Item 1A. "Risk Factors" of this filing contains a further discussion of these and other important factors that could cause actual results to differ from expectations. Due to these important factors and risks, we cannot give assurances with respect to our future performance, including without limitation our ability to maintain adequate premium levels or our ability to control our future medical and selling, general and administrative costs.

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Non-GAAP Financial Presentation

The Company is providing certain non-GAAP financial measures in this report as the Company believes that these figures are helpful in allowing investors to more accurately assess the ongoing nature of the Company's operations and measure the Company's performance more consistently across periods. The Company uses the presented non-GAAP financial measures internally to allow management to focus on period-to-period changes in the Company's core business operations. Therefore, the Company believes that this information is meaningful in addition to the information contained in the GAAP presentation of financial information. The presentation of this additional non-GAAP financial information is not intended to be considered in isolation or as a substitute for the financial information prepared and presented in accordance with GAAP.

Specifically, the Company believes the presentation of non-GAAP financial information that excludes amortization of acquired intangible assets, acquisition related expenses, as well as other items, allows investors to develop a more meaningful understanding of the Company's performance over time. The tables below provide reconciliations of non-GAAP items ($ in millions, except per share data). On December 12, 2018, the Board of Directors declared a two-for-one split of Centene's common stock in the form of a 100% stock dividend distributed on February 6, 2019 to stockholders of record as of December 24, 2018. All share, per share and stock price information presented in this Form 10-K has been adjusted for the two-for-one stock split.

	Year Ended December 31,		
	2018	2017	2016
GAAP net earnings attributable to Centene	$900	$828	$562
Amortization of acquired intangible assets	211	156	147
Acquisition related expenses	425	20	234
Other adjustments [1]	30	(7)	(134)
Income tax effects of adjustments [2]	(155)	(108)	(79)
Adjusted net earnings	$1,411	$889	$730
GAAP diluted earnings per share (EPS) attributable to Centene	$2.26	$2.34	$1.71
Amortization of acquired intangible assets [3]	0.41	0.28	0.29
Acquisition related expenses [4]	0.81	0.04	0.49
Other adjustments [1]	0.06	(0.14)	(0.27)
Adjusted Diluted EPS	$3.54	$2.52	$2.22

(1) Other adjustments include the following items:

2018 - the impact of retroactive changes to the California minimum medical loss ratio (MLR) of $30 million of expense or $0.06 per diluted share, net of an income tax benefit of $0.02;

2017 - (a) the Penn Treaty assessment expense of $56 million or $0.10 per diluted share, net of an income tax benefit of $0.06; (b) the cost sharing reduction (CSR) expense of $22 million or $0.04 per diluted share, net of an income tax benefit of $0.02; (c) the charitable contribution commitment of $40 million or $0.07 per diluted share, net of an income tax benefit of $0.05; and (d) the benefit associated with income tax reform of $125 million or $0.35 per diluted share; and

2016 - (a) the impact of retroactive changes to the California minimum medical loss ratio (MLR) of a $195 million benefit or $0.38 per diluted share, net of an income tax expense of $0.21; (b) the charitable contribution commitment

of $50 million or $0.09 per diluted share, net of an income tax benefit of $0.06; and (c) the debt extinguishment cost of $11 million or $0.02 per diluted share, net of an income tax benefit of $0.01.

(2) The income tax effects of adjustments are based on the effective income tax rates applicable to adjusted (non-GAAP) results. There is no additional income tax effect from income tax reform.

(3) Amortization of acquired intangible assets per diluted share is net of an income tax benefit of $0.12, $0.16, and $0.16 for the years ended December 31, 2018, 2017 and 2016, respectively.

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(4) Acquisition related expenses per diluted share are net of an income tax benefit of $0.25, $0.02 and $0.22 for the years ended December 31, 2018, 2017 and 2016, respectively.

	Year Ended December 31,		
	2018	2017	2016
GAAP selling, general and administrative expenses	$6,043	$4,446	$3,673
Acquisition related expenses	421	20	234
Penn Treaty assessment expense	—	56	—
Charitable contribution	—	40	50
Adjusted selling, general and administrative expenses	$5,622	$4,330	$3,389

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PART I
ITEM 1. Business

OVERVIEW

We are a diversified, multi-national healthcare enterprise that provides a portfolio of services to government sponsored and commercial healthcare programs, focusing on under-insured and uninsured individuals. We provide member-focused services through locally based staff by assisting in accessing care, coordinating referrals to related health and social services and addressing member concerns and questions. We also provide education and outreach programs to inform and assist members in accessing quality, appropriate healthcare services. We believe our local approach, including member and provider services, enables us to provide accessible, quality, culturally-sensitive healthcare coverage to our communities. Our health management, educational and other initiatives are designed to help members best utilize the healthcare system to ensure they receive appropriate, medically necessary services and effective management of routine, severe and chronic health problems, resulting in better health outcomes. We combine our decentralized local approach for care with a centralized infrastructure of support functions such as finance, information systems and claims processing.

Our initial health plan commenced operations in Wisconsin in 1984. We were organized in Wisconsin in 1993 as a holding company for our initial health plan and reincorporated in Delaware in 2001. Our stock is publicly traded on the New York Stock Exchange under the ticker symbol “CNC.”

We operate in two segments: Managed Care and Specialty Services. Our Managed Care segment provides health plan coverage to individuals through government subsidized and commercial programs. Our Specialty Services segment includes companies offering diversified healthcare services and products to our Managed Care segment and other external customers. For the year ended December 31, 2018, our Managed Care and Specialty Services segments accounted for 95% and 5%, respectively, of our total external revenues. Our membership totaled 14.0 million as of December 31, 2018. For the year ended December 31, 2018, our total revenues and net earnings attributable to Centene were $60.1 billion and $900 million, respectively, and our total cash flow from operations was $1.2 billion.

On July 1, 2018, we acquired substantially all of the assets of Fidelis Care for approximately $3.6 billion of cash consideration, which includes a working capital adjustment. The Fidelis Care Acquisition expanded our scale and presence to New York State.

On December 12, 2018, our Board of Directors declared a two-for-one split of our common stock in the form of a 100% stock dividend distributed on February 6, 2019 to stockholders of record as of December 24, 2018. All share, per share and stock price information presented in this Form 10-K has been adjusted for the two-for-one stock split.

INDUSTRY

We provide a full spectrum of managed healthcare products and services, primarily through Medicaid, commercial and Medicare products. We currently have operations domestically and internationally.

Medicaid

Established in 1965, Medicaid is the largest publicly funded program in the United States, and provides health insurance to low-income families and individuals with disabilities. Authorized by Title XIX of the Social Security Act, Medicaid is an entitlement program funded jointly by the federal and state governments and administered by the states. The majority of funding is provided at the federal level. Each state establishes its own eligibility standards,

benefit packages, payment rates and program administration within federal standards. As a result, there are 56 Medicaid programs - one for each U.S. state, each U.S. territory and the District of Columbia. Eligibility is based on a combination of household income and assets, often determined by an income level relative to the federal poverty level. Historically, children have represented the largest eligibility group. Many states have selected Medicaid managed care as a means of delivering quality healthcare and controlling costs. We refer to these states as mandatory managed care states.

Established in 1972 and authorized by Title XVI of the Social Security Act, Aged, Blind, or Disabled, or collectively ABD, covers low-income persons with chronic physical disabilities or behavioral health impairments. ABD beneficiaries represent a growing portion of all Medicaid recipients. In addition, ABD recipients typically utilize more services as a result of their health status.

The Balanced Budget Act of 1997 created the State Children's Health Insurance Program (CHIP) to help states expand coverage primarily to children whose families earned too much to qualify for Medicaid, yet not enough to afford private health insurance.

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Costs related to the largest eligibility group, children, are primarily composed of pediatrics and family care. These costs tend to be more predictable than those associated with other healthcare issues which predominantly affect the adult population.

Long-Term Services and Supports (LTSS) is a Medicaid product that covers Institutional/Residential Care (Nursing Facilities, Intermediate Care Facilities) and Home and Community Based Services (HCBS) for beneficiaries requiring assistance with their activities of daily living, such as bathing, dressing and transferring. The most common HCBS services include personal care, adult day care, non-emergent transportation, home-delivered meals and personal emergency response systems. LTSS services are provided for individuals requiring nursing home level of care, receiving waiver services, or entitled to state Medicaid LTSS benefits. The largest groups receiving LTSS, by spending, are older individuals and individuals with physical disabilities, followed by individuals with intellectual and developmental disabilities, those with serious mental illness and/or serious emotional disturbance and other populations. States are increasingly turning to managed care as a solution to provide coordinated, holistic care to their LTSS beneficiaries. According to the National Association of States United for Aging and Disabilities, 21 states utilize some form of managed LTSS up from eight in 2004.

The majority of youth and children in foster care qualify for Medicaid, most commonly through Title IV-E of the Social Security Act, which provides funding to support safe and stable out-of-home care for children who are removed from their homes. The federal government has enacted legislation establishing guidelines and requirements for state child welfare agencies related to the health and well-being of children in foster care, including the provision of grants and technical assistance to enable states to meet these needs and make explicit connections with state Medicaid. In addition, the ACA requires states to make former foster care children eligible for Medicaid until they reach the age of 26, provided that they turned 18 while in foster care, and were enrolled in Medicaid at that time.

CMS estimated the total Medicaid market to be approximately $582 billion in 2017, and estimated the market will grow to $1.0 trillion by 2026. Medicaid spending is estimated to have increased by 2.9% in 2017 and is projected to increase at an average annual rate of 5.8% between 2017 and 2026.

While Medicaid programs have directed funds to many individuals who cannot afford or otherwise maintain health insurance coverage, they did not initially address the inefficient and costly manner in which the Medicaid population tends to access healthcare. Medicaid recipients in non-managed care programs typically have not sought preventive care or routine treatment for chronic conditions, such as asthma and diabetes. Rather, they have sought healthcare in hospital emergency departments, which is typically more expensive. As a result, many states without managed care programs have found that the costs of providing Medicaid benefits have increased while the medical outcomes for the recipients remained unsatisfactory.

We believe managed care has been proven to improve the quality of care for Medicaid beneficiaries and lower costs. The majority of states have mandated that their Medicaid recipients enroll in managed care plans. Other states are considering moving to a mandated managed care approach for additional populations and products. As a result, we believe a significant market opportunity exists for managed care organizations with operations and programs focused on the distinct socio-economic, cultural and healthcare needs of the uninsured population and the Medicaid populations.

Commercial

We offer commercial healthcare products to individuals through the Health Insurance Marketplace and large and small employer groups. Our health maintenance organization (HMO) plans offer comprehensive benefits generally for a fixed fee or premium that does not vary with the extent or frequency of medical services actually received by the

member. We offer HMO plans with differing benefit designs and varying levels of co-payments at different premium rates. These plans are offered generally through contracts with participating network physicians, hospitals and other providers. When an individual enrolls in one of our HMO plans, he or she selects a primary care physician (PCP) from among the physicians participating in our network. Our preferred provider organization (PPO) plans offer coverage for services received from any healthcare provider, with benefits generally paid at a higher level when care is received from a participating network provider. Coverage typically is subject to deductibles and copayments or coinsurance. Our point of service (POS) plans and our elect open access (EOA) plans blend the characteristics of HMO, PPO and indemnity plans. Members can have comprehensive HMO-style benefits for services received from participating network providers with lower copayments (particularly within the medical group), but also have coverage, generally at higher copayment or coinsurance levels or with coverage limitations, for services received outside the network. Our Exclusive Provider Organization (EPO) plans and Healthcare Service Plans (HSPs) similarly blend elements of traditional HMO and PPO plans.

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In 2010, the ACA was enacted. While the constitutionality of the ACA was subsequently challenged in a number of legal actions, in June 2012, the Supreme Court upheld the constitutionality of the ACA, with one limited exception relating to the Medicaid expansion provision (Medicaid Expansion). The Supreme Court held that states could not be required to expand Medicaid and risk losing all federal money for their existing Medicaid programs. Under the ACA, Medicaid coverage was expanded to all individuals under age 65 with incomes up to 138% of the federal poverty level beginning January 1, 2014, subject to the states' elections. The federal government paid the entire costs for Medicaid Expansion coverage for newly eligible beneficiaries from 2014 through 2016, 95% of the costs in 2017, and 94% of the costs in 2018. Assuming that the current program remains in effect unchanged, in 2019 the federal share is scheduled to decline to 93%, and it would be 90% in 2020 and subsequent years.

Health Insurance Marketplaces are a key component of the ACA and provide an opportunity for individuals and small businesses to obtain health insurance. States have the option of operating their own Marketplace or partnering with the federal government. States choosing neither option currently default to a federally-facilitated Marketplace. Premium and cost sharing subsidies are available to make coverage more affordable and access to Marketplaces is limited to U.S. citizens and legal immigrants. Insurers are required to offer a minimum level of benefits with coverage that varies based on premiums and out-of-pocket costs. Premium subsidies are provided to families without access to other coverage and with incomes between 100-400% of the federal poverty level to help them purchase insurance through the Marketplaces. These subsidies are offered on a sliding scale basis.

Medicare

We contract with CMS under the Medicare Advantage program to provide Medicare Advantage products directly to Medicare beneficiaries as well as through employer and union groups. We provide or arrange healthcare benefits for services normally covered by Medicare, plus a broad range of healthcare benefits for services not covered by traditional Medicare, usually in exchange for a fixed monthly premium per member from CMS that varies based upon the county in which the member resides, demographic factors of the member such as age, gender and institutionalized status, and the health status of the member. Any benefits that are not covered by Medicare may result in an additional monthly premium charged to the enrollee or through portions of payments received from CMS that may be allocated to these benefits, according to CMS regulations and guidance. Many of our Medicare Advantage members pay no monthly premium to us for these additional benefits.

We provide a wide range of Medicare products, including Medicare Advantage plans with and without prescription drug coverage and Medicare supplement products that supplement traditional fee-for-service Medicare coverage. Our subsidiaries have a number of contracts with CMS under the Medicare Advantage program authorized under Title XVIII of the Social Security Act.

A portion of Medicare beneficiaries are dual-eligible, low-income seniors and people with disabilities who are enrolled in both Medicaid and Medicare. According to CMS, there were approximately 10.7 million dual-eligible enrollees in 2017. These dual-eligible members may receive assistance from Medicaid for benefits, such as nursing home care, HCBS, and/or assistance with Medicare premiums and cost sharing. Dual-eligibles also use more services due to their tendency to have more chronic health issues. We serve dual-eligibles through our ABD, LTSS, Medicare-Medicaid Plans (MMP) and Medicare Advantage Dual Special Needs Plan lines of business.

CMS developed the Medicare Advantage Star ratings system to help consumers choose among competing plans, awarding between 1.0 and 5.0 stars to Medicare Advantage plans based on performance in certain measures of quality. The Star ratings are used by CMS to award quality bonus payments to Medicare Advantage plans. Beginning with the 2014 Star ratings (calculated in 2013), Medicare Advantage plans are required to achieve a minimum of 4.0 Stars to qualify for a quality bonus payment. The methodology and measures included in the Star ratings system can be

modified by CMS annually and Star ratings thresholds are based on performance of Medicare Advantage plans nationally.

CMS estimated the total Medicare market was approximately $706 billion in 2017, and estimated the market will grow to approximately $1.4 trillion by 2026. Medicare spending is estimated to have increased 5.0% in fiscal 2017 and is projected to increase at an average annual rate of 7.4% between 2017 and 2026.

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International

We currently have a growing international presence in Spain and the United Kingdom. In Spain, our joint venture, Ribera Salud S.A. (Ribera Salud), and our majority owned subsidiary, Torrejón Salud, S.A. (Torrejón Salud), are health management businesses mainly operating in the health administrations concession sector in Valencia and Madrid. Ribera Salud also has other controlling and noncontrolling interests in Spain, Latin America, and Slovakia. In the United Kingdom, our subsidiary, The Practice (Group) Limited (TPG), is one of the largest provider networks in the United Kingdom. TPG delivers medical and community based services in the primary care sector of the National Health Service (NHS), which is the publicly funded, national healthcare system for England.

OUR COMPETITIVE STRENGTHS

Our approach is based on the following key competitive strengths:

- Expertise in Government Sponsored Programs. For more than 30 years, we have developed a specialized government services expertise that has helped us establish and maintain relationships with members, providers and state governments. We have implemented programs developed to achieve savings for state governments and improve health outcomes and quality of care for members. We work to assist the states in which we operate in addressing the operating challenges they face.

- Quality and Innovation. Our innovative medical management programs focus on improving quality of care in areas that have the greatest impact on our members. We concentrate on serving the whole person to impact outcomes and costs. We recognize the importance of member-focused delivery of quality managed care services and have developed award winning education and outreach programs including the CentAccount program, On.Demand Diabetes, Start Smart For Your Baby, and MemberConnections. It is our objective to provide access to the highest quality of care for our members. As a validation of that objective, we pursue accreditation by independent organizations that have been established to promote healthcare quality. We seek the National Committee for Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC) Health Plan Accreditation in eligible states.

- Innovative Technology and Scalable Systems. The ability to access data and translate it into meaningful information is essential to operating across a multi-state service area in a cost-effective manner. Our centralized information systems support our core processing functions under a set of integrated databases and are designed to be both replicable and scalable to accommodate organic growth and growth from acquisitions. We continue to enhance our systems in order to leverage the platform we have developed for our existing states for configuration into new states or health plan acquisitions. We believe our predictive modeling technology enables our medical management operations to proactively case and disease manage specific high risk members. It can recommend medical care opportunities using a mix of company defined algorithms and evidence based medical guidelines. Interventions are determined by the clinical indicators, the ability to improve health outcomes, and the risk profile of members. We believe our integrated approach helps to assure that consistent sources of claim and member information are provided across all of our health plans. Our membership and claims processing system is capable of expanding to support additional members in an efficient manner.

- Financial Strength and Scale. We are a large healthcare enterprise with over $60 billion in revenue and $1.2 billion in operating cash flow in 2018. Our strong historical operating performance, size, and scale allow us to continue to grow, diversify and invest in our businesses through strategic acquisitions and investments in technology and other resources that support our business, allowing us to navigate the changing healthcare landscape. We are the leader in the four largest Medicaid states. We seek to continue to increase our Medicaid, Medicare and Health Insurance

Marketplace membership through alliances with key providers, outreach efforts, development and implementation of community-specific products and acquisitions. For example, in 2018, we began providing managed care services to Illinois beneficiaries under a state-wide contract through our subsidiary, IlliniCare Health. In 2018 and 2019, we expanded our Health Insurance Marketplace and Medicare footprints in several existing markets.

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Diversified Business Lines. We continue to broaden our service offerings to address areas that we believe have been traditionally under-served by Medicaid managed care organizations. In addition to our Medicaid and Medicaid-related managed care services, our service offerings include behavioral health management, care management software, correctional healthcare services, dental benefits management, commercial programs, home-based primary care services, life and health management, vision benefits management, pharmacy benefits management, specialty pharmacy and telehealth services. With the acquisition of Health Net Inc. (Health Net), we further broadened our service offerings in 2016, which added government-sponsored care under its federal contracts with the Department of Defense (DoD), as well as Medicare Advantage, and small and large group commercial business lines. Through the utilization of a multi-business line approach, we are able to improve the quality of care, improve outcomes, diversify our revenues and help control our medical costs. In 2018, we served managed care members in 29 states through approximately 340 product solutions. We are constantly evaluating new opportunities for expansion both domestically and abroad.

Localized Approach with Centralized Support Infrastructure. We take a localized approach to managing our subsidiaries, including provider and member services. This approach enables us to facilitate access by our members to high quality, culturally sensitive healthcare services. Our systems and procedures have been designed to address these community-specific challenges through outreach, education, transportation and other member support activities. For example, our community outreach programs work with our members and their communities to promote health and self-improvement through education on how best to access care. We complement this localized approach with a centralized infrastructure of support functions such as finance, information systems and claims processing, which allows us to minimize selling, general and administrative (SG&A) expenses and to integrate and realize synergies from acquisitions. We believe this combined approach allows us to efficiently integrate new business opportunities in both Managed Care and Specialty Services while maintaining our local accountability and improved access.

MANAGED CARE

Benefits to Customers

We feel that our ability to establish and maintain a leadership position in the markets we serve results primarily from our demonstrated success in providing quality care while reducing and managing costs, and from our specialized programs in working with state governments. Among the benefits we are able to provide to the states with which we contract are:

- Significant cost savings and budget predictability compared to state paid reimbursement for services. We bring experience relating to quality of care improvement methods, utilization management procedures, an efficient claims payment system, and provider performance reporting, as well as managers and staff experienced in using these key elements to improve the quality of and access to care. We generally receive a contracted premium on a per member basis and are responsible for the medical costs and, as a result, provide budget predictability.

- Data-driven approaches to balance cost and verify eligibility. We seek to ensure effective outreach procedures for new members, then educate them and ensure they receive needed services as quickly as possible. Our IT department has created mapping/translation programs for loading membership and linking membership eligibility status to all of Centene's subsystems. We utilize predictive modeling technology to proactively case and disease manage specific high risk members. In addition, we have developed Centelligence, our enterprise data warehouse system to provide a seamless flow of data across our organization, enabling providers and case managers to access information, apply analytical insight and make informed decisions.

- Establishment of realistic and meaningful expectations for quality deliverables. We have collaborated with state agencies in redefining benefits, eligibility requirements and provider fee schedules with the goal of maximizing the number of individuals covered through Medicaid.

- Managed care expertise in government subsidized programs. Our expertise in Medicaid has helped us establish and maintain strong relationships with our constituent communities of members, providers and state governments. We provide access to services through local providers and staff that focus on the cultural norms of their individual communities. To that end, systems and procedures have been designed to address community-specific challenges through outreach, education, transportation and other member support activities.

- Improved quality and medical outcomes. We have implemented programs to enhance the ability of providers to improve the quality of healthcare delivered to our members. This is demonstrated through health plan accreditations and program awards.

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- Timely payment of provider claims. We are committed to ensuring that our information systems and claims payment systems meet or exceed state requirements. We continuously endeavor to update our systems and processes to improve the timeliness of our provider payments.

- Provider outreach and programs. Our health plans have adopted a physician-driven approach where network providers are actively engaged in developing and implementing healthcare delivery policies and strategies. We prepare provider comparisons on a severity adjusted basis. This approach is designed to eliminate unnecessary costs, improve services to members and simplify the administrative burdens placed on providers.

- Care management for complex populations. Through our experience with Medicaid populations and long-time presence in states with experience in long-term care for children and adolescents in the foster care system, we have developed care management, service coordination and crisis prevention/response programs that increase opportunities for successful outcomes for members. This experience has led to partnerships with specialized networks and community advocates as states transition to managed care programs for vulnerable and complex populations.

- Responsible collection and dissemination of utilization data. We gather utilization data from multiple sources, allowing for an integrated view of our members' utilization of services. These sources include medical, vision and behavioral health claims and encounter data, pharmacy data, dental vendor claims and authorization data from the authorization and case management system utilized by us to coordinate care.

- Timely and accurate reporting. Our information systems have reporting capabilities which have been instrumental in identifying the need for new and/or improved healthcare and specialty programs. For state agencies, our reporting capability is important in demonstrating an auditable program.

- Fraud, waste and abuse prevention. We have several systems in place to help identify, detect and investigate potential fraud, waste, and abuse, including pre and post payment review software. We collaborate with state and federal agencies and assist with investigation requests. We use nationally recognized standards to benchmark our processes.

Member Programs and Services

We recognize the importance of member-focused delivery of quality managed care services. Our locally-based staff assists members in accessing care, coordinating referrals to related health and social services and addressing member concerns and questions. While covered healthcare benefits vary from customer to customer and program to program, our health plans generally provide the following services:

- primary and specialty physician care
- inpatient and outpatient hospital care
- emergency and urgent care
- prenatal care
- laboratory and x-ray services
- home-based primary care
- transportation assistance
- vision care
- dental care
- telehealth services

- immunizations
- prescriptions and limited over-the-counter drugs
- specialty pharmacy
- provision of durable medical equipment
- behavioral health and substance abuse services
- 24-hour nurse advice line
- therapies
- social work services
- care coordination

We also provide a comprehensive set of education and outreach programs to inform, assist and incentivize members to access quality, appropriate healthcare services in an efficient manner. Many of these programs have been recognized with awards for their excellence in education, outreach and/or case management techniques. These awards include Case In Point, Hermes Awards, U.S. Environmental Protection Agency and National Health Information Awards.

- Start Smart For Your Baby, or Start Smart, is our award winning prenatal and infant health program designed to increase the percentage of pregnant women receiving early prenatal care, reduce the incidence of low-birth-weight and pre-term babies, identify high-risk pregnancies, increase participation in the federal Women, Infant and Children program, prevent hospital admissions in the first year of life and increase well-child visits.

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- Connections Plus is a cell phone program developed for high-risk members who have limited or no safe and reliable access to telephone. This program seeks to eliminate lack of safe, reliable access to a telephone as a barrier to coordinating care, thus reducing avoidable adverse events such as inappropriate emergency department utilization, hospital admissions and premature birth.

- MemberConnections is a community face-to-face outreach and education program designed to create a link between the member and the provider and help identify potential challenges or risk elements to a member's health, such as nutritional challenges and health education shortcomings.

- The ScriptAssist for Hepatitis C Adherence Program seeks to empower patients towards Hepatitis C virus treatment success through a series of telephonic interventions. Goals of the program include preventing premature treatment discontinuation due to medication side effects and access to therapy. Through its family of companies, Envolve clinicians and AcariaHealth patient care coordinators collaborate throughout a patient’s treatment course to ensure appropriate therapy management and regimen access.

- Health Initiatives for Children is aimed at educating child members on a variety of health topics. In order to empower and educate children, we have partnered with a nationally recognized children's author to develop our own children's book series on topics such as obesity prevention and healthy eating, asthma, diabetes, foster care, the ills of smoking, anti-bullying and heart health.

- Health Initiatives for Teens is aimed at empowering, educating and reinforcing life skills with our teenage members. We have developed an educational series that addresses health issues, dealing with chronic diseases including diabetes and asthma, as well as teen pregnancy.

- Living Well with Sickle Cell is our innovative program that assists with coordination of care for our sickle cell members. Our program ensures that sickle cell members have established a medical home and work on strategies to reduce unnecessary emergency department visits through proper treatment to control symptoms and chronic complications, as well as promote self-management.

- My Route for Health is our adult educational series used with our case management and disease management programs. The topics of this series include how to manage asthma, Chronic Obstructive Pulmonary Disease (COPD), diabetes, heart disease and HIV.

- The Diabetes Management Program is a robust holistic program designed to improve the quality of life for our members living with diabetes. The program employs advanced analytics to identify members and provide individualized diabetes-related education and health assessments, support with self-management, and assistance accessing care.

- On.Demand Diabetes is a diabetes management support product designed to eliminate diabetic supply waste while increasing compliance and improving health outcomes for members with diabetes. On.Demand provides cellular-enabled blood glucose meters and test strips to the testing diabetic population. On.Demand automatically monitors all member tests and provides an appropriate level of intervention in the event of dangerous glucose readings or member non-compliance. Additionally, On.Demand’s proprietary algorithm analyzes each member’s testing patterns and automatically replenishes testing supplies to ensure there are no gaps in the member’s ability to effectively monitor his or her condition.

- Community Health Record, our patient-centric electronic database, collects patient demographic data, clinician visit records, dispensed medications, vital sign history, lab results, allergy charts, and immunization data. Providers can

directly input additional or updated patient data and documentation into the database. All information is accessible anywhere, anytime to all authorized users, including health plan staff, greatly facilitating coordinated care among providers.

The CentAccount Program offers members financial incentives for performing certain healthy behaviors. The incentives are delivered through a restricted-use prepaid debit card. This incentive-based approach effectively increases the utilization of preventive services while strengthening the relationships between members and their primary care providers.

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- The Asthma Management Program integrates a hands-on approach with a flexible outreach methodology that can be customized to suit different age groups and populations affected by asthma. We provide proactive identification of members, stratification into appropriate levels of intervention including home visits, culturally sensitive education, and robust outcome reporting. The program also includes aggressive care coordination to ensure patients have basic services such as transportation to the doctor, electricity to power the nebulizer, and a clean, safe home environment.

- Fluvention is an outreach program aimed at educating members on preventing the transmission of the influenza virus by encouraging members to get the seasonal influenza vaccines and take everyday precautions to prevent illness.

- Preventive Care Programs are designed to educate our members on the benefits of Early and Periodic Screening, Diagnosis and Treatment, or EPSDT, services. We have a systematic program of communicating, tracking, outreach, reporting and follow-through that promotes state EPSDT programs.

- Readmission Reduction Program utilizes a proprietary scoring methodology to evaluate members' risks on preventable readmissions. Members with higher risk scores are identified at the point of admission to an acute care setting, then concurrently managed during the in-patient stay, and followed up with post discharge outreach to provide effective transition of care.

- Outcomes Improvement Central (OIC) is a highly collaborative initiative that empowers partners across the organization to develop evidence-based clinical programs to promote best practice information sharing, and to establish measurable outcomes for clinical studies. The OIC also serves as a repository of enterprise pilots and programs intended to improve the member's health outcomes.

- Promotores Health Network (PHN) is a volunteer-driven community health network designed to improve the community's health through health education specific to health conditions impacting their community and providing guidance and linkage to healthcare services and local resources. PHN provides face-to-face education to members where they live, shop, worship and congregate.

- myStrength ("The health club for your mind") is a web and mobile self-help resource to manage depression, anxiety, substance use, and chronic pain. myStrength empowers members to be active participants in their journey to becoming and staying mentally and physically healthy.

- OpiEnd is a clinical program designed to identify members at risk for an opioid abuse diagnosis based on a series of critical social and clinical indicators called the Opioid Risk Classification Algorithm (ORCA). Providers will leverage this risk score to flag members for case management and other appropriate interventions. High risk members identified by ORCA will receive educational outreach to provide evidenced-based resources to support pain addiction.

Providers

For each of our service areas, we establish a provider network consisting of primary and specialty care physicians, hospitals and ancillary providers. Our network of primary care physicians is a critical component in care delivery, management of costs and the attraction and retention of new members. Primary care physicians include family and general practitioners, pediatricians, internal medicine physicians and obstetricians and gynecologists. Specialty care physicians provide medical care to members generally upon referral by the primary care physicians. Specialty care physicians include, but are not limited to, orthopedic surgeons, cardiologists and otolaryngologists. We also provide education and outreach programs to inform and assist members in accessing quality, appropriate healthcare services.

Our health plans facilitate access to healthcare services for our members primarily through contracts with our providers. Our contracts with primary and specialty care physicians and hospitals usually are for one to three-year periods and renew automatically for successive one-year terms, but generally are subject to termination by either party upon prior written notice. In the absence of a contract, we typically pay providers at applicable state or federal reimbursement levels, depending on the product (e.g., Medicaid or Medicare). We pay providers under a variety of methods, including fee-for-service, capitation arrangements, and value-based arrangements.

- Under our fee-for-service contracts with providers, we pay a negotiated fee for covered services. This model is characterized as having no financial risk for the provider.

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- Under our capitated contracts, providers can be paid a set amount for their services as outlined in their respective provider agreements. A provider group's financial instability or failure to pay secondary providers for services rendered could lead secondary providers to demand payment from us, even though we have made our regular capitated payments to the provider group. Depending on state law and the regulatory environment, it may be necessary for us to pay such claims.

- Under value-based arrangements, providers are paid under a capitated or fee-for-service arrangement. The arrangement, however, contains provisions for additional payments to the providers or reimbursement from the providers based upon cost and quality measures.

In addition, we maintain a network of qualified physicians, facilities, and ancillary providers in the prime service areas of our TRICARE contract. Services are provided on a fee-for-service basis.

We often start our provider relationships with a pay-for-performance arrangement before we transition to a risk sharing arrangement, where we share total cost. As we advance along this continuum, it strengthens our partnerships with our providers enabling the delivery of high quality care.

We work with physicians to help them operate efficiently by providing financial and utilization information, physician and patient educational programs and disease and medical management programs. Our programs are also designed to help the physicians coordinate care rendered by other providers.

We believe our local and collaborative approach with physicians and other providers gives us a competitive advantage in entering new markets. Our physicians serve on local committees that assist us in implementing preventive care programs, managing costs and improving the overall quality of care delivered to our members, while also simplifying the administrative burdens on our providers. This approach has enabled us to strengthen our provider networks through improved physician recruitment and retention that, in turn, have helped to increase our membership base. The following are among the services we provide to support physicians:

- Provider Engagement Performance Tools and Processes lead to measurable improvements in quality and health outcomes, healthcare costs, and member satisfaction. High quality and performance levels are important as our key customers are increasingly using performance-based measures to select and pay health plans. We have rolled out a suite of network performance tools for use by physicians and other providers which monitor the outcomes and care gaps of their individual patient panel. Our specialists meet with the providers to review their performance issues and recommend strategies for improvements in their patient panel outcomes. Our tools also allow the physician and others to see where they stand within their value-based contract.

- Integrated Care Model is member-centric and managed by one care manager assigned to a member who looks at the total care for the member in a holistic manner. This single care manager will coordinate all care for that member including behavioral health, medical health, and home-based primary care in accordance with an individualized, integrated care plan. This care manager also coordinates meetings with the member's integrated care team to assess and alter the care plan as needed. This results in better outcomes and improvement in member satisfaction.

- Provider Portal provides claims and eligibility research, prior authorizations, member panels, care gaps, patient analytics, and provider analytics meant to drive provider engagement and better patient outcomes. Performance is supplied via a secure, user-friendly web-based provider portal. This is all provided through our suite of proprietary technology and abilities, including Interpreta and Casenet.

Our contracted physicians also benefit from several of the services offered to our members, including the MemberConnections, EPSDT case management and health management programs. For example, the MemberConnections staff facilitates doctor/patient relationships by connecting members with physicians, the EPSDT programs encourage routine checkups for children with their physicians and the health management programs assist physicians in managing their patients with chronic disease.

Where appropriate, our health plans contract with our specialty services organizations to provide services and programs such as care management software, dental benefits management, home-based primary care services, life and health management, managed vision, pharmacy benefits management, specialty pharmacy and telehealth services. When necessary, we also contract with third-party providers on a negotiated fee arrangement for physical therapy, home healthcare, diagnostic laboratory tests, x-ray examinations, transportation, ambulance services and durable medical equipment.

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Quality Management

Our medical management programs focus on improving quality of care in areas that have the greatest impact on our members. We employ strategies, including health management and complex case management, which are adjusted for implementation in our individual markets by a system of physician committees chaired by local physician leaders. This process promotes physician participation and support, both critical factors in the success of any clinical quality improvement program.

We have implemented specialized information systems to support our medical quality management activities. Information is drawn from our data warehouse, clinical databases and our membership and claims processing system to identify opportunities to improve care and to track the outcomes of the interventions implemented to achieve those improvements. Some examples of these programs include:

- use of nationally recognized InterQual or Milliman criteria to help ensure our members receive the right level of care in the most appropriate setting;
- pre-authorized high-risk medication and services that are commonly over or inappropriately prescribed;
- member education and the provision of appropriate and easily accessed urgent care services to help members avoid unnecessary and costly emergency department visits and improve their healthcare experience;
- emphasis on care management and care coordination where clinicians, such as nurses and social workers who are employed to assist high-risk and other selected members with the coordination of healthcare services that meet their specific needs;
- disease management for chronic illnesses, such as asthma and diabetes through a comprehensive, multidisciplinary and collaborative approach;
- prenatal case management for women with high-risk pregnancies to help them deliver full-term, healthy infants; and
- pharmacy treatment compliance programs driven by evidence-based clinical policies and focused on identifying the appropriate medication in the correct dose, delivered in an efficient format and utilized for the correct duration.

We provide reporting on a regular basis using our data warehouse. State and Health Employer Data and Information Set (HEDIS) reporting constitutes the core of the information base that drives our clinical quality performance efforts. This reporting is monitored by Plan Quality Improvement Committees and our corporate medical management and quality improvement teams.

In an effort to ensure the quality of our provider networks, we verify the credentials and background of our providers using standards that are supported by the NCQA.

It is our objective to provide access to the highest quality of care for our members. As a validation of that objective, we pursue accreditation by independent organizations that have been established to promote healthcare quality. The NCQA Health Plan Accreditation and URAC Health Plan Accreditation programs provide unbiased, third party reviews to verify and publicly report results on specific quality care metrics. While we have achieved or are pursuing accreditation for all of our plans, accreditation is only one measure of our ability to provide access to quality care for our members. We have received NCQA health plan accreditation in 21 of 23 eligible states and are pursing

accreditation in the remaining two states.

CMS developed the Medicare Advantage Star ratings system to help consumers choose among competing plans, awarding between 1.0 and 5.0 stars to Medicare Advantage plans based on performance in certain measures of quality. For the 2019 Star rating (calculated in 2018 for the quality bonus payment in 2020), our California contracts, Oregon HMO, and Oregon PPO contracts received 4.0 out of 5.0 Stars. The Texas D-SNP, Florida D-SNP, Wisconsin D-SNP, and Arizona D-SNP contracts were measured at 3.5 Stars, and our Arizona HMO and Oregon Trillium HMO contracts received 3.0 Stars. In addition, for the 2019 Star rating, we carry a 4.0 Star parent organization rating.

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SPECIALTY SERVICES

Our specialty services are a key component of our healthcare strategy and complement our core Managed Care business. Our provision of specialty services diversifies our revenue stream, enhances the quality of health outcomes for our members and others, and allows Centene to manage costs. Our Envolve brand brings together our extensive portfolio of specialty healthcare solutions. Envolve leverages our collective expertise in pharmacy solutions; health, triage, wellness and disease management; vision and dental services; and management services, to provide integrated and comprehensive healthcare for members and other organizations. Our specialty services are provided primarily as follows:

- Pharmacy Solutions. Envolve Pharmacy Solutions utilizes innovative, flexible solutions and customized care management. We offer traditional pharmacy benefits management as well as comprehensive specialized pharmacy benefit services through our specialty pharmacy, AcariaHealth. Our traditional pharmacy benefits management program offers progressive pharmacy benefits management services that are specifically designed to improve quality of care while containing costs. This is achieved through a low cost strategy that helps optimize clients' pharmacy benefits. Services that we provide include claims processing, pharmacy network management, benefit design consultation, drug utilization review, formulary and rebate management, online drug management tools, mail order pharmacy services, home delivery services, analytics and clinical consulting and patient and physician intervention. AcariaHealth offers specialized care management services for complex diseases and enhances the patient care offering through collaboration with providers and the capture of relevant data to measure patient outcomes.

- Health, Triage, Wellness, and Disease Management Services. Envolve PeopleCare brings together our nurse advice, telehealth, and health, wellness and disease guidance programs, allowing for a focus on individual health management through education and empowerment. Our life and health management programs specialize to encourage healthy behaviors, promote healthier workplaces, improve workforce and societal productivity and reduce healthcare costs. We offer telehealth services where members engage with customer service representatives and nursing staff who provide health education and triage advice and offer continuous access to health plan functions. Our staff can arrange for urgent pharmacy refills, transportation and qualified behavioral health professionals for crisis stabilization assessments.

- Vision and Dental Services. Envolve Benefit Options coordinates benefits beyond traditional medical benefits to offer fully integrated vision and dental health services. Our vision benefit program administers routine and medical surgical eye care benefits through a contracted national network of eye care providers. Through the dental benefit, we are dedicated to improving oral health through a contracted network of dental healthcare providers.

- Care Management Software. Casenet is a provider of innovative population health and care management solutions that automate the clinical, administrative and technical components of care management programs, which are used by our health plans and available for sale to third parties.

- Correctional Healthcare Services. Centurion provides comprehensive healthcare services to individuals incarcerated in state correctional facilities and detainees in detention facilities in various states. Centurion also provides staffing services to correctional systems and other government agencies.

- Home-based Primary Care. U.S. Medical Management (USMM) provides home-based primary care services for high acuity populations and participates as an Accountable Care Organization (ACO) through the CMS Medicare Shared Savings Program.

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Management Services. Envolve provides comprehensive management services for managed care organizations and partners with organizations to offer coordinated healthcare services and programs to their members. Envolve management services provide organizations with the strategies, people and processes necessary to provide value-based, affordable care and drive healthcare transformation.

Federal Services. Health Net Federal Services (HNFS) has a Managed Support Contract in the West Region for the DoD TRICARE program. We provide administrative services to Military Health System eligible beneficiaries, which includes eligible active duty service members and their families, retired service members and their families, survivors of retired service members and qualified former spouses. Additionally, our wholly owned subsidiary, MHN Government Services, is party to a MFLC contract that was awarded by the DoD to implement, administer and monitor the non-medical counseling MFLC program.

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- Community Medical Group (CMG). CMG provides clinical healthcare encompassing primary care, access to certain specialty services, and a suite of social and other support services from its medical centers and offices in south Florida through an at-risk primary care provider model through its providers in Florida, focusing on clinical and social care to at-risk beneficiaries.

- Interpreta, Inc. Interpreta uses its analytics engine to provide real-time insights to providers, care managers, and payers in the areas of member prioritization, quality management, and risk adjustment. Interpreta's solutions are used by our health plans and available for sale to third parties.

We currently have NCQA accreditation and URAC accreditation for several of our specialty companies.

CORPORATE COMPLIANCE

Our Ethics and Compliance program assists the organization in developing effective internal controls that promote prevention and detection of fraud, waste and abuse and resolution of instances of conduct that do not conform to federal and state law and private payor healthcare program requirements, as well as our own ethics and business policies. Responsibilities also include the ongoing maintenance of our privacy program and oversight of the Health Insurance Portability and Accountability Act (HIPAA) as they pertain to us and our business units from a compliance, business, and technical perspective.

Three standards by which corporate compliance programs in the healthcare industry are measured are the Federal Organizational Sentencing Guidelines, the CMS Chapter Guidance and the Compliance Program Guidance series issued by the Department of Health and Human Services' Office of the Inspector General (OIG). Our program contains each of the seven elements suggested by these authorities. These key components are:

- written standards of conduct;
- designation of compliance officers and compliance committees;
- effective training and education;
- effective lines for reporting and communication;
- enforcement of standards through well-publicized disciplinary guidelines and actions;
- internal monitoring and auditing; and
- prompt response to detected offenses and development of corrective action plans.

The goal of our program is to build a culture of ethics and compliance, which is assessed periodically to measure the values and engagement of the organization. Our Corporate Compliance intranet site, accessible to all employees, contains our Business Ethics and Code of Conduct, Compliance Program description and resources for employees to report concerns or ask questions. If needed, employees have access to the contact information for our Board of Directors' Audit Committee Chairman to report concerns. Our Ethics and Compliance Helpline is a toll-free number and web-based reporting tool operated by a third party independent of the Company and allows employees or other persons to report suspected incidents of misconduct, fraud, waste, abuse or other compliance violations anonymously. Furthermore, our Board of Directors has established a Corporate Compliance Committee that, among other things, reviews ethics and compliance reports on a quarterly basis.

COMPETITION

We operate in a highly competitive environment in an industry subject to ongoing significant changes, including business consolidations, new strategic alliances, market pressures, and regulatory and legislative reform both at the federal and state level. This is including but not limited to the federal and state healthcare reform legislation described

under the heading "Regulation." In addition, changes to the political environment may drive additional changes to the competitive landscape.

In our business, our principal competitors for customers, members, and providers consist of the following types of organizations:

- Medicaid Managed Care Organizations that focus on providing healthcare services to Medicaid recipients. These organizations consist of national and regional organizations, as well as not-for-profits and organizations that operate in a small geographic location and are owned by providers, primarily hospitals.

- National and Regional Commercial Managed Care Organizations that have Medicaid and Medicare members in addition to members in private commercial plans. Some of these organizations offer a range of specialty services including pharmacy benefits management, behavioral health management, health management, and nurse triage call support centers.

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- Primary Care Case Management Programs that are established by the states through contracts with primary care providers. Under these programs, physicians provide primary care services to Medicaid recipients, as well as limited medical management oversight.

- Accountable Care Organizations that consist of groups of doctors, hospitals, and other healthcare providers, who come together to provide coordinated high quality care to their patients.

We compete with other Managed Care Organizations and specialty companies for state, county, federal, and commercial contracts. In addition, the impact of the ACA and potential growth in our segment may attract new competitors including technology companies, new joint ventures, financial services firms, consulting firms and other non-traditional competitors. Before granting a contract, state and federal government agencies consider many competitive factors. These factors include quality of care, financial condition, stability and resources, and established or scalable infrastructure with a demonstrated ability to deliver services and establish comprehensive provider networks. Our specialty companies compete with other providers, such as disease management companies, individual health insurance companies, and pharmacy benefits managers for non-governmental contracts.

We also compete to enroll new members and retain existing members. People who wish to enroll in a managed healthcare plan or to change healthcare plans typically choose a plan based on the quality of care and services offered, ease of access to services, a specific provider being part of the network and the availability of supplemental benefits. We believe that the principal competitive features affecting our ability to retain and increase membership include the range and prices of benefit plans offered, size and quality of provider network, quality of service, responsiveness to customer demands, financial stability, comprehensiveness of coverage, diversity of product offerings, market presence and reputation. The relative importance of each of these factors and the identity of our key competitors varies by market and product. We believe that we compete effectively against other healthcare industry participants.

We also compete with other managed care organizations in establishing provider networks. When contracting with various health plans, we believe that providers consider existing and potential member volume, reimbursement rates, medical management programs, speed of reimbursement and administrative service capabilities. See “Risk Factors - Competition may limit our ability to increase penetration of the markets that we serve.”

The relative importance of each of the aforementioned competitive factors and the identity of our key competitors varies by market, including by geography and by product.

REGULATION

Our operations are comprehensively regulated at local, state, and federal levels. Government regulation of the provision of healthcare products and services is a changing area of law that varies from jurisdiction to jurisdiction. States have implemented National Association of Insurance Commissioners (NAIC) model regulations, requiring governance practices and risk and solvency assessment reporting. States have adopted these or similar measures to enhance regulations relating to corporate governance and internal controls of HMOs and insurance companies. We are required to maintain a risk management framework and file reports with state insurance regulators.

Regulatory agencies generally have substantial discretion to issue regulations and interpret and enforce laws and rules. Changes in the regulatory environment and applicable laws and rules also may occur periodically, including in connection with changes in political party or administration at the state and federal or national levels. For example, the current administration and certain members of Congress have indicated that they may continue to pursue significant amendments to the ACA. Even if the ACA is not amended or repealed, the current administration could propose

changes impacting implementation of the ACA. The ultimate content and timing of any legislation enacted under the current administration that would affect the ACA remains uncertain. Most recently, a December 2018 partial summary judgment ruling in Texas v. United States of America held that the ACA's individual mandate requirement was essential to the ACA, and without it, the remainder of the ACA was invalid. This ruling is being appealed and the ACA remains in effect until the appeal is concluded. The ultimate content, timing or effect of any potential future legislation enacted under the current administration remains uncertain.

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The ACA transformed the U.S. healthcare system through a series of complex initiatives. Some of the ACA's most significant provisions include the imposition of significant fees, assessments and taxes, including the non-deductible tax (technically called a "fee") on health insurers based on prior year net premiums written (the "health insurer fee" or "HIF"); the establishment of federally-facilitated and state-based Health Insurance Marketplaces where individuals and small groups may purchase health coverage; the implementation of certain premium stabilization programs designed to apportion risk amongst insurers; and the optional Medicaid Expansion. State and federal regulators have continued to provide additional guidance and specificity to the ACA, and we continue to monitor this new information and evaluate its potential impact on our business. For a further discussion of the implementation of the ACA, as well as the potential repeal of, or changes to, the ACA, see “Risk Factors - The implementation of Health Reform Legislation, as well as potential repeal of or changes to Health Reform Legislation, could materially and adversely affect our results of operations, financial position and cash flows” below.

Our regulated subsidiaries are licensed to operate as health maintenance organizations (HMOs), preferred provider organizations (PPOs), third party administrators, utilization review organizations, pharmacies, direct care providers and/or insurance companies in their respective states. In each of the jurisdictions in which we operate, we are regulated by the relevant insurance, health and/or human services departments, departments of insurance, boards of pharmacy and other healthcare providers, and departments of health that oversee the activities of managed care organizations and health plans providing or arranging to provide services to enrollees.

The process for obtaining authorization to operate as a managed care organization, health insurance plan, pharmacy or provider organization is complex and requires us to demonstrate to the regulators the adequacy of the health plan's organizational structure, financial resources, utilization review, quality assurance programs, proper billing, complaint procedures, and an adequate provider network and procedures for covering emergency medical conditions. For example, under both state managed care organization statutes and insurance laws, our health plan subsidiaries, as well as our applicable specialty companies, must comply with minimum statutory capital and other financial solvency requirements, such as deposit and surplus requirements. Insurance regulations may also require prior state approval of acquisitions of other managed care organization businesses and the payment of dividends, as well as notice for loans or the transfer of funds. Our subsidiaries are also subject to periodic state and federal reporting requirements. In addition, each health plan and individual healthcare provider must meet criteria to secure the approval of state regulatory authorities before implementing certain operational changes, including without limitation changes to existing offerings, the development of new product offerings, certain organizational restructurings and, in some states, the expansion of service areas.

States have adopted a number of regulations that may affect our business and results of operations. These regulations in certain states include:

- premium taxes or similar assessments imposed on us;
- stringent prompt payment laws requiring us to pay claims within a specified period of time;
- disclosure requirements regarding provider fee schedules and coding procedures; and
- programs to monitor and supervise the activities and financial solvency of provider groups.

Federal law has also implemented other health programs that are partially funded by the federal government, such as the Medicaid program. Our Medicaid programs are regulated and administered by various state regulatory bodies. Federal funding remains critical to the viability of these programs. Federal law permits the federal government to oversee and, in some cases, to enact, regulations and other requirements that must be followed by states with respect to these programs. Medicaid is administered at the federal level by CMS. Comprehensive legislation, specifically Title XVIII of the Social Security Act, governs our Medicare program. In addition, our Medicare contracts are subject to regulation by CMS. CMS has the right to audit Medicare contractors and the healthcare providers and administrative

contractors who provide certain services on their behalf to determine the quality of care being rendered and the degree of compliance with CMS contracts and regulations.

We are regulated as an insurance holding company and are subject to the insurance holding company acts of the states in which our insurance company and HMO subsidiaries are domiciled. These acts contain certain reporting requirements as well as restrictions on transactions between an insurer or HMO and its affiliates. These holding company laws and regulations generally require insurance companies and HMOs within an insurance holding company system to register with the insurance department of each state where they are domiciled and to file with those states' insurance departments reports describing capital structure, ownership, financial condition, intercompany transactions and general business operations. In addition, depending on the size and nature of the transaction, there are various notice and reporting requirements that generally apply to transactions between insurance companies and HMOs and their affiliates within an insurance holding company structure. Some insurance holding company laws and regulations require prior regulatory approval or, in certain circumstances, prior notice of certain material intercompany transfers of assets as well as certain transactions between insurance companies, HMOs, their parent holding companies and affiliates. Among other provisions, state insurance and HMO laws may restrict the ability of our regulated subsidiaries to pay dividends.

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Additionally, the holding company regulations of the states in which our subsidiaries are domiciled restrict the ability of any person to obtain control of an insurance company or HMO without prior regulatory approval. Under those statutes, without such approval or an exemption, no person may acquire any voting security of an insurance holding company, which controls an insurance company or HMO, or merge with such a holding company, if as a result of such transaction such person would "control" the insurance holding company. "Control" is generally defined as the direct or indirect power to direct or cause the direction of the management and policies of a company and is presumed to exist if a person directly or indirectly owns or controls 10% or more of the voting securities of a company.

PPO regulation also varies by state and covers all or most of the subject area referred to above.

Our pharmacies must be licensed to do business as pharmacies in the states in which they are located. Our pharmacies must also register with the U.S. Drug Enforcement Administration and individual state controlled substance authorities to dispense controlled substances. In many of the states where our pharmacies deliver pharmaceuticals, there are laws and regulations that require out-of-state mail order pharmacies to register with that state's board of pharmacy or similar regulatory body. These states generally permit the pharmacy to follow the laws of the state in which the mail order pharmacy is located, although some states require that we also comply with certain laws in that state.

Our healthcare providers must be licensed to practice medicine and do business as care providers in the state in which they are located. In addition, they must be in good standing with the applicable medical board, board of nursing or other applicable entity. Furthermore, they cannot be excluded from participation at either the state or federal levels. Our facilities are periodically reviewed by state departments of health and other regulatory agencies to ensure the environment is safe to provide care.

We must also comply with laws and regulations related to the award, administration and performance of U.S. Government contracts. Government contract laws and regulations affect how we do business with our customers and, in some instances, impose added costs on our business. Money laundering is a method of attempting to conceal the origins of money gained through illegal activity and is itself a crime that can result in substantial criminal and civil sanctions including fines and imprisonment. To ensure compliance with anti-money laundering laws and regulations, it is our policy to conduct business only with legitimate customers and counterparties whose funds are derived from legitimate commercial activity. In addition, as a result of our international operations, we are also subject to the U.S. Foreign Corrupt Practices Act (FCPA) and similar worldwide anti-corruption laws, including the U.K. Bribery Act of 2010, which generally prohibit companies and their intermediaries from making improper payments to non-U.S. officials for the purpose of obtaining or retaining business. A violation of specific laws and regulations by us and/or our agents could result in, among other things, the imposition of fines and penalties on us, changes to our business practices, the termination of our contracts or debarment from bidding on contracts.

State and Federal Contracts

In addition to being a licensed insurance company or HMO, in order to be a Medicaid managed care organization in each of the states in which we operate, we generally must operate under a contract with the state's Medicaid agency. States generally either use a formal proposal process, reviewing a number of bidders, or award individual contracts to qualified applicants that apply for entry to the program. Under these state Medicaid program contracts, we receive monthly payments based on specified capitation rates determined on an actuarial basis. These rates differ by membership category and by state depending on the specific benefits and policies adopted by each state. In addition, several of our Medicaid contracts require us to maintain Medicare Advantage special needs plans, which are regulated by CMS, for dual eligible individuals within the state. We also contract with states to provide healthcare services to

correctional facilities.

We provide Medicare Advantage, Dual Eligible Special Needs Plans (D-SNPs), and Medicare-Medicaid Plans (MMP) which are provided under contracts with CMS and subject to federal regulation regarding the award, administration and performance of such contracts. CMS also has the right to audit our performance to determine our compliance with these contracts, as well as other CMS regulations and the quality of care we provide to Medicare beneficiaries under these contracts. We additionally provide behavioral and other healthcare services to correctional systems under contracts in certain states which are also subject to state regulation.

Our government contracts include government-sponsored managed care and administrative services contracts through the TRICARE program, the Department of Defense Military and Family Life Counseling program, and certain other healthcare-related government contracts.

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Our state and federal contracts and the regulatory provisions applicable to us generally set forth the requirements for operating in the Medicaid and Medicare sectors, including provisions relating to:

- eligibility, enrollment and dis-enrollment processes
- covered services
- eligible providers
- subcontractors
- record-keeping and record retention
- periodic financial and informational reporting
- quality assurance
- accreditation

- health education and wellness and prevention programs
- timeliness of claims payment
- financial standards
- safeguarding of member information
- fraud, waste and abuse detection and reporting
- grievance procedures
- organization and administrative systems

A health plan or individual health insurance provider's compliance with these requirements is subject to monitoring by state regulators and by CMS. A health plan is also subject to periodic comprehensive quality assurance evaluations by a third-party reviewing organization and generally by the insurance department of the jurisdiction that licenses the health plan. A health plan or individual health insurance provider must also submit reports to various regulatory agencies, including quarterly and annual statutory financial statements and utilization reports.

Our health plans operate through individual state contracts, generally with an initial term of one to five years. The contracts often have renewal or extension terms or are renewable through the state's reprocurement process. The contracts generally are subject to termination for cause, an event of default or lack of funding, among other things.

Marketplace Contracts

We operate in 20 states under federally-facilitated and state-based marketplace contracts with CMS that expire annually. This includes marketplace contracts that commenced in 2019 in Pennsylvania, North Carolina, South Carolina, and Tennessee.

We operate under a contract with the Arkansas Department of Human Services Division of Medical Services and the Arkansas Insurance Department to participate in the Medicaid expansion model that Arkansas has adopted (referred to as "Arkansas Works").

Privacy Regulations

We are subject to various international, federal, state and local laws and rules regarding the use, security and disclosure of protected health information, personal information, and other categories of confidential or legally protected data that our businesses handle. Such laws and rules include, without limitation, the Health Insurance Portability and Accountability Act (HIPAA), the Federal Trade Commission Act, the Gramm-Leach-Bliley Financial

Modernization Act of 1999 (Gramm-Leach-Bliley Act), state privacy and security laws such as the California Confidentiality of Medical Information Act and the California Online Privacy Protection Act. Privacy and security laws and regulations often change due to new or amended legislation, regulations or administrative interpretation. A variety of state and federal regulators enforce these laws, including but not limited to the U.S. Department of Health and Human Services (HHS), the Federal Trade Commission, state attorneys general and other state regulators.

HIPAA is designed to improve the portability and continuity of health insurance coverage, simplify the administration of health insurance through standard transactions and ensure the privacy and security of individual health information. Among the requirements of HIPAA are the Administrative Simplification provisions which include: standards for processing health insurance claims and related transactions (Transactions Standards); requirements for protecting the privacy and limiting the use and disclosure of medical records and other personal health information (Privacy Rule); and standards and specifications for safeguarding personal health information which is maintained, stored or transmitted in electronic format (Security Rule). The Health Information Technology for Economic and Clinical Health (HITECH) Act amended certain provisions of HIPAA and enhanced data security obligations for covered entities and their business associates. HITECH also mandated individual notifications in instances of a data breach, provided enhanced penalties for HIPAA violations, and granted enforcement authority to states' Attorneys Generals in addition to the HHS Office for Civil Rights. The HIPAA Omnibus Rule further enhanced the changes under the HITECH Acts and the Genetic Information Nondiscrimination Act of 2008 (GINA) which clarified that genetic information is protected under HIPAA and prohibits most health plans from using or disclosing genetic information for underwriting purposes. This Omnibus rule enhances the privacy protections and strengthens the government's ability to enforce the law. These regulations also establish significant criminal penalties and civil sanctions for non-compliance. The preemption provisions of HIPAA provide that the federal standards will not preempt state laws that are more stringent than the related federal requirements.

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The Privacy and Security Rules and HITECH/Omnibus enhancements established requirements to protect the privacy of medical records and safeguard personal health information maintained and used by healthcare providers, health plans, healthcare clearinghouses, and their business associates.

The Security Rule requires healthcare providers, health plans, healthcare clearinghouses, and their business associates to implement administrative, physical and technical safeguards to ensure the privacy and confidentiality of health information electronically stored, maintained or transmitted. The HITECH Act and Omnibus Rule enhanced a federal requirement for notification when the security of protected health information is breached. In addition, there are state laws that have been adopted to provide for, among other things, private rights of action for breaches of data security and mandatory notification to persons whose identifiable information is obtained without authorization.

The requirements of the Transactions Standards apply to certain healthcare related transactions conducted using "electronic media." Since "electronic media" is defined broadly to include "transmissions that are physically moved from one location to another using portable data, magnetic tape, disk or compact disk media," many communications are considered to be electronically transmitted. Under HIPAA, health plans and providers are required to have the capacity to accept and send all covered transactions in a standardized electronic format. Penalties can be imposed for failure to comply with these requirements. The transaction standards were modified on October 1, 2015 with the implementation of the ICD-10 coding system.

In addition, we process and maintain personal card data, particularly in connection with our Marketplace business. As a result, we must maintain compliance with the Payment Card Industry (PCI) Data Security Standard, which is a multifaceted security standard intended to optimize the security of credit, debit and cash card transactions and protect cardholders against misuse of their personal information.

Other Fraud, Waste and Abuse Laws

Investigating and prosecuting healthcare fraud, waste and abuse continues to be a top priority for state and federal law enforcement entities. The focus of these efforts has been directed at Medicare, Medicaid, Health Insurance Marketplace and commercial products. The fraud, waste and abuse laws include the federal False Claims Act, which prohibits the known filing of a false claim or the known use of false statements to obtain payment from the federal government. Many states have false claim act statutes that closely resemble the federal False Claims Act. The laws and regulations relating to fraud, waste and abuse and the requirements applicable to health plans and providers participating in these programs are complex and change regularly. Compliance with these laws may require substantial resources. We are constantly looking for ways to improve our fraud, waste and abuse detection methods. While we have both prospective and retrospective processes to identify abusive patterns and fraudulent billing, we continue to increase our capabilities to proactively detect inappropriate billing prior to payment.

EMPLOYEES

As of December 31, 2018, we had approximately 47,300 employees. We believe our relationships with our employees are positive.

EXECUTIVE OFFICERS OF THE REGISTRANT

The following table sets forth information regarding our executive officers, including their ages, at February 16, 2019:

Name	Age	Position
Michael F. Neidorff	76	Chairman and Chief Executive Officer

Christopher D. Bowers	63	Executive Vice President, Markets
Mark J. Brooks	49	Executive Vice President and Chief Information Officer
Brandy Burkhalter	46	Executive Vice President, Operations
Jesse N. Hunter	43	Executive Vice President and Chief Strategy Officer
Christopher R. Isaak	52	Senior Vice President, Corporate Controller and Chief Accounting Officer
Jeffrey A. Schwaneke	43	Executive Vice President, Chief Financial Officer and Treasurer
Keith H. Williamson	66	Executive Vice President, General Counsel and Secretary

Michael F. Neidorff. Mr. Neidorff has served as our Chairman and Chief Executive Officer since November 2017. From May 2004 to November 2017, he served as Chairman, President and Chief Executive Officer. From May 1996 to May 2004, he served as President, Chief Executive Officer and as a member of our Board of Directors.

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Christopher D. Bowers. Mr. Bowers has served as our Executive Vice President of Markets since November 2016. From March 2007 to November 2016, he served as our Senior Vice President of Health Plans.

Mark J. Brooks. Mr. Brooks has served as our Executive Vice President and Chief Information Officer since November 2017. From April 2016 to November 2017, he served as Senior Vice President and Chief Information Officer. Prior to joining Centene, he served as the Chief Information Officer at Health Net from 2012 to 2016.

Brandy Burkhalter. Ms. Burkhalter has served as our Executive Vice President, Operations since June 2018. From December 2015 to June 2018, she served as Executive Vice President, Internal Audit & Risk Management. From April 2012 to December 2015, she served as Senior Vice President, Internal Audit.

Jesse N. Hunter. Mr. Hunter has served as our Executive Vice President and Chief Strategy Officer since November 2017. From January 2016 to November 2017, he served as Executive Vice President, Products. From December 2012 to January 2016, he served as Executive Vice President, Chief Business Development Officer. From February 2012 to December 2012, he served as our Executive Vice President, Operations.

Christopher R. Isaak. Mr. Isaak has served as our Senior Vice President, Corporate Controller and Chief Accounting Officer since April 2016. Prior to joining Centene, he served as Vice President, Corporate Controller at TTM Technologies from 2015 to 2016 and Vice President, Corporate Controller at Viasystems Group, Inc. from 2006 to 2015 and served as Chief Accounting Officer from 2010 to 2015.

Jeffrey A. Schwaneke. Mr. Schwaneke has served as our Executive Vice President, Chief Financial Officer and Treasurer since March 2016. From July 2008 to March 2016, he served as our Senior Vice President, Corporate Controller and served as our Chief Accounting Officer from September 2008 to March 2016.

Keith H. Williamson. Mr. Williamson has served as our Executive Vice President, General Counsel and Secretary since November 2012.

Available Information

We are subject to the reporting and information requirements of the Securities Exchange Act of 1934, as amended (Exchange Act) and, as a result, we file periodic reports and other information with the Securities and Exchange Commission, or SEC. We make these filings available on our website free of charge, the URL of which is http://www.centene.com, as soon as reasonably practicable after we electronically file such material with, or furnish it to, the SEC. The SEC maintains a website (http://www.sec.gov) that contains our annual, quarterly and current reports and other information we file electronically with the SEC. Information on our website does not constitute part of this Annual Report on Form 10-K.

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ITEM 1A. Risk Factors.

FACTORS THAT MAY AFFECT FUTURE RESULTS AND THE
TRADING PRICE OF OUR COMMON STOCK

You should carefully consider the risks described below before making an investment decision. The trading price of our common stock could decline due to any of these risks, in which case you could lose all or part of your investment. You should also refer to the other information in this filing, including our consolidated financial statements and related notes. The risks and uncertainties described below are those that we currently believe may materially affect our Company. Additional risks and uncertainties that we are unaware of or that we currently deem immaterial also may become important factors that affect our Company.

Reductions in funding, changes to eligibility requirements for government sponsored healthcare programs in which we participate and any inability on our part to effectively adapt to changes to these programs could substantially affect our financial position, results of operations and cash flows.

The majority of our revenues come from government subsidized healthcare programs including Medicaid, Medicare, TRICARE, CHIP, LTSS, ABD, Foster Care and Health Insurance Marketplace premiums. Under most programs, the base premium rate paid for each program differs, depending on a combination of factors such as defined upper payment limits, a member's health status, age, gender, county or region and benefit mix. Since Medicaid was created in 1965, the federal government and the states have shared the costs for this program, with the federal share currently averaging around 59%. We are therefore exposed to risks associated with U.S. and state government contracting or participating in programs involving a government payor, including but not limited to the general ability of the federal and/or state governments to terminate contracts with it, in whole or in part, without prior notice, for convenience or for default based on performance; potential regulatory or legislative action that may materially modify amounts owed; and our dependence upon Congressional or legislative appropriation and allotment of funds and the impact that delays in government payments could have on our operating cash flow and liquidity. For example, future levels of funding and premium rates may be affected by continuing government efforts to contain healthcare costs and may further be affected by state and federal budgetary constraints. Governments periodically consider reducing or reallocating the amount of money they spend for Medicaid, Medicare, TRICARE, VA, CHIP, LTSS, ABD and Foster Care. Furthermore, Medicare remains subject to the automatic spending reductions imposed by the Budget Control Act of 2011 and the American Taxpayer Relief Act of 2012 ("sequestration"), subject to a 2% cap, which was extended by the Bipartisan Budget Act of 2018 for an additional two years through 2027. In addition, reductions in defense spending could have an adverse impact on certain government programs in which we currently participate by, among other things, terminating or materially changing such programs, or by decreasing or delaying payments made under such programs. Adverse economic conditions may continue to put pressures on state budgets as tax and other state revenues decrease while the population that is eligible to participate in these programs remains steady or increases, creating more need for funding. We anticipate this will require government agencies to find funding alternatives, which may result in reductions in funding for programs, contraction of covered benefits, and limited or no premium rate increases or premium rate decreases. A reduction (or less than expected increase), a protracted delay, or a change in allocation methodology in government funding for these programs, as well as termination of the contract for the convenience of the government, may materially and adversely affect our results of operations, financial position and cash flows. In addition, if a federal government shutdown were to occur for a prolonged period of time, federal government payment obligations, including its obligations under Medicaid, Medicare, TRICARE, VA, CHIP, LTSS, ABD, Foster Care and the Health Insurance Marketplaces, may be delayed. Similarly, if state government shutdowns were to occur, state payment obligations may be delayed. If the federal or state governments fail to make payments under these programs

on a timely basis, our business could suffer, and our financial position, results of operations or cash flows may be materially affected.

Payments from government payors may be delayed in the future, which, if extended for any significant period of time, could have a material adverse effect on our results of operations, financial position, cash flows or liquidity. In addition, delays in obtaining, or failure to obtain or maintain, governmental approvals, or moratoria imposed by regulatory authorities, could adversely affect our revenues or membership, increase costs or adversely affect our ability to bring new products to market as forecasted. Other changes to our government programs could affect our willingness or ability to participate in any of these programs or otherwise have a material adverse effect on our business, financial condition or results of operations.

Finally, changes in these programs could reduce the number of persons enrolled in or eligible for these programs or increase our administrative or healthcare costs under these programs. For example, maintaining current eligibility levels could cause states to reduce reimbursement or reduce benefits in order for states to afford to maintain eligibility levels. If any state in which we operate were to decrease premiums paid to us or pay us less than the amount necessary to keep pace with our cost trends, it could have a material adverse effect on our results of operations, financial position and cash flows.

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Our Medicare programs are subject to a variety of risks that could adversely impact our financial results.

If we fail to design and maintain programs that are attractive to Medicare participants; if our Medicare operations are subject to negative outcomes from program audits, sanctions or penalties; if we do not submit adequate bids in our existing markets or any expansion markets; if our existing contracts are terminated; or if we fail to maintain or improve our quality Star ratings, our current Medicare business and our ability to expand our Medicare operations could be materially and adversely affected, negatively impacting our financial performance. For example, our parent Star rating for the 2018 rating year was 3.5, which will negatively affect quality bonus payments for Medicare Advantage plans in 2019. These lowered Star ratings for the 2018 rating year for the Medicare Advantage plan (H0562) and the Company may have reduced the attractiveness of the affected plans and our other offerings to members, reduce revenue from the affected plan and impact our Medicare expansion efforts, which are a strategic focus for the Company.

There are also specific additional risks under Title XVIII, Part D of the Social Security Act associated with our provision of Medicare Part D prescription drug benefits as part of our Medicare Advantage plan offerings. These risks include potential uncollectibility of receivables, inadequacy of pricing assumptions, inability to receive and process information and increased pharmaceutical costs, as well as the underlying seasonality of this business, and extended settlement periods for claims submissions. Our failure to comply with Part D program requirements can result in financial and/or operational sanctions on our Part D products, as well as on our Medicare Advantage products that offer no prescription drug coverage.

Our business could be adversely affected by the single-payer national health insurance system currently contemplated by members of Congress. The Expanded and Improved Medicare for All Act would establish a single public or quasi-public agency that organizes healthcare financing, but healthcare delivery would remain private.

Failure to accurately estimate and price our medical expenses or effectively manage our medical costs or related administrative costs could negatively affect our financial position, results of operations and cash flows.

Our profitability, to a significant degree, depends on our ability to estimate and effectively manage expenses related to health benefits through, among other things, our ability to contract favorably with hospitals, physicians and other healthcare providers. For example, our Medicaid revenue is often based on bids submitted before the start of the initial contract year. If our actual medical expenses exceed our estimates, our Health Benefits Ratio (HBR), or our expenses related to medical services as a percentage of premium revenues, would increase and our profits would decline. Because of the narrow margins of our health plan business, relatively small changes in our HBR can create significant changes in our financial results. Changes in healthcare regulations and practices, the level of utilization of healthcare services, hospital and pharmaceutical costs, disasters, the potential effects of climate change, major epidemics, pandemics or newly emergent viruses, new medical technologies, new pharmaceutical compounds, increases in provider fraud and other external factors, including general economic conditions such as inflation and unemployment levels, are generally beyond our control and could reduce our ability to accurately predict and effectively control the costs of providing health benefits. Also, member behavior could continue to be influenced by the uncertainty surrounding changes to the ACA, including the repeal of the ACA's individual mandate in the Tax Cuts and Jobs Act of 2017 (TCJA).

Our medical expenses include claims reported but not paid, estimates for claims incurred but not reported, and estimates for the costs necessary to process unpaid claims at the end of each period. Our development of the medical claims liability estimate is a continuous process which we monitor and refine on a monthly basis as claims receipts and payment information as well as inpatient acuity information becomes available. As more complete information

becomes available, we adjust the amount of the estimate, and include the changes in estimates in medical expenses in the period in which the changes are identified. Given the uncertainties inherent in such estimates, there can be no assurance that our medical claims liability estimate will be adequate, and any adjustments to the estimate may unfavorably impact our results of operations and may be material.

Additionally, when we commence operations in a new state, region or product, we have limited information with which to estimate our medical claims liability. For a period of time after the inception of the new business, we base our estimates on government-provided historical actuarial data and limited actual incurred and received claims and inpatient acuity information. The addition of new categories of eligible individuals, as well as evolving Health Insurance Marketplace plans, may pose difficulty in estimating our medical claims liability.

From time to time in the past, our actual results have varied from our estimates, particularly in times of significant changes in the number of our members. If it is determined that our estimates are significantly different than actual results, our results of operations and financial position could be adversely affected. In addition, if there is a significant delay in our receipt of premiums, our business operations, cash flows, or earnings could be negatively impacted.

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The implementation of the ACA, as well as potential repeal of or changes to the ACA, could materially and adversely affect our results of operations, financial position and cash flows.

In March 2010, the ACA was enacted. While the constitutionality of the ACA was generally upheld by the Supreme Court in 2012, the Court determined that states could elect to opt out of the Medicaid expansion portion of ACA without losing all federal money for their existing Medicaid programs.

Under the ACA, Medicaid coverage was expanded to all individuals under age 65 with incomes up to 138% of the federal poverty level beginning January 1, 2014, subject to each state's election. The federal government paid the entire cost for Medicaid coverage for newly eligible beneficiaries for three years (2014 through 2016). Beginning in 2017, the federal share began to decline, and will end at 90% for 2020 and subsequent years. As of December 31, 2018, 36 states and the District of Columbia have expanded Medicaid eligibility, and additional states continue to discuss expansion. The ACA also maintained CHIP eligibility standards through September 2019.

The ACA required the establishment of Health Insurance Marketplaces for individuals and small employers to purchase health insurance coverage. The ACA also required insurers participating on the Health Insurance Marketplaces to offer a minimum level of benefits and included guidelines on setting premium rates and coverage limitations. On December 22, 2017, the TCJA was signed, repealing the individual mandate requirement of the ACA beginning in 2019. On August 1, 2018, the U.S. HHS issued a final rule permitting the duration of short-term health insurance plans to be extended up to 36 months in total. The final rule, which went into effect on October 2, 2018, is currently being challenged at the state level and in pending litigation against the current administration. Additionally, the U.S. Department of Labor issued a final rule on June 19, 2018 which expanded flexibility regarding the regulation and formation of association health plans (AHPs) provided by small employer groups and associations. This final rule allows more employer groups and associations to form AHPs based upon common geography and industry sector. In July 2018, twelve states' attorneys general filed suit against the current administration in the U.S. District Court in Washington D.C. to block the final rule. The lawsuit is currently ongoing. Short-term health insurance plans and AHPs often provide fewer benefits than the traditional ACA insurance benefits. These changes and other potential changes involving the functioning of the Health Insurance Marketplaces as a result of new legislation, regulation or executive action, could impact our business and results of operations.

Any failure to adequately price products offered or reduction in products offered in the Health Insurance Marketplaces may have a negative impact on our results of operations, financial position and cash flow. Among other things, due to the repeal of the individual mandate in the TCJA, we may be adversely selected by individuals who have higher acuity levels than those individuals who selected us in the past and healthy individuals may decide to opt out of the pool altogether. In addition, the risk adjustment, provisions of the ACA established to apportion risk amongst insurers may not be effective in appropriately mitigating the financial risks related to the Marketplace product. Further, changes in the competitive marketplace over time may exacerbate the uncertainty in these relatively new markets. For example, competitors seeking to gain a foothold in the changing market may introduce pricing that we may not be able to match, which may adversely affect our ability to compete effectively. Competitors may also choose to exit the market altogether or otherwise suffer financial difficulty, which could adversely impact the pool of potential insured, or require us to increase premium rates. Any significant variation from our expectations regarding acuity, enrollment levels, adverse selection, or other assumptions utilized in setting adequate premium rates could have a material adverse effect on our results of operations, financial position and cash flows.

The HHS has stated that it will consider a limited number of premium assistance demonstration proposals from states that want to privatize Medicaid expansion. States must provide a choice between at least two qualified health plans and offer very similar benefits as those available in the Health Insurance Marketplaces. Arkansas was the first state to obtain federal approval to use Medicaid funding to purchase private insurance for low-income residents, and we began

operations under the program beginning January 1, 2014. As of December 31, 2018, eight states had approved Section 1115 waivers to implement the ACA's Medicaid expansion in ways that extend beyond the flexibility provided by the federal law.

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The ACA imposed an annual insurance industry assessment of $8.0 billion in 2014, and $11.3 billion in each of 2015 and 2016, with increasing annual amounts thereafter. The health insurer fee payable in 2017 was suspended by the Consolidated Appropriations Act for fiscal year 2016. However, the $14.3 billion payment resumed in 2018. Collection of the health insurer fee for 2019 has also been suspended. Such assessments are not deductible for federal and most state income tax purposes. The fee is allocated based on health insurers' premium revenues in the previous year. Each health insurer's fee is calculated by multiplying its market share by the annual fee. Market share is based on commercial, Medicare, and Medicaid premium revenues. Not-for-profit insurers may have a competitive advantage since they are exempt from paying the fee if they receive at least 80% of their premium revenues from Medicare, Medicaid, and CHIP, and other not-for-profit insurers are allowed to exclude 50% of their premium revenues from the fee calculation. There are ongoing challenges pending against the federal government regarding the requirement to reimburse Medicaid managed care organizations for the industry assessment. If we are not reimbursed by the states for the cost of the federal premium assessment (including the associated tax impact), or if we are unable to otherwise adjust our business model to address this new assessment, our results of operations, financial position and cash flows may be materially adversely affected.

There are numerous steps regulators require for continued implementation of the ACA, including the promulgation of a substantial number of potentially more onerous federal regulations. For example, in April 2016, CMS issued final regulations that revised existing Medicaid managed care rules by establishing a minimum MLR standard for Medicaid of 85% and strengthening provisions related to network adequacy and access to care, enrollment and disenrollment protections, beneficiary support information, continued service during beneficiary appeals, and delivery system and payment reform initiatives, among others. If we fail to effectively implement or appropriately adjust our operational and strategic initiatives with respect to the implementation of healthcare reform, or do not do so as effectively as our competitors, our results of operations may be materially adversely affected.
On March 23, 2018, Congress further bolstered the current administration’s position to end cost-sharing subsidies by omitting cost sharing subsidy payments from the two-year Omnibus Spending Bill. This bill, coupled with the current administration’s decision to end payments, could affect our earnings and potential premium rate adjustments in 2019.

Changes to, or repeal of, portions or the entirety of the ACA, as well as judicial interpretations in response to legal and other constitutional challenges, could materially and adversely affect our business and financial position, results of operations or cash flows. Even if the ACA is not amended or repealed, the current administration could propose changes impacting implementation of the ACA, which could materially and adversely affect our financial position or operations. Most recently, a December 2018 partial summary judgment ruling in Texas v. United States of America held that the ACA’s individual mandate requirement was essential to the ACA, and without it, the remainder of the ACA was invalid. This ruling is being appealed and the ACA remains in effect until the appeal is concluded. The ultimate content, timing or effect of any potential future legislation enacted under the current administration or the outcome of the lawsuit cannot be predicted.

Our business activities are highly regulated and new laws or regulations or changes in existing laws or regulations or their enforcement or application could force us to change how we operate and could harm our business.

Our business is extensively regulated by the states in which we operate and by the federal government. In addition, the managed care industry has received negative publicity that has led to increased legislation, regulation, review of industry practices and private litigation in the commercial sector. Such negative publicity may adversely affect our stock price and damage our reputation in various markets.

In each of the jurisdictions in which we operate, we are regulated by the relevant insurance, health and/or human services or government departments that oversee the activities of managed care organizations providing or arranging

to provide services to Medicaid, Medicare, Health Insurance Marketplace enrollees or other beneficiaries. For example, our health plan subsidiaries, as well as our applicable specialty companies, must comply with minimum statutory capital and other financial solvency requirements, such as deposit and surplus requirements.

The frequent enactment of, changes to, or interpretations of laws and regulations could, among other things: force us to restructure our relationships with providers within our network; require us to implement additional or different programs and systems; restrict revenue and enrollment growth; increase our healthcare and administrative costs; impose additional capital and surplus requirements; and increase or change our liability to members in the event of malpractice by our contracted providers. In addition, changes in political party or administrations at the state, federal or country level may change the attitude towards healthcare programs and result in changes to the existing legislative or regulatory environment.

Additionally, the taxes and fees paid to federal, state and local governments may increase due to several factors, including: enactment of, changes to, or interpretations of tax laws and regulations, audits by governmental authorities, geographic expansions into higher taxing jurisdictions and the effect of expansions into international markets.

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Our contracts with states may require us to maintain a minimum HBR or may require us to share profits in excess of certain levels. In certain circumstances, our plans may be required to return premium back to the state in the event profits exceed established levels or HBR does not meet the minimum requirement. Factors that may impact the amount of premium returned to the state include transparent pharmacy pricing initiatives. Other states may require us to meet certain performance and quality metrics in order to maintain our contract or receive additional or full contractual revenue.

The governmental healthcare programs in which we participate are subject to the satisfaction of certain regulations and performance standards. For example, under the ACA, Congress authorized CMS and the states to implement managed care demonstration programs to serve dually eligible beneficiaries to improve the coordination of their care. Participation in these demonstration programs is subject to CMS approval and the satisfaction of conditions to participation, including meeting certain performance requirements. Our inability to improve or maintain adequate quality scores and Star ratings to meet government performance requirements or to match the performance of our competitors could result in limitations to our participation in or exclusion from these or other government programs. Specifically, several of our Medicaid contracts require us to maintain a Medicare health plan. Additionally, CMS issued a Notice of Proposed Rulemaking on November 8, 2018, advancing CMS' efforts to streamline the Medicaid and CHIP managed care regulatory framework and a broader strategy to relieve regulatory burdens, support state flexibility and local leadership, and promote transparency, flexibility, and innovation in the delivery of care, with public comments due by January 9, 2019. Although we strive to comply with all existing regulations and to meet performance standards applicable to our business, failure to meet these requirements could result in financial fines and penalties. Also, states or other governmental entities may not allow us to continue to participate in their government programs, or we may fail to win procurements to participate in such programs which could materially and adversely affect our results of operations, financial position and cash flows.

In addition, as a result of the expansion of our businesses and operations conducted in foreign countries, we face political, economic, legal, compliance, regulatory, operational and other risks and exposures that are unique and vary by jurisdiction. These foreign regulatory requirements with respect to, among other items, environmental, tax, licensing, intellectual property, privacy, data protection, investment, capital, management control, labor relations, and fraud and corruption regulations are different than those faced by our domestic businesses. In addition, we are subject to U.S. laws that regulate the conduct and activities of U.S.-based businesses operating abroad, such as the FCPA. Our failure to comply with laws and regulations governing our conduct outside the United States or to successfully navigate international regulatory regimes that apply to us could adversely affect our ability to market our products and services, which may have a material adverse effect on our business, financial condition and results of operations.

Our businesses providing pharmacy benefit management (PBM) and specialty pharmacy services face regulatory and other risks and uncertainties which could materially and adversely affect our results of operations, financial position and cash flows.

We provide PBM and specialty pharmacy services, including through our Envolve Pharmacy Solutions product. These businesses are subject to federal and state laws that govern the relationships of the business with pharmaceutical manufacturers, physicians, pharmacies, customers and consumers. We also conduct business as a mail order pharmacy and specialty pharmacy, which subjects these businesses to extensive federal, state and local laws and regulations. In addition, federal and state legislatures regularly consider new regulations for the industry that could materially and adversely affect current industry practices, including the receipt or disclosure of rebates from pharmaceutical companies, the development and use of formularies, and the use of average wholesale prices.

Our PBM and specialty pharmacy businesses would be materially and adversely affected by an inability to contract on favorable terms with pharmaceutical manufacturers and other suppliers, including with respect to the pricing of new

specialty and generic drugs. In addition, our PBM and specialty pharmacy businesses could face potential claims in connection with purported errors by our mail order or specialty pharmacies, including in connection with the risks inherent in the authorization, compounding, packaging and distribution of pharmaceuticals and other healthcare products. Disruptions at any of our mail order or specialty pharmacies due to an event that is beyond our control could affect our ability to process and dispense prescriptions in a timely manner and could materially and adversely affect our results of operations, financial position and cash flows.

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If any of our government contracts are terminated or are not renewed on favorable terms or at all, or if we receive an adverse finding or review resulting from an audit or investigation, our business may be adversely affected.

A substantial portion of our business relates to the provision of managed care programs and selected services to individuals receiving benefits under governmental assistance or entitlement programs. We provide these and other healthcare services under contracts with government entities in the areas in which we operate. Our government contracts are generally intended to run for a fixed number of years and may be extended for an additional specified number of years if the contracting entity or its agent elects to do so. When our contracts with the government expire, they may be opened for bidding by competing healthcare providers, and there is no guarantee that our contracts will be renewed or extended. Competitors may buy their way into the market by submitting bids with lower pricing. Even if our responsive bids are successful, the bids may be based upon assumptions or other factors which could result in the contracts being less profitable than we had anticipated. Further, our government contracts contain certain provisions regarding eligibility, enrollment and dis-enrollment processes for covered services, eligible providers, periodic financial and informational reporting, quality assurance, timeliness of claims payment and agreement to maintain a Medicare plan in the state and financial standards, among other things, and are subject to cancellation if we fail to perform in accordance with the standards set by regulatory agencies.

We are also subject to various reviews, audits and investigations to verify our compliance with the terms of our contracts with various governmental agencies, as well as compliance with applicable laws and regulations. Any adverse review, audit or investigation could result in, among other things: cancellation of our contracts; refunding of amounts we have been paid pursuant to our contracts; imposition of fines, penalties and other sanctions on us; loss of our right to participate in various programs; increased difficulty in selling our products and services; loss of one or more of our licenses; lowered quality Star ratings; or require changes to the way we do business. In addition, under government procurement regulations and practices, a negative determination resulting from a government audit of our business practices could result in a contractor being fined, debarred and/or suspended from being able to bid on, or be awarded, new government contracts for a period of time.

If any of our government contracts are terminated, not renewed, renewed on less favorable terms, or not renewed on a timely basis, or if we receive an adverse finding or review resulting from an audit or investigation, our business and reputation may be adversely impacted, our goodwill could be impaired and our financial position, results of operations or cash flows may be materially affected.

We contract with independent third-party vendors and service providers who provide services to us and our subsidiaries or to whom we delegate selected functions. Violations of, or noncompliance with, laws and regulations governing our business by such third parties, or governing our dealings with such parties, could, among other things, subject us to additional audits, reviews and investigations and other adverse effects.

Ineffectiveness of state-operated systems and subcontractors could adversely affect our business.

A number of our health plans rely on other state-operated systems or subcontractors to qualify, solicit, educate and assign eligible members into managed care plans. The effectiveness of these state operations and subcontractors can have a material effect on a health plan’s enrollment in a particular month or over an extended period. When a state implements new programs to determine eligibility, new processes to assign or enroll eligible members into health plans, or chooses new subcontractors, there is an increased potential for an unanticipated impact on the overall number of members assigned to managed care plans.

Our investment portfolio may suffer losses which could materially and adversely affect our results of operations or liquidity.

We maintain a significant investment portfolio of cash equivalents and short-term and long-term investments in a variety of securities, which are subject to general credit, liquidity, market and interest rate risks and will decline in value if interest rates increase or one of the issuers' credit ratings is reduced. As a result, we may experience a reduction in value or loss of our investments, which may have a negative adverse effect on our results of operations, liquidity and financial condition.

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Execution of our growth strategy may increase costs or liabilities, or create disruptions in our business.

Our growth strategy includes, without limitation, the acquisition and expansion of health plans participating in government sponsored healthcare programs and specialty services businesses, contract rights and related assets of other health plans both in our existing service areas and in new markets and start-up operations in new markets or new products in existing markets. We continue to pursue opportunistic acquisitions to expand into new geographies and complementary business lines as well as to augment existing operations and may be in discussions with respect to one or multiple targets at any given time. Although we review the records of companies or businesses we plan to acquire, it is possible that we could assume unanticipated liabilities or adverse operating conditions, or an acquisition may not perform as well as expected or may not achieve timely profitability. We also face the risk that we will not be able to effectively integrate acquisitions into our existing operations effectively without substantial expense, delay or other operational or financial problems and we may need to divert more management resources to integration than we planned.

In connection with start-up operations and system migrations, we may incur significant expenses prior to commencement of operations and the receipt of revenue. For example, in order to obtain a certificate of authority in most jurisdictions, we must first establish a provider network, have systems in place and demonstrate our ability to administer a state contract and process claims. We may experience delays in operational start dates. As a result of these factors, start-up operations may decrease our profitability. In addition, we are planning to expand our business internationally and we will be subject to additional risks, including, but not limited to, political risk, an unfamiliar regulatory regime, currency exchange risk and exchange controls, cultural and language differences, foreign tax issues, and different labor laws and practices.

If we are unable to effectively execute our growth strategy, our future growth will suffer and our results of operations could be harmed.

If competing managed care programs are unwilling to purchase specialty services from us, we may not be able to successfully implement our strategy of diversifying our business lines.

We are seeking to diversify our business lines into areas that complement our government sponsored health plan business in order to grow our revenue stream and balance our dependence on risk reimbursement. In order to diversify our business, we must succeed in selling the services of our specialty subsidiaries not only to our managed care plans, but to programs operated by third parties. Some of these third-party programs may compete with us in some markets, and they therefore may be unwilling to purchase specialty services from us. In any event, the offering of these services will require marketing activities that differ significantly from the manner in which we seek to increase revenues from our government sponsored programs. Our ineffectiveness in marketing specialty services to third parties may impair our ability to execute our business strategy.

Adverse credit market conditions may have a material adverse effect on our liquidity or our ability to obtain credit on acceptable terms.

In the past, the securities and credit markets have experienced extreme volatility and disruption. The availability of credit, from virtually all types of lenders, has at times been restricted. In the event we need access to additional capital to pay our operating expenses, fund subsidiary surplus requirements, make payments on or refinance our indebtedness, pay capital expenditures, or fund acquisitions, our ability to obtain such capital may be limited and the cost of any such capital may be significant, particularly if we are unable to access our existing credit facility.

Our access to additional financing will depend on a variety of factors such as prevailing economic and credit market conditions, the general availability of credit, the overall availability of credit to our industry, our credit ratings and credit capacity, and perceptions of our financial prospects. Similarly, our access to funds may be impaired if regulatory authorities or rating agencies take negative actions against us. If a combination of these factors were to occur, our internal sources of liquidity may prove to be insufficient, and in such case, we may not be able to successfully obtain sufficient additional financing on favorable terms, within an acceptable time, or at all.

If state regulators do not approve payments of dividends and distributions by our subsidiaries to us, we may not have sufficient funds to implement our business strategy.

We principally operate through our health plan subsidiaries. As part of normal operations, we may make requests for dividends and distributions from our subsidiaries to fund our operations. These subsidiaries are subject to regulations that limit the amount of dividends and distributions that can be paid to us without prior approval of, or notification to, state regulators. If these regulators were to deny our subsidiaries' requests to pay dividends, the funds available to us would be limited, which could harm our ability to implement our business strategy.

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We derive a majority of our premium revenues from operations in a limited number of states, and our financial position, results of operations or cash flows would be materially affected by a decrease in premium revenues or profitability in any one of those states.

Operations in a limited number of states have accounted for most of our premium revenues to date. If we were unable to continue to operate in any of those states or if our current operations in any portion of one of those states were significantly curtailed, our revenues could decrease materially. Our reliance on operations in a limited number of states could cause our revenues and profitability to change suddenly and unexpectedly depending on legislative or other governmental or regulatory actions and decisions, economic conditions and similar factors in those states. For example, states we currently serve may open the bidding for their Medicaid program to other health insurers through a request for proposal process. Our inability to continue to operate in any of the states in which we operate could harm our business.

Competition may limit our ability to increase penetration of the markets that we serve.

We compete for members principally on the basis of size and quality of provider networks, benefits provided and quality of service. We compete with numerous types of competitors, including other health plans and traditional state Medicaid programs that reimburse providers as care is provided, as well as technology companies, new joint ventures, financial services firms, consulting firms and other non-traditional competitors. In addition, the administration of the ACA has the potential to shift the competitive landscape in our segment.

Some of the health plans with which we compete have greater financial and other resources and offer a broader scope of products than we do. In addition, significant merger and acquisition activity has occurred in the managed care industry, as well as complementary industries, such as the hospital, physician, pharmaceutical, medical device and health information systems businesses. To the extent that competition intensifies in any market that we serve, as a result of industry consolidation or otherwise, our ability to retain or increase members and providers, or maintain or increase our revenue growth, pricing flexibility and control over medical cost trends may be adversely affected.

If we are unable to maintain relationships with our provider networks, our profitability may be harmed.

Our profitability depends, in large part, upon our ability to contract at competitive prices with hospitals, physicians and other healthcare providers. Our provider arrangements with our primary care physicians, specialists and hospitals generally may be canceled by either party without cause upon 90 to 120 days prior written notice. We cannot provide any assurance that we will be able to continue to renew our existing contracts or enter into new contracts on a timely basis or under favorable terms enabling us to service our members profitably. Healthcare providers with whom we contract may not properly manage the costs of services, maintain financial solvency or avoid disputes with other providers. Any of these events could have a material adverse effect on the provision of services to our members and our operations.

In any particular market, physicians and other healthcare providers could refuse to contract, demand higher payments, or take other actions that could result in higher medical costs or difficulty in meeting regulatory or accreditation requirements, among other things. In some markets, certain healthcare providers, particularly hospitals, physician/hospital organizations or multi-specialty physician groups, may have significant market positions or near monopolies that could result in diminished bargaining power on our part. In addition, accountable care organizations, practice management companies, which aggregate physician practices for administrative efficiency and marketing leverage, and other organizational structures that physicians, hospitals and other healthcare providers choose may change the way in which these providers interact with us and may change the competitive landscape. Such

organizations or groups of healthcare providers may compete directly with us, which could adversely affect our operations, and our results of operations, financial position and cash flows by impacting our relationships with these providers or affecting the way that we price our products and estimate our costs, which might require us to incur costs to change our operations. Provider networks may consolidate, resulting in a reduction in the competitive environment. In addition, if these providers refuse to contract with us, use their market position to negotiate contracts unfavorable to us or place us at a competitive disadvantage, our ability to market products or to be profitable in those areas could be materially and adversely affected.

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From time to time, healthcare providers assert or threaten to assert claims seeking to terminate non-cancelable agreements due to alleged actions or inactions by us. If we are unable to retain our current provider contract terms or enter into new provider contracts timely or on favorable terms, our profitability may be harmed. In addition, from time to time, we may be subject to class action or other lawsuits by healthcare providers with respect to claim payment procedures or similar matters. For example, our wholly owned subsidiary, Health Net Life Insurance Company (HNL), is and may continue to be subject to such disputes with respect to HNL's payment levels in connection with the processing of out-of-network provider reimbursement claims for the provision of certain substance abuse related services. HNL expects to vigorously defend its claims payment practices. Nevertheless, in the event HNL receives an adverse finding in any related legal proceeding or from a regulator, or is otherwise required to reimburse providers for these claims at rates that are higher than expected or for claims HNL otherwise believes are unallowable, our financial condition and results of operations may be materially adversely affected. In addition, regardless of whether any such lawsuits brought against us are successful or have merit, they will still be time-consuming and costly and could distract our management's attention. As a result, under such circumstances we may incur significant expenses and may be unable to operate our business effectively.

We may be unable to attract, retain or effectively manage the succession of key personnel.

We are highly dependent on our ability to attract and retain qualified personnel to operate and expand our business. We would be adversely impacted if we are unable to adequately plan for the succession of our executives and senior management. While we have succession plans in place for members of our executive and senior management team, these plans do not guarantee that the services of our executive and senior management team will continue to be available to us. Our ability to replace any departed members of our executive and senior management team or other key employees may be difficult and may take an extended period of time because of the limited number of individuals in the Managed Care and Specialty Services industry with the breadth of skills and experience required to operate and successfully expand a business such as ours. Competition to hire from this limited pool is intense, and we may be unable to hire, train, retain or motivate these personnel. If we are unable to attract, retain and effectively manage the succession plans for key personnel, executives and senior management, our business and financial position, results of operations or cash flows could be harmed.

If we are unable to integrate and manage our information systems effectively, our operations could be disrupted.

Our operations depend significantly on effective information systems. The information gathered and processed by our information systems assists us in, among other things, monitoring utilization and other cost factors, processing provider claims, and providing data to our regulators. Our healthcare providers also depend upon our information systems for membership verifications, claims status and other information. Our information systems and applications require continual maintenance, upgrading and enhancement to meet our operational needs and regulatory requirements. We regularly upgrade and expand our information systems' capabilities. If we experience difficulties with the transition to or from information systems or do not appropriately integrate, maintain, enhance or expand our information systems, we could suffer, among other things, operational disruptions, loss of existing members and difficulty in attracting new members, regulatory problems and increases in administrative expenses. In addition, our ability to integrate and manage our information systems may be impaired as the result of events outside our control, including acts of nature, such as earthquakes or fires, or acts of terrorists.

From time to time, we may become involved in costly and time-consuming litigation and other regulatory proceedings, which require significant attention from our management.

From time to time, we are a defendant in lawsuits and regulatory actions and are subject to investigations relating to our business, including, without limitation, medical malpractice claims, claims by members alleging failure to pay for

or provide healthcare, claims related to non-payment or insufficient payments for out-of-network services, claims alleging bad faith, investigations regarding our submission of risk adjuster claims, putative securities class actions, and claims related to the imposition of new taxes, including but not limited to claims that may have retroactive application. Due to the inherent uncertainties of litigation and regulatory proceedings, we cannot accurately predict the ultimate outcome of any such proceedings. An unfavorable outcome could have a material adverse impact on our business and financial position, results of operations and/or cash flows and may affect our reputation. In addition, regardless of the outcome of any litigation or regulatory proceedings, such proceedings are costly and time consuming and require significant attention from our management, and could therefore harm our business and financial position, results of operations or cash flows.

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An impairment charge with respect to our recorded goodwill and intangible assets could have a material impact on our results of operations.

We periodically evaluate our goodwill and other intangible assets to determine whether all or a portion of their carrying values may be impaired, in which case a charge to earnings may be necessary. Changes in business strategy, government regulations or economic or market conditions have resulted and may result in impairments of our goodwill and other intangible assets at any time in the future. Our judgments regarding the existence of impairment indicators are based on, among other things, legal factors, market conditions, and operational performance. For example, the non-renewal of our health plan contracts with the state in which they operate may be an indicator of impairment. If an event or events occur that would cause us to revise our estimates and assumptions used in analyzing the value of our goodwill and other intangible assets, such revision could result in a non-cash impairment charge that could have a material impact on our results of operations in the period in which the impairment occurs.

If we fail to comply with applicable privacy, security, and data laws, regulations and standards, including with respect to third-party service providers that utilize sensitive personal information on our behalf, our business, reputation, results of operations, financial position and cash flows could be materially and adversely affected.

As part of our normal operations, we collect, process and retain confidential member information. We are subject to various federal state and international laws and rules regarding the use and disclosure of confidential member information, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, the Gramm-Leach-Bliley Act, and the General Data Protection Regulation (GDPR), which require us to protect the privacy of medical records and safeguard personal health information we maintain and use. Certain of our businesses are also subject to the Payment Card Industry Data Security Standard, which is a multifaceted security standard that is designed to protect credit card account data as mandated by payment card industry entities. Despite our best attempts to maintain adherence to information privacy and security best practices, as well as compliance with applicable laws, rules and contractual requirements, our facilities and systems, and those of our third-party service providers, may be vulnerable to privacy or security breaches, acts of vandalism or theft, malware or other forms of cyber-attack, misplaced or lost data including paper or electronic media, programming and/or human errors or other similar events. In the past, we have had data breaches resulting in disclosure of confidential or protected health information that have not resulted in any material financial loss or penalty to date. However, future data breaches could require us to expend significant resources to remediate any damage, interrupt our operations and damage our reputation, subject us to state or federal agency review and could also result in enforcement actions, material fines and penalties, litigation or other actions which could have a material adverse effect on our business, reputation and results of operations, financial position and cash flows.

In addition, HIPAA broadened the scope of fraud and abuse laws applicable to healthcare companies. HIPAA established new enforcement mechanisms to combat fraud and abuse, including civil and, in some instances, criminal penalties for failure to comply with specific standards relating to the privacy, security and electronic transmission of protected health information. The HITECH Act expanded the scope of these provisions by mandating individual notification in instances of breaches of protected health information, providing enhanced penalties for HIPAA violations, and granting enforcement authority to states' Attorneys General in addition to the HHS Office for Civil Rights. It is possible that Congress may enact additional legislation in the future to increase penalties and to create a private right of action under HIPAA, which could entitle patients to seek monetary damages for violations of the privacy rules. HHS continued its auditing program in 2016 to assess compliance efforts by covered entities and business associates. Through a second phase of audits, which commenced for covered entities in July 2016, HHS focused on a review of policies and procedures adopted and employed by covered entities and their business associates to meet selected standards and implementation specifications of the HIPAA Privacy, Security, and Breach

Notification Rules. The HHS Office for Civil Rights reported that as of February 2018, the Phase 2 desk audits of covered entities and business associates were completed, and additional comprehensive on-site audits would be conducted as a part of a permanent audit program going forward. An audit resulting in findings or allegations of noncompliance could have a material adverse effect on our results of operations, financial position and cash flows.

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If we fail to comply with the extensive federal and state fraud and abuse laws, our business, reputation, results of operations, financial position and cash flows could be materially and adversely affected.

We, along with all other companies involved in public healthcare programs are the subject of fraud and abuse investigations from time to time. The regulations and contractual requirements applicable to participants in these public sector programs are complex and subject to change. Violations of fraud and abuse laws applicable to us could result in civil monetary penalties, criminal fines and imprisonment, and/or exclusion from participation in Medicaid, Medicare, TRICARE, VA and other federal healthcare programs and federally funded state health programs. Fraud and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, incorrect and unsubstantiated billing or billing for unnecessary medical services, improper marketing and violations of patient privacy rights. These fraud and abuse laws include the federal False Claims Act, which prohibits the known filing of a false claim or the known use of false statements to obtain payment from the federal government and the federal anti-kickback statute, which prohibits the payment or receipt of remuneration to induce referrals or recommendations of healthcare items or services. Many states have false claim act and anti-kickback statutes that closely resemble the federal False Claims Act and the federal anti-kickback statute. In addition, the Deficit Reduction Act of 2005 encouraged states to enact state-versions of the federal False Claims Act that establish liability to the state for false and fraudulent Medicaid claims and that provide for, among other things, claims to be filed by qui tam relators. Federal and state governments have made investigating and prosecuting healthcare fraud and abuse a priority. In the event we fail to comply with the extensive federal and state fraud and abuse laws, our business, reputation, results of operations, financial position and cash flows could be materially and adversely affected.

A failure in or breach of our operational or security systems or infrastructure, or those of third parties with which we do business, including as a result of cyber-attacks, could have an adverse effect on our business.

Information security risks have significantly increased in recent years in part because of the proliferation of new technologies, the use of the internet and telecommunications technologies to conduct our operations, and the increased sophistication and activities of organized crime, hackers, terrorists and other external parties, including foreign state agents. Our operations rely on the secure processing, transmission and storage of confidential, proprietary and other information in our computer systems and networks.

Security breaches may arise from external or internal threats. External breaches include hacking personal information for financial gain, attempting to cause harm or interruption to our operations, or intending to obtain competitive information. We experience attempted external hacking or malicious attacks on a regular basis. We maintain a rigorous system of preventive and detective controls through our security programs; however, our prevention and detection controls may not prevent or identify all such attacks on a timely basis, or at all. Internal breaches may result from inappropriate security access to confidential information by rogue employees, consultants or third party service providers. Any security breach involving the misappropriation, loss or other unauthorized disclosure or use of confidential member information, financial data, competitively sensitive information, or other proprietary data, whether by us or a third party, could have a material adverse effect on our business reputation, financial condition, cash flows, or results of operations.

The market price of our common stock may decline as a result of significant acquisitions.

The market price of our common stock is generally subject to volatility, and there can be no assurances regarding the level or stability of our share price at any time. The market price of our common stock may decline as a result of acquisitions if, among other things, we are unable to achieve the expected growth in earnings, or if the operational cost savings estimates in connection with the integration of acquired businesses with ours are not realized, or if the transaction costs related to the acquisitions and integrations are greater than expected. The market price also may

decline if we do not achieve the perceived benefits of the acquisitions as rapidly or to the extent anticipated by financial or industry analysts or if the effect of the acquisitions on our financial position, results of operations or cash flows is not consistent with the expectations of financial or industry analysts.

We may be unable to successfully integrate our business with the assets acquired in the Fidelis Care Acquisition, and realize the anticipated benefits of the Fidelis Care Acquisition.

We completed the Fidelis Care Acquisition on July 1, 2018. The success of the Fidelis Care Acquisition will depend, in part, on our ability to successfully combine the businesses of the Company and Fidelis Care and realize the anticipated benefits, including synergies, cost savings, growth in earnings, innovation and operational efficiencies, from the combinations. If we are unable to achieve these objectives within the anticipated time frame, or at all, the anticipated benefits may not be realized fully or at all, or may take longer to realize than expected and the value of our common stock may be harmed.

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The integration of Fidelis Care's business with our existing business is a complex, costly and time-consuming process. The integration may result in material challenges, including, without limitation:

- the diversion of management's attention from ongoing business concerns and performance shortfalls as a result of the devotion of management's attention to the integration;
- managing a larger combined company;
- maintaining employee morale and retaining key management and other employees;
- the possibility of faulty assumptions underlying expectations regarding the integration process;
- retaining existing business and operational relationships and attracting new business and operational relationships;
- consolidating corporate and administrative infrastructures and eliminating duplicative operations;
- coordinating geographically separate organizations;
- unanticipated issues in integrating information technology, communications and other systems;
- unanticipated changes in federal or state laws or regulations, including the ACA and any regulations enacted thereunder;
- unforeseen expenses or delays associated with the acquisition and/or integration; and
- decreases in premiums paid under government sponsored healthcare programs by any state in which we operate.

Many of these factors will be outside of our control and any one of them could result in delays, increased costs, decreases in the amount of expected revenues and diversion of management's time and energy, which could materially affect our financial position, results of operations and cash flows.

Our future results may be adversely impacted if we do not effectively manage our expanded operations as a result of the Fidelis Care Acquisition.

As a result of the Fidelis Care Acquisition, the size of our business is significantly larger. Our ability to successfully manage the expanded business will depend, in part, upon management's ability to design and implement strategic initiatives that address the increased scale and scope of the combined business with its associated increased costs and complexity. There can be no assurances that we will be successful in managing our expanded operations as a result of the Fidelis Care Acquisition or that we will realize the expected growth in earnings, operating efficiencies, cost savings and other benefits.

We have substantial indebtedness outstanding and may incur additional indebtedness in the future. Such indebtedness could reduce our agility and may adversely affect our financial condition.

As of December 31, 2018, we had consolidated indebtedness of approximately $6,686 million. We may further increase our indebtedness in the future. This increased indebtedness and any resulting higher debt-to-equity ratio will have the effect, among other things, of reducing our flexibility to respond to changing business and economic conditions and increasing borrowing costs.

Among other things, our revolving credit facility and the indentures governing our notes require us to comply with various covenants that impose restrictions on our operations, including our ability to incur additional indebtedness, create liens, pay dividends, make investments or other restricted payments, sell or otherwise dispose of substantially all of our assets and engage in other activities. Our revolving credit facility also requires us to comply with a maximum leverage ratio and a minimum fixed charge coverage ratio. These restrictive covenants could limit our ability to pursue our business strategies. In addition, any failure by us to comply with these restrictive covenants could result in an event of default under the revolving credit facility and, in some circumstances, under the indentures governing our notes, which, in any case, could have a material adverse effect on our financial condition.

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Changes in the method pursuant to which the LIBOR rates are determined and potential phasing out of LIBOR after 2021 may affect the value of the financial obligations to be held or issued by us that are linked to LIBOR or our results of operations or financial condition.

As of December 31, 2018, we held $2.7 billion notional amount of interest rate swaps that use the London interbank offered rate (LIBOR) as a reference rate and borrowings under our revolving credit agreement bear interest based upon various reference rates, including LIBOR. On July 27, 2017, the Financial Conduct Authority (the authority that regulates LIBOR) announced that it intends to stop compelling banks to submit rates for the calculation of LIBOR after 2021. It is unclear whether new methods of calculating LIBOR will be established such that it continues to exist after 2021. The U.S. Federal Reserve, in conjunction with the Alternative Reference Rates Committee, a steering committee comprised of large U.S. financial institutions, announced replacement of U.S. dollar LIBOR with a new index calculated by short-term repurchase agreements, backed by U.S. Treasury securities called the Secured Overnight Financing Rate ("SOFR"). The first publication of SOFR was released in April 2018. Whether or not SOFR attains market traction as a LIBOR replacement tool remains in question and the future of LIBOR at this time is uncertain. As a result, it is not possible to predict the effect of any changes, establishment of alternative references rates or other reforms to LIBOR that may be enacted in the U.K. or elsewhere. The elimination of LIBOR or any other changes or reforms to the determination or supervision of LIBOR could have an adverse impact on the market for or value of any LIBOR-linked securities, loans, derivatives and other financial obligations or extensions of credit held by or due to us or on our overall financial condition or results of operations.

We incurred substantial expenses related to the completion of the Fidelis Care Acquisition and expect to incur substantial expenses related to the integration of our business with Fidelis Care.

We incurred substantial expenses in connection with the completion of the Fidelis Care Acquisition and expect to incur substantial expense related to the integration of our business with the acquired assets of Fidelis Care. There are a large number of processes, policies, procedures, operations, technologies and systems that must be integrated, including purchasing, accounting and finance, sales, payroll, pricing, revenue management, marketing and benefits. In addition, our businesses and Fidelis Care will continue to maintain a presence in St. Louis, Missouri and New York, New York, respectively. The substantial majority of these costs will be non-recurring expenses related to the Fidelis Care Acquisition (including the financing of the Fidelis Care Acquisition), and facilities and systems consolidation costs. We may incur additional costs to maintain employee morale and to retain key employees. We will also incur transaction fees and costs related to formulating integration plans for the combined business, and the execution of these plans may lead to additional unanticipated costs. These incremental transaction and acquisition related costs may exceed the savings we expect to achieve from the elimination of duplicative costs and the realization of other efficiencies related to the integration of the businesses, particularly in the near term and in the event there are material unanticipated costs.

Future issuances and sales of additional shares of preferred or common stock could reduce the market price of our shares of common stock.

We may, from time to time, issue additional securities to raise capital or in connection with acquisitions. We often acquire interests in other companies by using a combination of cash and our common stock or just our common stock. Further, shares of preferred stock may be issued from time to time in one or more series as our Board of Directors may from time to time determine each such series to be distinctively designated. The issuance of any such preferred stock could materially adversely affect the rights of holders of our common stock. Any of these events may dilute your ownership interest in our company and have an adverse impact on the price of our common stock.

Item 1B. Unresolved Staff Comments

None.

Item 2. Properties

We own our corporate office headquarters buildings and land located in St. Louis, Missouri, which is used by each of our reportable segments. We generally lease space in the states where our health plans, specialty companies and claims processing facilities operate. We are required by various insurance and regulatory authorities to have offices in the service areas where we provide benefits. We believe our current facilities and expansion plans are adequate to meet our operational needs for the foreseeable future.

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Item 3. Legal Proceedings

A description of the legal proceedings to which we and our subsidiaries are a party is contained in Note 17. Contingencies to the consolidated financial statements included in Part II of this Annual Report on Form 10-K, and is incorporated herein by reference.

Item 4. Mine Safety Disclosures

Not applicable.

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PART II

Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities

Market for Common Stock; Dividends

Our common stock has been traded and quoted on the New York Stock Exchange under the symbol “CNC” since October 16, 2003. On December 12, 2018, the Board of Directors declared a two-for-one split of Centene's common stock in the form of a 100% stock dividend distributed on February 6, 2019 to stockholders of record as of December 24, 2018. All share, per share and stock price information presented in this Form 10-K has been adjusted for the two-for-one stock split. The high and low prices, as reported by the NYSE, are set forth below for the periods indicated.

	2019 Stock Price (through February 15, 2019)		2018 Stock Price		2017 Stock Price	
	High	Low	High	Low	High	Low
First Quarter	$69.25	$54.86	$56.21	$48.81	$36.62	$28.00
Second Quarter			63.15	52.14	42.90	34.60
Third Quarter			74.12	60.51	49.36	39.53
Fourth Quarter			74.49	54.25	52.33	41.78

As of February 15, 2019, there were 1,166 holders of record of our common stock.

We have never declared any cash dividends on our capital stock and currently anticipate that we will retain any future earnings for the development, operation and expansion of our business.

Issuer Purchases of Equity Securities

In 2009, our Board of Directors extended our stock repurchase program. The program authorizes the repurchase of up to 16 million shares of our common stock from time to time on the open market or through privately negotiated transactions. We have 7 million available shares remaining under the program for repurchases as of December 31, 2018. No duration has been placed on the repurchase program. We reserve the right to discontinue the repurchase program at any time. During the year ended December 31, 2018, we did not repurchase any shares through this publicly announced program.

Issuer Purchases of Equity Securities
Fourth Quarter 2018
(shares in thousands)

Period	Total Number of Shares Purchased[1]	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans	Maximum Number of Shares that May Yet Be Purchased Under the Plans or Programs[2]

			or Programs	
October 1 – October 31, 2018	8	$ 66.95	—	6,671
November 1 – November 30, 2018	3	68.60	—	6,671
December 1 – December 31, 2018	815	65.72	—	6,671
Total	826	$ 65.74	—	6,671

(1) Shares acquired represent shares relinquished to the Company by certain employees for payment of taxes or option cost upon vesting of restricted stock units or option exercise.
(2) Our Board of Directors adopted a stock repurchase program which allows for repurchases of up to a remaining amount of 7 million shares. No duration has been placed on the repurchase program.

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Stock Performance Graph

The graph below compares the cumulative total stockholder return on our common stock for the period from December 31, 2013 to December 31, 2018 with the cumulative total return of the New York Stock Exchange Composite Index, the Standard & Poor's Supercomposite Managed Healthcare Index and the Standard & Poor's 500 over the same period. Standard & Poor's 500 is included because our common stock is within the index. The graph assumes an investment of $100 on December 31, 2013 in our common stock (at the last reported sale price on such day), the New York Stock Exchange Composite Index, the Standard & Poor's Supercomposite Managed Healthcare Index, and the Standard & Poor's 500 and assumes the reinvestment of any dividends.

	December 31,					
	2013	2014	2015	2016	2017	2018
Centene Corporation	$100.00	$176.15	$223.24	$191.69	$342.20	$391.11
New York Stock Exchange Composite Index	100.00	104.22	97.53	106.31	123.16	109.37
S&P Supercomposite Managed Healthcare Index	100.00	133.00	159.65	188.73	268.48	296.08
S&P 500	100.00	111.39	110.58	121.13	144.65	135.63
Centene Corporation closing stock price	$14.74	$25.97	$32.91	$28.26	$50.44	$57.65
Centene Corporation annual shareholder return	43.8 %	76.2 %	26.7 %	(14.1)%	78.5 %	14.3 %

In accordance with the rules of the SEC, the information contained in the Stock Performance Graph on this page shall not be deemed to be “soliciting material,” or to be “filed” with the SEC or subject to the SEC’s Regulation 14A, or to the liabilities of Section 18 of the Exchange Act, except to the extent that Centene specifically requests that the information be treated as soliciting material or specifically incorporates it by reference into a document filed under the Securities Act, or the Exchange Act.

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Item 6. Selected Financial Data

The following selected consolidated financial data should be read in conjunction with the consolidated financial statements and related notes and “Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations” included in our Annual Report on Form 10-K.

	Year Ended December 31,				
	2018	2017	2016	2015	2014
	(In millions, except share data in dollars and membership data)				
Income Statement Data:					
Total Revenues	$60,116	$48,382	$40,607	$22,760	$16,560
Net earnings attributable to Centene Corporation	$900	$828	$562	$355	$271
Per Share Data:					
Net income attributable to Centene:					
Basic	$2.31	$2.40	$1.76	$1.49	$1.16
Diluted	$2.26	$2.34	$1.71	$1.44	$1.12
Other Information (unaudited):					
Health benefits ratio [1]	85.9 %	87.3 %	86.5 %	88.9 %	89.3 %
Selling, general and administrative expense ratio [2]	10.7 %	9.7 %	9.8 %	8.5 %	8.3 %
Membership	14,019,600	12,207,100	11,441,800	5,107,900	4,060,900
Consolidated Balance Sheet Data:					
Cash and cash equivalents, Investments and Restricted deposits	$13,480	$10,050	$9,118	$3,978	$3,167
Total assets	30,901	21,855	20,197	7,339	5,824
Medical claims liability	6,831	4,286	3,929	2,298	1,723
Long-term debt	6,648	4,695	4,651	1,216	874
Total stockholders' equity	11,013	6,864	5,909	2,168	1,743

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(1) Health benefits ratio represents medical costs as a percentage of premium revenue.

(2) Selling, general and administrative (SG&A) expense ratio represents SG&A expenses as a percentage of premium and service revenues.

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ITEM 7. Management's Discussion and Analysis of Financial Condition and Results of Operations

The following discussion of our financial condition and results of operations should be read in conjunction with our consolidated financial statements and the related notes included elsewhere in this filing. The discussion contains forward-looking statements that involve known and unknown risks and uncertainties, including those set forth under Part I, Item 1A."Risk Factors" of this Form 10-K.

EXECUTIVE OVERVIEW

General

We are a diversified, multi-national healthcare enterprise that provides services to government sponsored and commercial healthcare programs, focusing on under-insured and uninsured individuals. We provide member-focused services through locally based staff by assisting in accessing care, coordinating referrals to related health and social services and addressing member concerns and questions.

Results of operations depend on our ability to manage expenses associated with health benefits (including estimated costs incurred) and selling, general and administrative (SG&A) costs. We measure operating performance based upon two key ratios. The health benefits ratio (HBR) represents medical costs as a percentage of premium revenues, excluding premium tax and health insurer fee revenues that are separately billed, and reflects the direct relationship between the premiums received and the medical services provided. The SG&A expense ratio represents SG&A costs as a percentage of premium and service revenues, excluding premium tax and health insurer fee revenues that are separately billed.

On December 12, 2018, the Board of Directors declared a two-for-one split of our common stock in the form of a 100% stock dividend distributed on February 6, 2019 to stockholders of record as of December 24, 2018. All share, per share and stock price information presented in this Form 10-K has been adjusted for the two-for-one stock split.

Fidelis Care Acquisition

On July 1, 2018, we acquired substantially all of the assets of New York State Catholic Health Plan, Inc., d/b/a Fidelis Care New York (Fidelis Care) for approximately $3.6 billion of cash consideration, which includes a working capital adjustment. The cash consideration was funded through approximately $2.8 billion of new equity, and approximately $1.8 billion of new long-term debt. Both offerings were completed in May 2018. The Fidelis Care Acquisition expanded our health plan footprint to New York State. As a result of the completion of the Fidelis Care Acquisition, our results of operations for the year ended December 31, 2018 include the results of operations of Fidelis Care from July 1, 2018 to December 31, 2018. Due to the size of the acquisition, one of the primary drivers of the year-over-year variances discussed throughout this section is related to the Fidelis Care Acquisition.

As part of the regulatory approval process in connection with the Fidelis Care Acquisition, we entered into certain undertakings with the New York State Department of Health. These undertakings contain various commitments by us effective upon completion of the Fidelis Care Acquisition. One of the undertakings includes a $340 million contribution by us to the State of New York to be paid over a five-year period for initiatives consistent with our mission of providing high quality healthcare to vulnerable populations within New York State. The present value of the $340 million contribution to the State of New York, approximately $328 million, was expensed during 2018.

Acquisitions and Investments

We continued to execute on our growth strategy through acquisitions and investments during 2018. In the first quarter of 2018, we acquired Community Medical Holdings Corp., d/b/a Community Medical Group (CMG), an at-risk primary care provider serving Medicaid, Medicare Advantage, and Health Insurance Marketplace patients in Miami-Dade County, Florida. CMG has a multi-payor strategy and serves members of our Florida health plan. The acquisition increases our scale and capabilities and creates a vertical integration opportunity with providers. In the first quarter of 2018, we also acquired an additional 61% ownership in Interpreta Holdings, Inc. (Interpreta), a clinical and genomics data analytics business, bringing our total ownership to 80%. In the first and second quarters of 2018, we completed a 28% equity method investment in RxAdvance (RxA), a full-service pharmacy benefit manager (PBM) with an innovative technology platform. In the third quarter of 2018, we made an additional investment in RxA in the form of convertible preferred stock. Both the Interpreta and RxA transactions reflect our commitment to technological innovation and providing comprehensive and integrated specialty services.

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In the second quarter of 2018, we acquired MHM Services Inc. (MHM), a provider of behavioral health, medical and dental services to correctional facilities, state hospitals, courts, juvenile facilities and community clinics. Under the terms of the agreement, we also acquired the remaining 49% ownership of Centurion, the correctional healthcare services joint venture between MHM and us, expanding our national footprint in the correctional healthcare sector.

In the fourth quarter of 2018, our Spanish subsidiary, Primero Salud, acquired 89% of Torrejón Salud, the concessionaire of the University Hospital of Torrejón de Ardoz in the Community of Madrid, expanding our presence in Spain.

Regulatory Trends and Uncertainties

In December 2018, a federal district judge in Texas ruled that the entire Affordable Care Act (ACA) is unconstitutional in the case of “Texas v. United States of America.” The case centers on the argument that the law's individual mandate requirement was essential to the ACA, and without it, the remainder of the ACA was invalid. The Company remains focused on the promise of delivering access to quality, affordable healthcare to all of its members, following the District Court decision regarding the constitutionality of the ACA. The ACA will remain in its current form for 2019. We believe the ACA will remain in its current form or in modified form that ensures the continuation of coverage for existing members beyond 2019.

We have more than three decades of experience, spanning six presidents from both sides of the aisle, in delivering high-quality healthcare services on behalf of states and the Federal government to uninsured families, commercial organizations and military families. We continue to believe we have both the capacity and capability to successfully navigate industry changes to the benefit of our members, customers and shareholders.

For additional information regarding regulatory trends and uncertainties, see Part I, Item 1 "Business - Regulation" and Item 1A, "Risk Factors."

2018 Highlights

Our financial performance for 2018 is summarized as follows:

- Year-end managed care membership of 14.0 million, an increase of 1.8 million members, or 15% over 2017.
- Total revenues of $60.1 billion, representing 24% growth year-over-year.
- HBR of 85.9% for 2018, compared to 87.3% for 2017.
- SG&A expense ratio of 10.7% for 2018, compared to 9.7% for 2017.
- Adjusted SG&A expense ratio of 10.0% for 2018, compared to 9.5% for 2017.
- Diluted EPS of $2.26 for 2018, compared to $2.34 for 2017.
- Adjusted Diluted EPS of $3.54 for 2018, compared to $2.52 for 2017.
- Operating cash flows of $1.2 billion, or 1.4 times net earnings, for 2018.

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A reconciliation from GAAP diluted EPS to Adjusted Diluted EPS is highlighted below, and additional detail is provided above under the heading "Non-GAAP Financial Presentation":

	Year Ended December 31,	
	2018	2017
GAAP diluted EPS attributable to Centene	$2.26	$2.34
Amortization of acquired intangible assets	0.41	0.28
Acquisition related expenses	0.81	0.04
Other adjustments [(1)]	0.06	(0.14)
Adjusted Diluted EPS	$3.54	$2.52

(1) Other adjustments include the following items:

- 2018 - the impact of retroactive changes to the California minimum MLR of $30 million or $0.06 per diluted share, net of an income tax benefit of $0.02; and

- 2017 - (a) the Penn Treaty assessment expense of $56 million or $0.10 per diluted share, net of an income tax benefit of $0.06; (b) the cost sharing reduction (CSR) expense of $22 million or $0.04 per diluted share, net of an income tax benefit of $0.02; (c) the charitable contribution commitment of $40 million or $0.07 per diluted share, net of an income tax benefit of $0.05, and (d) the benefit associated with income tax reform of $125 million or $0.35 per diluted share.

The 2018 results include the following items, which in the aggregate had no net effect on diluted EPS:

- During the year ended December 31, 2018, we received 2014-2017 cost reconciliation information related to the California Medicaid in-home support services (IHSS) program, which ended December 31, 2017. As a result, our 2018 results include an estimated pre-tax benefit of $140 million related to the IHSS program reconciliation. The 2014-2016 reconciliation is expected to be finalized by early 2019, with the final 2017 reconciliation to follow.

- On September 30, 2018, our contract to provide health care coordination services to the U.S. Department of Veterans Affairs under the Patient-Centered Community Care and Veterans Choice Programs expired. In connection with the conclusion of the contract, during the year ended December 31, 2018, we recorded a pre-tax charge of $110 million for negotiated settlements and severance costs. We will continue to provide close out and transition services through 2021.

- During the year ended December 31, 2018, we recorded pre-tax expense of $30 million associated with a contribution commitment to our charitable foundation.

The following items contributed to our revenue and membership growth in 2018 and 2017:

- Arizona. In October 2018, our Arizona subsidiary, Health Net Access, began providing physical and behavioral health care services under a new integrated contract through the Arizona Health Care Cost Containment System Complete Care program in the Central region and the Southern region. In January 2017, we continued our participation as a qualified health plan issuer in the Arizona Health Insurance Marketplace and exited the Health Net preferred provider organization offerings in Arizona.

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Arkansas. In February 2018, our Arkansas subsidiary, Arkansas Total Care, began managing a Medicaid special needs population comprised of people with high behavioral health needs and individuals with developmental/intellectual disabilities. Arkansas Total Care is expected to assume full-risk on this population beginning in March 2019.

- CMG. In March 2018, we completed the acquisition of CMG, an at-risk primary care provider serving Medicaid, Medicare Advantage, and Health Insurance Marketplace patients in Miami-Dade County, Florida.

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Correctional. In December 2018, Centurion began operating under a new contract to provide comprehensive healthcare services to detainees of Volusia County detention facilities located near Daytona, Florida. In April 2018, we completed the acquisition of MHM, a national provider of healthcare and staffing services to correctional systems and other government agencies. Under the terms of the agreement, Centene also acquired the remaining 49% ownership of Centurion, the correctional healthcare services joint venture between Centene and MHM. In June 2017, Centurion began operating under an expanded contract to provide correctional healthcare services for the Florida Department of Corrections in South Florida.

- Fidelis Care. In July 2018, we completed the acquisition of substantially all of the assets of Fidelis Care for $3.6 billion of cash consideration, making Fidelis Care Centene's health plan in New York State.

- Health Insurance Marketplace. In January 2018, we expanded our offerings in the 2018 Health Insurance Marketplace. We entered Kansas, Missouri and Nevada, and expanded our footprint in the following six existing markets: Florida, Georgia, Indiana, Ohio, Texas, and Washington. In January 2017, we added over 500,000 new members across our Health Insurance Marketplace service areas.

- Health Net Federal Services. In January 2018, our subsidiary, Health Net Federal Services, began operating under the TRICARE West Region contract to provide administrative services to Military Health System eligible beneficiaries.

- Illinois. In January 2018, our Illinois subsidiary, IlliniCare Health, began operating under a state-wide contract for the Medicaid Managed Care Program. Implementation dates varied by region and the contract was fully implemented statewide in April 2018. The new contract will include children who are in need through the Department of Children and Family Services/Youth in Care by the Illinois Department of Healthcare and Family Services and Foster Care. These additional products are expected to be implemented in 2019.

- Interpreta. In March 2018, we acquired an additional 61% ownership in Interpreta, a clinical and genomics data analytics business, bringing our total ownership to 80%.

- Maryland. In July 2017, our specialty solutions subsidiary, Envolve, Inc., began providing health plan management services for Medicaid operations in Maryland.

- Medicare. In January 2018, we expanded our offerings in Medicare. We entered Arkansas, Indiana, Kansas, Louisiana, Missouri, Pennsylvania, South Carolina, and Washington and expanded our footprint in Ohio.

- Missouri. In May 2017, our Missouri subsidiary, Home State Health, began providing managed care services to MO HealthNet Managed Care beneficiaries under an expanded statewide contract.

- Nebraska. In January 2017, our Nebraska subsidiary, Nebraska Total Care, began operating under a contract with the Nebraska Department of Health and Human Services' Division of Medicaid and Long-Term Care as one of three managed care organizations to administer its new Heritage Health Program for Medicaid, ABD, CHIP, Foster Care and LTSS enrollees.

- Nevada. In July 2017, our Nevada subsidiary, SilverSummit Healthplan, began serving Medicaid recipients enrolled in Nevada's Medicaid managed care program.

- Pennsylvania. In January 2018, our Pennsylvania subsidiary, Pennsylvania Health & Wellness, began serving enrollees in the Community HealthChoices program. Contract commencement dates vary by zone and will be fully implemented statewide by January 2020.

- RxAdvance. In March 2018, we made a 25% equity method investment in RxAdvance, a full-service PBM, and expect to use its platform to improve health outcomes and reduce avoidable drug-impacted medical and administrative costs. This partnership includes both a customer relationship and a strategic investment in RxAdvance. As part of the initial transaction, Centene has certain rights to expand its equity investment in the future. In May 2018, we made an additional investment in RxAdvance, bringing the total ownership to 28%. In September 2018, we made an additional investment in convertible preferred stock. In 2018, we began moving our health plans onto the RxAdvance pharmacy platform, beginning with the transition of our Mississippi health plan in December 2018.

- Washington. In January 2018, our Washington State subsidiary, Coordinated Care of Washington, began providing managed care services to Apple Health's Fully Integrated Managed Care beneficiaries in the North Central Region.

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- In addition, we realized the full year benefit in 2017 of acquisitions, investments, and business commenced during 2016, including the March 2016 acquisition of Health Net for $6.0 billion, including the assumption of debt.

The growth items listed above were partially offset by the following items:

- We were successful in reprocuring our contracts in Georgia, Indiana, and Mississippi. However, the Medicaid programs were expanded to include additional insurers, which has reduced our market share. In addition, we are no longer serving LTSS members in Arizona or Medicaid and correctional members in Massachusetts.

- Beginning in January 2018, the State of California no longer includes costs for IHSS in its Medicaid contracts.

- Effective October 2018, we no longer provide health care coordination services to veterans under the Patient-Centered Community Care and Veterans Choice Programs.

We expect the following items to contribute to our revenue or future growth potential:

- We expect to realize the full year benefit in 2019 of acquisitions, investments, and business commenced during 2018, as discussed above.

- In February 2019, our North Carolina joint venture, Carolina Complete Health, was awarded a contract for the Medicaid Managed Care program. Under the agreement, Carolina Complete Health will provide Medicaid managed care services in Regions 3 and 5. Pending regulatory approval, the new three-year contract is effective February 1, 2020.

- In February 2019, Centurion began operating under a new contract to provide comprehensive healthcare services to detainees of the Metropolitan Detention Center located in Albuquerque, New Mexico.

- In January 2019, Centurion was notified by Arizona’s Department of Corrections of the state’s intent to award a contract to provide comprehensive healthcare services to inmates housed in Arizona’s state prison system. The contract is expected to commence July 1, 2019, subject to customary contract negotiation.

- In January 2019, we expanded our offerings in the 2019 Health Insurance Marketplace. We entered North Carolina, Pennsylvania, South Carolina and Tennessee, and expanded our footprint in six existing markets: Florida, Georgia, Indiana, Kansas, Missouri and Texas.

- In January 2019, our New Mexico subsidiary, Western Sky Community Care, began operating under a new statewide contract in New Mexico for the Centennial Care 2.0 Program.

- In January 2019, our Pennsylvania subsidiary, Pennsylvania Health & Wellness, began serving enrollees in the Community HealthChoices program in the Southeast region as part of the statewide contract that is expected to be fully implemented by January 2020.

- In January 2019, our Kansas subsidiary, Sunflower Health Plan, continued providing managed care services to KanCare beneficiaries statewide under a new contract.

- In December 2018, our Spanish subsidiary, Primero Salud, acquired 89% of Torrejón Salud, a public-private partnership in the Community of Madrid.

- In December 2018, our Florida subsidiary, Sunshine Health, began providing physical and behavioral health care services through Florida's Statewide Medicaid Managed Care Program under its new five year contract which was implemented for all 11 regions by February 2019.

- In October 2018, CMS published updated Medicare Star quality ratings for the 2019 rating year. Our Star ratings returned to a 4.0 Star parent rating. The 2019 rating year will positively affect quality bonus payments for Medicare Advantage plans in 2020.

- In July 2018, we announced a joint venture with Ascension to establish a Medicare Advantage plan. The plan is expected to be implemented in multiple geographic markets beginning in 2020.

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- In July 2018, our subsidiary, Health Net Federal Services, was awarded the next generation Military & Family Life Counseling Program contract. The awarded contract is up to ten years, including multiple one-year option periods.

- In July 2018, Centurion began operating under a contract to provide healthcare services for correctional facilities in Pima County, Arizona. In addition, Centurion's contracts for correctional facilities were reprocured in Florida, New Hampshire and Tennessee.

- In May 2018, our Iowa subsidiary, Iowa Total Care, Inc., was selected to negotiate a new statewide contract for the IA Health Link Program. The contract is expected to commence on July 1, 2019.

The future growth items listed above are partially offset by the following item:

- In the first quarter of 2018, Health Net of Arizona, Inc. notified the Arizona Department of Insurance of its decision to discontinue and non-renew all of its Employer Group plans for small and large business groups in Arizona beginning January 1, 2019. The effective date of coverage termination for existing groups is dependent on remaining renewals; however, coverage will no longer be provided to any group policyholders and/or members after December 31, 2019.

- We were successful in reprocuring our contract in Washington. However, we expect market share to decrease as a result of the award.

MEMBERSHIP

From December 31, 2016 to December 31, 2018, we increased our managed care membership by 2.6 million, or 23%. The following table sets forth our membership by line of business:

	December 31		
	2018	2017	2016
Medicaid:			
TANF, CHIP & Foster Care	7,356,200	5,807,300	5,630,000
ABD & LTSS	1,002,100	846,200	785,400
Behavioral Health	36,500	463,700	466,600
Total Medicaid	8,394,800	7,117,200	6,882,000
Commercial	1,978,000	1,558,300	1,239,100
Medicare [(1)]	416,900	333,700	334,300
Correctional	151,300	157,500	139,400
Total at-risk membership	10,941,000	9,166,700	8,594,800
TRICARE eligibles	2,858,900	2,824,100	2,847,000
Non-risk membership	219,700	216,300	—
Total	14,019,600	12,207,100	11,441,800

(1) Membership includes Medicare Advantage, Medicare Supplement, Special Needs Plans, and Medicare-Medicaid Plans (MMP).

The following table sets forth additional membership statistics, which are included in the membership information above:

	December 31

	2018	2017	2016
Dual-eligible [(2)]	598,200	474,500	441,400
Health Insurance Marketplace	1,459,100	959,600	537,200
Medicaid Expansion	1,262,100	1,091,500	1,080,500

(2) Membership includes dual-eligible ABD & LTSS and dual-eligible Medicare membership in the table above.

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From December 31, 2017 to December 31, 2018, our membership increased as a result of:
- the Fidelis Care Acquisition; and
- membership growth in our Health Insurance Marketplace service areas.

These increases were partially offset by a net decrease in our behavioral health membership as many states are combining these services within our physical health contracts in order to integrate physical and behavioral health care to achieve a more holistic care model for our members.

From December 31, 2016 to December 31, 2017, our membership increased as a result of:
- membership growth in our Health Insurance Marketplace service areas;
- the commencement of health plan management services for Medicaid operations in Maryland;
- an expanded statewide managed care contract in Missouri; and
- the commencement of new managed care contracts in Nebraska and Nevada.

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RESULTS OF OPERATIONS

The following discussion and analysis is based on our Consolidated Statements of Operations, which reflect our results of operations for each of the three years ended December 31, 2018, prepared in accordance with generally accepted accounting principles in the United States ($ in millions, except per share data in dollars):

	2018	2017	2016	% Change 2017-2018	% Change 2016-2017
Premium	$53,629	$43,353	$35,399	24 %	22 %
Service	2,806	2,267	2,180	24 %	4 %
Premium and service revenues	56,435	45,620	37,579	24 %	21 %
Premium tax and health insurer fee	3,681	2,762	3,028	33 %	(9)%
Total revenues	60,116	48,382	40,607	24 %	19 %
Medical costs	46,057	37,851	30,636	22 %	24 %
Cost of services	2,386	1,847	1,864	29 %	(1)%
Selling, general and administrative expenses	6,043	4,446	3,673	36 %	21 %
Amortization of acquired intangible assets	211	156	147	35 %	6 %
Premium tax expense	3,252	2,883	2,563	13 %	12 %
Health insurer fee expense	709	—	461	100 %	(100)%
Earnings from operations	1,458	1,199	1,263	22 %	(5)%
Investment and other income (expense), net	(90)	(65)	(103)	(38)%	37 %
Earnings from operations, before income tax expense	1,368	1,134	1,160	21 %	(2)%
Income tax expense	474	326	599	45 %	(46)%
Net earnings	894	808	561	11 %	44 %
Loss attributable to noncontrolling interests	6	20	1	(70)%	n.m.
Net earnings attributable to Centene Corporation	$900	$828	$562	9 %	47 %
Amounts attributable to Centene Corporation common shareholders:					
Earnings from operations, net of income tax expense	$900	$828	$562	9 %	47 %
Diluted earnings per common share attributable to Centene Corporation:	$2.26	$2.34	$1.71	(3)%	37 %

n.m.: not meaningful

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Year Ended December 31, 2018 Compared to Year Ended December 31, 2017

Total Revenues

The following table sets forth supplemental revenue information for the year ended December 31, ($ in millions):

	2018	2017	% Change 2017-2018
Medicaid	$39,427	$33,048	19 %
Commercial	12,391	8,207	51 %
Medicare [(1)]	5,093	4,477	14 %
Other	3,205	2,650	21 %
Total Revenues	$60,116	$48,382	24 %

(1) Medicare includes Medicare Advantage, Medicare Supplement, Special Needs Plans, and MMP.

Total revenues increased 24% in the year ended December 31, 2018, over the corresponding period in 2017, primarily due to the acquisition of Fidelis Care, growth in the Health Insurance Marketplace business, expansions and new programs in many of our states, and the reinstatement of the health insurer fee in 2018. This was partially offset by lower revenues as a result of the removal of the IHSS program from California's Medicaid contract in January 2018. During the twelve months ended December 31, 2018, we received Medicaid premium rate adjustments which yielded a net 1% composite change across all of our markets.

Operating Expenses

Medical Costs

Results of operations depend on our ability to manage expenses associated with health benefits and to accurately estimate costs incurred. The HBR represents medical costs as a percentage of premium revenues, excluding premium tax and health insurer fee revenues that are separately billed, and reflects the direct relationship between the premiums received and the medical services provided.

The HBR for the year ended December 31, 2018 was 85.9%, a decrease of 140 basis points over the comparable period in 2017. The HBR decrease compared to last year was driven by membership growth in the Health Insurance Marketplace business, the reinstatement of the health insurer fee in 2018, and the recognition of the previously mentioned IHSS program reconciliation. This was partially offset by the acquisition of Fidelis Care, which operates at a higher HBR.

Cost of Services

Cost of services increased by $539 million in the year ended December 31, 2018, compared to the corresponding period in 2017. This was primarily due to the acquisition of Foundation Care in October 2017 and growth in our correctional services business, including the acquisition of MHM.

The cost of service ratio for the year ended December 31, 2018 was 85.0%, compared to 81.5% in 2017. The cost of service ratio was negatively impacted by approximately 110 basis points for the costs associated with the Veterans

Affairs contract expiration. The increase in the cost of service ratio was also due to lower margins associated with our other federal services business and growth in our specialty pharmacy business due to the acquisition of Foundation Care in October 2017, which operates at a higher cost of service ratio. These increases were partially offset by growth in our correctional services business resulting from the acquisition of MHM, which operates at a lower cost of service ratio.

Selling, General and Administrative Expenses

SG&A increased by $1.6 billion in the year ended December 31, 2018, compared to the corresponding period in 2017. This was primarily due to the acquisition of Fidelis Care, including acquisition related expenses, costs associated with the previously mentioned Veterans Affairs contract expiration, and expansions, new programs and growth in many of our states in 2018, including growth in the Health Insurance Marketplace business. These increases were partially offset by the $56 million recognized during 2017 for our estimated share of the undiscounted guaranty association assessment resulting from the liquidation of Penn Treaty.

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The SG&A expense ratio was 10.7% for the year ended December 31, 2018, compared to 9.7% for the year ended December 31, 2017. The year-over-year increase was primarily due to increased acquisition related expenses. The Adjusted SG&A expense ratio was 10.0% for the year ended December 31, 2018, compared to 9.5% for the year ended December 31, 2017. The SG&A and Adjusted SG&A expense ratios both increased due to growth in the Health Insurance Marketplace business and the impact of the removal of the IHSS program from California's Medicaid contract in January 2018. These increases in both ratios were partially offset by the acquisition of Fidelis Care.

Health Insurer Fee Expense

Health insurance fee expense was $709 million for the year ended December 31, 2018. As a result of the health insurer fee moratorium, which suspended the health insurance provider fee for the 2017 calendar year, we did not record health insurer fee expense for the year ended December 31, 2017.

Other Income (Expense)

The following table summarizes the components of other income (expense) for the year ended December 31, ($ in millions):

	2018	2017
Investment and other income	$253	$190
Interest expense	(343)	(255)
Other income (expense), net	$(90)	$(65)

The increase in investment income in 2018 reflects higher interest rates and investment balances over 2017, including the impact of higher investment balances as a result of organic portfolio growth and the Fidelis Care acquisition. These increases were partially offset by 2017 interest income from the State of Illinois related to capitation payment delays. Interest expense increased by $88 million in the year ended December 31, 2018, compared to the corresponding period in 2017, reflecting a net increase in borrowings, primarily related to the financing of the Fidelis Care acquisition and the effect of our interest rate swaps.

Income Tax Expense

For the year ended December 31, 2018, we recorded income tax expense of $474 million on pre-tax earnings of $1.4 billion, or an effective tax rate of 34.6%. The effective tax rate reflects the lower corporate tax rate as enacted in the TCJA, partially offset by an increased tax rate due to the non-deductibility of the health insurer fee. For the year ended December 31, 2017, we recorded income tax expense of $326 million on pre-tax earnings of $1.1 billion, or an effective tax rate of 28.7%, which reflects the higher corporate tax rate for 2017, the one-time effects of the TCJA, and the impact of the health insurer fee moratorium.

Segment Results

The following table summarizes our consolidated operating results by segment for the year ended December 31, ($ in millions):

	2018	2017	% Change 2017-2018
Total Revenues			
Managed Care	$57,099	$45,842	25 %
Specialty Services	12,506	12,055	4 %

Eliminations	(9,489)	(9,515)	—	%
Consolidated Total	$60,116	$48,382	24	%
Earnings from Operations				
Managed Care	$1,310	$917	43	%
Specialty Services	148	282	(48)	%
Consolidated Total	$1,458	$1,199	22	%

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Managed Care

Total revenues increased 25% in the year ended December 31, 2018, compared to the corresponding period in 2017, primarily as a result of the acquisition of Fidelis Care and expansions, new programs, and growth in many of our states, particularly Florida, Georgia, Illinois, Missouri, Pennsylvania, and Texas, including growth in the Health Insurance Marketplace business. Total revenues also increased as a result of the reinstatement of the health insurer fee in 2018. These increases were partially offset by the impact of the removal of the IHSS program from California's Medicaid contract in January 2018 and a reduction in pass through payments from the State of California in 2018 compared to 2017. Earnings from operations increased $393 million between years primarily as a result of the acquisition of Fidelis Care, growth in the Health Insurance Marketplace business, and the reinstatement of the health insurer fee in 2018, partially offset by increased acquisition related expenses. In addition, 2017 was negatively impacted by the Penn Treaty assessment expense.

Specialty Services

Total revenues increased 4% in the year ended December 31, 2018, compared to the corresponding period in 2017, resulting primarily from increased services associated with membership growth in the Managed Care segment and acquisitions. These increases were partially offset by a decline in revenue for our behavioral health services business as a result of many states combining these services within our physical health contracts in order to integrate physical and behavioral health care to achieve a more holistic care model for our members. Earnings from operations decreased $134 million between years primarily due to costs associated with the previously mentioned Veterans Affairs contract expiration and lower margins in our other federal services and behavioral health services businesses, partially offset by growth in our pharmacy benefits management business.

Beginning in the second quarter of 2019, we expect lower earnings in our Specialty Services segment and corresponding higher earnings in our Managed Care segment as we move to transparent pharmacy pricing. This reflects our commitment to transparency and more closely aligns the costs of care within each segment. It also aligns with our continued transition to the next generation RxAdvance pharmacy platform during 2019 and 2020.

Year Ended December 31, 2017 Compared to Year Ended December 31, 2016

Total Revenues

	2017	2016	% Change 2016-2017
Medicaid	$33,048	$29,437	12 %
Commercial	8,207	5,059	62 %
Medicare [1]	4,477	3,308	35 %
Other	2,650	2,803	(5)%
Total Revenues	$48,382	$40,607	19 %

(1) Medicare includes Medicare Advantage, Medicare Supplement, Special Needs Plans, and MMP.

Total revenues increased 19% in the year ended December 31, 2017, over the corresponding period in 2016, primarily as a result of a full year of Health Net's results, as well as the impact of growth in the Health Insurance Marketplace business in 2017 and expansions and new programs in many of our states in 2016 and 2017. This was partially offset by the moratorium of the health insurer fee in 2017, lower membership in the commercial business in California as a

result of margin improvement actions taken in 2016, and lower specialty pharmacy revenues. As a result of the health insurer fee moratorium, which suspended the health insurance provider fee for the 2017 calendar year, we did not recognize health insurer fee revenue in 2017, compared to $531 million recognized in 2016. During the year ended December 31, 2017, we received Medicaid premium rate adjustments which yielded an approximate net 1% composite rate change across all of our markets.

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Operating Expenses

Medical Costs

The HBR for the year ended December 31, 2017 was 87.3%, an increase of 80 basis points over the comparable period in 2016. The increase compared to last year was primarily a result of the $195 million of revenue recognized in 2016 relating to the minimum MLR change in California, which reduced the 2016 HBR by 50 basis points, a premium rate reduction for California Medicaid Expansion effective July 1, 2017, an increase in flu related costs over 2016, and the impact of new or expanded health plans, which initially operate at a higher HBR. These increases were partially offset by growth in the Health Insurance Marketplace business, which operates at a lower HBR.

Cost of Services

Cost of services decreased by $17 million in the year ended December 31, 2017, compared to the corresponding period in 2016. This was primarily due to lower specialty pharmacy sales and decreased costs associated with our federal services business, partially offset by growth in our correctional business. The cost of service ratio for the year ended December 31, 2017 was 81.5%, compared to 85.5% in 2016. The decrease in the cost of service ratio is primarily due to decreased costs associated with our federal services business and the results of the shared savings programs in our home-based primary care business.

Selling, General and Administrative Expenses

SG&A increased by $773 million in the year ended December 31, 2017, compared to the corresponding period in 2016. This was primarily a result of:

- a full year of the Health Net business in our 2017 results;
- the impact of new programs in many of our states in 2016 and 2017;
- higher business expansion costs;
- additional expense recognized for our estimated share of the undiscounted guaranty association assessment resulting from the liquidation of Penn Treaty; and
- higher variable compensation expenses based on the performance of the business in 2017.

The increases above are partially offset by a decrease in acquisition related expenses of $214 million.

The SG&A expense ratio was 9.7% for the year ended December 31, 2017, compared to 9.8% for the year ended December 31, 2016. The decrease in the SG&A expense ratio was primarily attributable to lower acquisition related expenses, partially offset by higher business expansion costs over 2016, the Penn Treaty assessment and our results including a full year of the Health Net business, which operates at a higher SG&A expense ratio due to a greater mix of commercial and Medicare business.

The Adjusted SG&A expense ratio was 9.5% for the year ended December 31, 2017, compared to 9.0% for the year ended December 31, 2016. The increase in the Adjusted SG&A expense ratio was primarily attributable to higher business expansion costs over 2016 and a full year of the Health Net business in our 2017 results, which operates at a higher SG&A expense ratio due to a greater mix of commercial and Medicare business.

Health Insurer Fee Expense

As a result of the health insurer fee moratorium, which suspended the health insurance provider fee for the 2017 calendar year, we did not recognize health insurer fee expense for the year ended December 31, 2017, compared to $461 million recognized for the year ended December 31, 2016.

Other Income (Expense)

The following table summarizes the components of other income (expense) for the year ended December 31, ($ in millions):

	2017	2016
Investment and other income	$190	$114
Interest expense	(255)	(217)
Other income (expense), net	$(65)	$(103)

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The increase in investment income in 2017 reflects higher interest rates and investment balances over 2016, as well as interest income from the State of Illinois related to capitation payment delays. Interest expense increased during the year ended December 31, 2017 by $38 million due to an increase in net borrowings, primarily related to the issuance of an additional $2.4 billion in senior notes in February 2016 in connection with the financing of the Health Net transaction.

Income Tax Expense

For the year ended December 31, 2017, we recorded income tax expense of $326 million on pre-tax earnings of $1.1 billion, or an effective tax rate of 28.7%. The effective tax rate reflects the effect of income tax reform and the health insurer fee moratorium. For the year ended December 31, 2017, we recorded lower income tax expense of $125 million related to the provisional effect of the income tax rate reduction, primarily represented as a reduction to our deferred income tax liabilities. For the year ended December 31, 2016, we recorded income tax expense of $599 million on pre-tax earnings of $1.2 billion, or an effective tax rate of 51.6%, which reflects the non-deductibility of the health insurer fee expense as well as the non-deductibility of certain acquisition related costs incurred in connection with the closing of our acquisition of Health Net.

Segment Results

The following table summarizes our consolidated operating results by segment for the year ended December 31, ($ in millions):

	2017	2016	% Change 2016-2017
Total Revenues			
Managed Care	$45,842	$38,382	19 %
Specialty Services	12,055	8,377	44 %
Eliminations	(9,515)	(6,152)	(55)%
Consolidated Total	$48,382	$40,607	19 %
Earnings from Operations			
Managed Care	$917	$1,080	(15)%
Specialty Services	282	183	54 %
Consolidated Total	$1,199	$1,263	(5)%

In January 2017, we reclassified Cenpatico Behavioral Health of Arizona, LLC and the related Cenpatico Integrated Care health plan from the Specialty Services segment to the Managed Care segment due to a reorganization of the Arizona management structure following the Health Net integration. As a result, the financial results of Cenpatico Behavioral Health of Arizona, LLC and the related Cenpatico Integrated Care health plan have been reclassified from the Specialty Services segment to the Managed Care segment for all periods presented.

Managed Care

Total revenues increased 19% in the year ended December 31, 2017, compared to the corresponding period in 2016, primarily as a result of a full year of the Health Net business in our 2017 results and growth, expansions or new programs in many of our states, particularly Arkansas, Florida, Georgia, Indiana, Louisiana, Missouri, Nebraska, Ohio, and Texas, partially offset by the health insurer fee moratorium. Earnings from operations decreased $163 million between years primarily as a result of the $195 million of revenue recognized in 2016 relating to the minimum MLR change in California, the health insurer fee moratorium in 2017, and new or expanded health plans, which initially operate at a higher HBR and incur start-up costs. These drivers were partially offset by $214 million of lower

acquisition related expenses and growth in the Health Insurance Marketplace business.

Specialty Services

Total revenues increased 44% in the year ended December 31, 2017, compared to the corresponding period in 2016, resulting primarily from the a full year of the Health Net business in our 2017 results, the continued integration of Health Net into our specialty services, increased services associated with membership growth in the Managed Care segment, and growth in our correctional services and home-based primary care businesses. Earnings from operations increased $99 million between years primarily due to a full year of the Health Net business in our 2017 results.

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LIQUIDITY AND CAPITAL RESOURCES

Shown below is a condensed schedule of cash flows for the years ended December 31, 2018, 2017 and 2016, used in the discussion of liquidity and capital resources ($ in millions).

	Year Ended December 31,		
	2018	2017	2016
Net cash provided by operating activities	$1,234	$1,489	$1,851
Net cash used in investing activities	(4,585)	(1,254)	(2,469)
Net cash provided by (used in) financing activities	4,612	(82)	2,717
Effect of exchange rate changes on cash and cash equivalents	—	—	(1)
Net increase in cash and cash equivalents	$1,261	$153	$2,098

Cash Flows Provided by Operating Activities

Normal operations are funded primarily through operating cash flows and borrowings under our revolving credit facility. Cash flows from operating activities for 2018 were $1.2 billion, or 1.4 times net earnings, compared to $1.5 billion in 2017. The cash provided by operations in 2018 was primarily due to net earnings and an increase in medical claims liabilities, primarily resulting from growth in the Health Insurance Marketplace business. Cash flows from operations were partially offset by an increase in premium and trade receivables of $1.2 billion, due to growth in the business. Additionally, cash flows from operations were negatively affected by the repayment of approximately $1.0 billion of Medicaid expansion rate overpayments and Medicaid expansion MLR rebates in California, which was previously accrued.

Cash flows from operating activities for 2017 was $1.5 billion, compared to $1.9 billion in 2016. Cash provided by operations in 2017 was primarily due to net earnings, an increase in medical claims liabilities resulting from growth in the Health Insurance Marketplace business and the commencement of the Nebraska and Nevada health plans. Cash flows from operating activities for 2016 was $1.9 billion. Cash provided by operations in 2016 was primarily due to net earnings, an increase in accounts payable and accrued expenses and medical claims liabilities, and a decrease in other assets and premium and trade receivables. Additionally, cash provided by operations in 2016 was increased by approximately $445 million due to the timing of cash receipts shortly following the acquisition date.

Cash flows from operations in each year were impacted by the timing of payments we received from our states. States may prepay the following month premium payment, which we record as unearned revenue, or they may delay our premium payment, which we record as a receivable. We typically receive capitation payments monthly; however, the states in which we operate may decide to adjust their payment schedules which could positively or negatively impact our reported cash flows from operating activities in any given period.

	Year Ended December 31,		
	2018	2017	2016
(Increase) decrease in premium and trade receivables	$(1,173)	$(50)	$74
Increase (decrease) in unearned revenue	(52)	19	43
Net increase (decrease) in operating cash flow	$(1,225)	$(31)	$117

Cash Flows Used in Investing Activities

Investing activities used cash of $4.6 billion for the year ended December 31, 2018, $1.3 billion in 2017, and $2.5 billion in 2016. Cash flows used in investing activities in 2018 primarily consisted of the Fidelis Care and other

acquisitions, the net additions to the investment portfolio of our regulated subsidiaries (including transfers from cash and cash equivalents to long-term investments), the investments in RxAdvance, and capital expenditures.

We spent $675 million and $422 million in the year ended December 31, 2018 and 2017, respectively, on capital expenditures for system enhancements and market and corporate headquarters expansions.

As of December 31, 2018, our investment portfolio consisted primarily of fixed-income securities with a weighted average duration of 3.3 years. We had unregulated cash and investments of $478 million at December 31, 2018, compared to $310 million at December 31, 2017. Unregulated cash and investments include private equity investments and company owned life insurance contracts.

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Cash flows used in investing activities in 2017 primarily consisted of net additions to the investment portfolio of our regulated subsidiaries, including transfers from cash and cash equivalents to long-term investments, and capital expenditures.

Cash flows used in investing activities in 2016 primarily consisted of our acquisition of Health Net, net additions to the investment portfolio of our regulated subsidiaries, including transfers from cash and cash equivalents to long-term investments, and capital expenditures. In March 2016, we acquired Health Net for approximately $6.0 billion, including the assumption of $703 million of debt. The total consideration for the acquisition was $5.3 billion, consisting of Centene common shares valued at $3.0 billion, $2.2 billion in cash, and $2 million related to the fair value adjustment to stock based compensation associated with pre-combination service.

Cash Flows Provided by (Used in) Financing Activities

Our financing activities provided cash of $4.6 billion in 2018, compared to using cash of $82 million in 2017 and providing cash of $2.7 billion in 2016, respectively. Financing activities in 2018, 2017 and 2016 are discussed below.

2018

During 2018, our net financing activities primarily related to our offering of $2.8 billion in shares of common stock, par value $0.001 per share, approximately $1.8 billion of 5.375% senior notes at par due 2026, and additional borrowings on our revolving credit agreement. Proceeds from both offerings were used to fund the Fidelis Care acquisition which closed on July 1, 2018, to pay related fees and expenses, and for general corporate purposes, including the repayment of outstanding indebtedness. Cash flows provided by financing activities were partially offset by common stock repurchases resulting from stock relinquished to us by employees for payment of taxes upon vesting of restricted stock units and the purchase of noncontrolling interest.

2017

During 2017, our net financing activities primarily related to common stock repurchases resulting from stock relinquished to us by employees for payment of taxes upon vesting of restricted stock units and the purchase of noncontrolling interest, partially offset by increased borrowings on our revolving credit agreement. In December 2017, we amended and increased our $1.0 billion unsecured revolving credit facility (Revolving Credit Facility) to $1.5 billion.

2016

During 2016, our financing activities primarily related to the proceeds from the issuance of senior notes in February 2016 associated with the Health Net acquisition, the issuance of additional senior notes in June 2016 and November 2016, partially offset by the redemption of our 5.75% senior notes due 2017, the redemption of our 6.375% senior notes due 2017, and the repayment of amounts outstanding under our Revolving Credit Facility.

In February 2016, our wholly owned unrestricted subsidiary (Escrow Issuer) issued $1.4 billion of 5.625% senior notes ($1.4 Billion Notes) at par due 2021 and $1.0 billion of 6.125% senior notes ($1.0 Billion Notes) at par due 2024. We used the net proceeds of the offering, together with borrowings under the our new $1.0 billion revolving credit facility and cash on hand, to fund the cash consideration for the Health Net acquisition and to pay acquisition and offering related fees and expenses. In connection with the February 2016 issuance, we entered into interest rate swap agreements for notional amounts of $600 million and $1.0 billion, at floating rates of interest based on the three

month LIBOR plus 4.22% and the three month LIBOR plus 4.44%, respectively. Gains and losses due to changes in the fair value of the interest rate swaps completely offset changes in the fair value of the hedged portion of the underlying debt and are recorded as an adjustment to the $1.4 Billion Notes and $1.0 Billion Notes.

In connection with the closing of the Health Net acquisition on March 24, 2016, our then-existing unsecured $500 million revolving credit facility was terminated and simultaneously replaced with the Revolving Credit Facility. Borrowings under the agreement bear interest based upon LIBOR rates, the Federal Funds Rate or the Prime Rate.

In June 2016, we issued an additional $500 million of 4.75% senior notes due 2022 at a premium to yield 4.41% ($500 Million Add-on Notes). The $500 Million Add-on Notes were offered as additional debt securities under the indenture governing the $500 million of 4.75% senior notes issued April 2014. We used the net proceeds of the offering to repay amounts outstanding under our Revolving Credit Facility and to pay offering related fees and expenses.

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In November 2016, we issued $1.2 billion of 4.75% senior notes due 2025 ($1.2 Billion Notes). We used the net proceeds to redeem our $425 million of 5.75% senior notes due 2017 and Health Net's $400 million of 6.375% senior notes due 2017, to repay amounts outstanding under our Revolving Credit Facility, to pay related fees and expenses and for general purposes.

Liquidity Metrics

The credit agreement underlying our Revolving Credit Facility contains non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios and maximum debt-to-EBITDA ratios. We are required to not exceed a maximum debt-to-EBITDA ratio of 3.5 to 1.0. As of December 31, 2018, we had $284 million in borrowings outstanding under our Revolving Credit Facility, and we were in compliance with all covenants. As of December 31, 2018, there were no limitations on the availability under the revolving credit agreement as a result of the debt-to-EBITDA ratio.

We have a $200 million non-recourse construction loan to fund the expansion of our corporate headquarters. The loan bears interest based on the one month LIBOR plus 2.70% and matures in April 2021 with an optional one-year extension. The agreement contains financial and non-financial covenants aligning with our revolving credit agreement. We have guaranteed completion of the construction project associated with the loan. As of December 31, 2018, we had $63 million of borrowings outstanding under the loan.

We had outstanding letters of credit of $56 million as of December 31, 2018, which were not part of our revolving credit facility. We also had letters of credit for $27 million (valued at the December 31, 2018 conversion rate), or €24 million, representing our proportional share of the letters of credit issued to support Ribera Salud's outstanding debt which are a part of the revolving credit facility. Collectively, the letters of credit bore weighted interest of 0.99% as of December 31, 2018. In addition, we had outstanding surety bonds of $496 million as of December 31, 2018.

The indentures governing our various maturities of senior notes contain non-financial and financial covenants of Centene Corporation, including requirements of a minimum fixed charge coverage ratio. As of December 31, 2018, we were in compliance with all covenants.

As discussed above, in May 2018, we issued approximately $2.8 billion of new equity, and approximately $1.8 billion of 5.375% senior notes at par due 2026. Proceeds from the offerings were used to fund the Fidelis Care acquisition which closed on July 1, 2018, to pay related fees and expenses, and for general corporate purposes, including the repayment of outstanding indebtedness.

At December 31, 2018, we had working capital, defined as current assets less current liabilities, of $27 million, compared to negative $629 million at December 31, 2017. We manage our short-term and long-term investments with the goal of ensuring that a sufficient portion is held in investments that are highly liquid and can be sold to fund short-term requirements as needed.

At December 31, 2018, our debt to capital ratio, defined as total debt divided by the sum of total debt and total equity, was 37.8%, compared to 40.6% at December 31, 2017. Excluding the $120 million non-recourse mortgage note and construction loan, our debt to capital ratio was 37.4% as of December 31, 2018, compared to 40.3% at December 31, 2017. We utilize the debt to capital ratio as a measure, among others, of our leverage and financial flexibility.

We have a stock repurchase program authorizing us to repurchase up to 16 million shares of common stock from time to time on the open market or through privately negotiated transactions. We have 7 million available shares remaining

under the program for repurchases as of December 31, 2018. No duration has been placed on the repurchase program. We reserve the right to discontinue the repurchase program at any time. We did not make any repurchases under this plan during 2018, 2017 or 2016.

During the year ended December 31, 2018, 2017 and 2016, we received dividends of $475 million, $312 million, and $121 million, respectively, from our regulated subsidiaries.

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2019 Expectations

During 2019, we expect to make net capital contributions to our insurance subsidiaries of approximately $327 million associated with our growth and spend approximately $650 million in additional capital expenditures primarily associated with system enhancements and market and corporate headquarters expansions. These amounts are expected to be funded by unregulated cash flow generation and borrowings on our Revolving Credit Facility and construction loan. However, from time to time we may elect to raise additional funds for these and other purposes, either through issuance of debt or equity, the sale of investment securities or otherwise, as appropriate. In addition, we may strategically pursue refinancing opportunities to extend maturities and/or improve terms of our indebtedness if we believe such opportunities are favorable to us.

Based on our operating plan, we expect that our available cash, cash equivalents and investments, cash from our operations and cash available under our credit facility will be sufficient to finance our general operations and capital expenditures for at least 12 months from the date of this filing.

CONTRACTUAL OBLIGATIONS

The following table summarizes future contractual obligations. These obligations contain estimates and are subject to revision under a number of circumstances. Our debt consists of borrowings from our senior notes, Revolving Credit Facility, mortgages and capital leases. The purchase obligations consist primarily of software purchases and maintenance contracts. The contractual obligations and estimated period of payment over the next five years and beyond are as follows ($ in millions):

	Payments Due by Period				
	Total	Less Than 1 Year	1-3 Years	3-5 Years	More Than 5 Years
Medical claims liability	$6,831	$6,831	$—	$—	$—
Debt and interest	8,561	382	2,134	1,742	4,303
Lease obligations	865	188	314	168	195
Purchase obligations	326	141	127	45	13
Other long-term liabilities [(1)]	—	—	—	—	—
Total	$16,583	$7,542	$2,575	$1,955	$4,511

(1) Our Consolidated Balance Sheet as of December 31, 2018, includes $1,259 million of other long-term liabilities. This consists primarily of long-term deferred income taxes, liabilities under our deferred compensation plan, liabilities related to certain undertakings, reserves for uncertain tax positions and retirement benefit obligations. These liabilities have been excluded from the table above as the timing and/or amount of any cash payment is uncertain.

Commitments

As part of the regulatory approval process in connection with the Fidelis Care Acquisition, we entered into certain undertakings with the New York State Department of Health. These undertakings contain various commitments by us that were effective upon completion of the Fidelis Care Acquisition. One of the undertakings includes a $340 million contribution by us to the State of New York to be paid over a five-year period for initiatives consistent with our mission of providing high quality healthcare to vulnerable populations within New York State. The present value of the contribution to the State of New York, approximately $328 million, was expensed during 2018.

In addition, in connection with obtaining regulatory approval of the Health Net acquisition from the California Department of Insurance and the California Department of Managed Health Care, in 2016 we committed to certain undertakings (the California Undertakings). The California Undertakings included, among other items, operational commitments around premiums, dividend restrictions, minimum Risk Based Capital (RBC) levels, local offices, growth, accreditation, HEDIS scores and other quality measures, network adequacy, certifications, investments and capital expenditures. Specifically, we agreed to, among other things:

- invest an additional $30 million through the California Organized Investment Network over the five years following completion of the acquisition;
- build a service center in an economically distressed community in California, investing $200 million over 10 years and employing at least 300 people, of which we have incurred $8 million through 2018;

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- contribute $65 million to improve enrollee health outcomes ($10 million over five years), support locally-based consumer assistance programs ($5 million over five years) and strengthen the healthcare delivery system ($50 million over five years), of which we have contributed $13 million through 2018, and;
- invest $75 million of its investment portfolio in vehicles supporting California's healthcare infrastructure, of which we have invested $12 million through 2018.

The California Undertakings require significant investments by us, may restrict or impose additional material costs on our future obligations and strategic initiatives in certain geographies, and subject us to various enforcement mechanisms.

REGULATORY CAPITAL AND DIVIDEND RESTRICTIONS

Our operations are conducted through our subsidiaries. As managed care organizations, most of our subsidiaries are subject to state regulations and other requirements that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and restrict the timing, payment and amount of dividends and other distributions that may be paid to us. Generally, the amount of dividend distributions that may be paid by a regulated subsidiary without prior approval by state regulatory authorities is limited based on the entity's level of statutory net income and statutory capital and surplus.

Our regulated subsidiaries are required to maintain minimum capital requirements prescribed by various regulatory authorities in each of the states in which we operate. As of December 31, 2018, our subsidiaries had aggregate statutory capital and surplus of $7,259 million, compared with the required minimum aggregate statutory capital and surplus requirements of $3,279 million. During the year ended December 31, 2018, we contributed $154 million of net statutory capital to our subsidiaries. For our subsidiaries that file with the National Association of Insurance Commissioners (NAIC), we estimate our RBC percentage to be in excess of 350% of the Authorized Control Level.

Under the California Knox-Keene Health Care Service Plan Act of 1975, as amended ("Knox-Keene"), certain of our California subsidiaries must comply with tangible net equity (TNE) requirements. Under these Knox-Keene TNE requirements, actual net worth less unsecured receivables and intangible assets must be more than the greater of (i) a fixed minimum amount, (ii) a minimum amount based on premiums or (iii) a minimum amount based on healthcare expenditures, excluding capitated amounts. In addition, certain of our California subsidiaries have made certain undertakings to the DMHC to restrict dividends and loans to affiliates, to the extent that the payment of such would reduce such entities' TNE below the required amount as specified in the undertaking.

Under the New York State Department of Health Codes, Rules and Regulations Title 10, Part 98, our New York subsidiary must comply with contingent reserve requirements. Under these requirements, net worth based upon admitted assets must equal or exceed a minimum amount based on annual net premium income.

The NAIC has adopted rules which set minimum risk-based capital requirements for insurance companies, managed care organizations and other entities bearing risk for healthcare coverage. As of December 31, 2018, each of our health plans was in compliance with the risk-based capital requirements enacted in those states.

As a result of the above requirements and other regulatory requirements, certain of our subsidiaries are subject to restrictions on their ability to make dividend payments, loans or other transfers of cash to their parent companies. Such restrictions, unless amended or waived or unless regulatory approval is granted, limit the use of any cash generated by these subsidiaries to pay our obligations. The maximum amount of dividends that can be paid by our insurance company subsidiaries without prior approval of the applicable state insurance departments is subject to restrictions relating to statutory surplus, statutory income and unassigned surplus. As of December 31, 2018, the amount of capital and surplus or net worth that was unavailable for the payment of dividends or return of capital to us

was $3,279 million in the aggregate.

RECENT ACCOUNTING PRONOUNCEMENTS

For this information, refer to Note 2. Summary of Significant Accounting Policies, in the Notes to the Consolidated Financial Statements, included herein.

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CRITICAL ACCOUNTING POLICIES AND ESTIMATES

Our discussion and analysis of our results of operations and liquidity and capital resources are based on our consolidated financial statements which have been prepared in accordance with GAAP. Our significant accounting policies are more fully described in Note 2. Summary of Significant Accounting Policies, to our consolidated financial statements included elsewhere herein. Our accounting policies regarding intangible assets, medical claims liability and revenue recognition are particularly important to the portrayal of our financial position and results of operations and require the application of significant judgment by our management. As a result, they are subject to an inherent degree of uncertainty. We have reviewed these critical accounting policies and related disclosures with the Audit Committee of our Board of Directors.

Goodwill and Intangible Assets

We have made several acquisitions that have resulted in our recording of intangible assets. These intangible assets primarily consist of customer relationships, purchased contract rights, provider contracts, trade names and goodwill. Key assumptions used in the valuation of these intangible assets include, but are not limited to, member attrition rates, contract renewal probabilities, revenue growth rates, expectations of profitability, discount and royalty rates. We allocate the fair value of purchase consideration to the assets acquired and liabilities assumed based on their fair values at the acquisition date. The excess of the fair value of consideration transferred over the fair value of the net assets acquired is recorded as goodwill. Goodwill is generally attributable to the value of the synergies between the combined companies and the value of the acquired assembled workforce, neither of which qualifies for recognition as an intangible asset. At December 31, 2018, we had $7,015 million of goodwill and $2,239 million of other intangible assets.

Intangible assets are amortized using the straight-line method over the following periods:

Intangible Asset	Amortization Period
Purchased contract rights	5 - 15 years
Provider contracts	4 - 15 years
Customer relationships	3 - 15 years
Trade names	7 - 20 years
Developed technologies	2 - 7 years

Our management evaluates whether events or circumstances have occurred that may affect the estimated useful life or the recoverability of the remaining balance of goodwill and other identifiable intangible assets. If the events or circumstances indicate that the remaining balance of the intangible asset or goodwill may be impaired, the potential impairment will be measured based upon the difference between the carrying amount of the intangible asset or goodwill and the fair value of such asset. Our management must make assumptions and estimates, such as the discount factor, future utility and other internal and external factors, in determining the estimated fair values. While we believe these assumptions and estimates are appropriate, other assumptions and estimates could be applied and might produce significantly different results.

Goodwill is reviewed annually during the fourth quarter for impairment. In addition, an impairment analysis of intangible assets would be performed based on other factors. These factors include significant changes in membership, state funding, medical contracts and provider networks and contracts.

We first assess qualitative factors to determine whether it is necessary to perform the two-step quantitative goodwill impairment test. We generally do not calculate the fair value of a reporting unit unless we determine, based on a

qualitative assessment, that it is more likely than not that its fair value is less than its carrying amount. However, in certain circumstances, such as recent acquisitions, we may elect to perform a quantitative assessment without first assessing qualitative factors. The goodwill of $267 million associated with our home health business is expected to be recovered. However, the penetration of this business model into our Medicaid population has been slower than anticipated. The associated decreased profitability has been offset by the performance of our shared savings demonstration programs. To the extent the demonstration programs change substantially in advance of the Medicaid penetration, the reporting unit could be at risk for impairment.

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Medical Claims Liability

Our medical claims liability includes claims reported but not yet paid, or inventory, estimates for claims incurred but not reported, or IBNR, and estimates for the costs necessary to process unpaid claims at the end of each period. We estimate our medical claims liability using actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. These actuarial methods consider factors such as historical data for payment patterns, cost trends, product mix, seasonality, utilization of healthcare services and other relevant factors.

Actuarial Standards of Practice generally require that the medical claims liability estimates be adequate to cover obligations under moderately adverse conditions. Moderately adverse conditions are situations in which the actual claims are expected to be higher than the otherwise estimated value of such claims at the time of estimate. In many situations, the claims amounts ultimately settled will be different than the estimate that satisfies the Actuarial Standards of Practice. We include in our IBNR an estimate for medical claims liability under moderately adverse conditions which represents the risk of adverse deviation of the estimates in our actuarial method of reserving.

We use our judgment to determine the assumptions to be used in the calculation of the required estimates. The assumptions we consider when estimating IBNR include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, healthcare service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to fee schedules, and the incidence of high dollar or catastrophic claims.

We apply various estimation methods depending on the claim type and the period for which claims are being estimated. For more recent periods, incurred non-inpatient claims are estimated based on historical per member per month claims experience adjusted for known factors. Incurred hospital inpatient claims are estimated based on known inpatient utilization data and prior claims experience adjusted for known factors. For older periods, we utilize an estimated completion factor based on our historical experience to develop IBNR estimates. The completion factor is an actuarial estimate of the percentage of claims incurred during a given period that have been received or adjudicated as of the reporting period to the estimate of the total ultimate incurred costs. When we commence operations in a new state or region, we have limited information with which to estimate our medical claims liability. See “Risk Factors - Failure to accurately estimate and price our medical expenses or effectively manage our medical costs or related administrative costs could negatively affect our financial position, results of operations and cash flows.” These approaches are consistently applied to each period presented.

Additionally, we contract with independent actuaries to review our estimates on a quarterly basis. The independent actuaries provide us with a review letter that includes the results of their analysis of our medical claims liability. We do not solely rely on their report to adjust our claims liability. We utilize their calculation of our claims liability only as additional information, together with management's judgment, to determine the assumptions to be used in the calculation of our liability for claims.

Our development of the medical claims liability estimate is a continuous process which we monitor and refine on a monthly basis as additional claims receipts and payment information becomes available. As more complete claims information becomes available, we adjust the amount of the estimates, and include the changes in estimates in medical costs in the period in which the changes are identified. In every reporting period, our operating results include the effects of more completely developed medical claims liability estimates associated with previously reported periods. We consistently apply our reserving methodology from period to period. As additional information becomes known to us, we adjust our actuarial models accordingly to establish medical claims liability estimates.

The paid and received completion factors, claims per member per month and per diem cost trend factors are the most significant factors affecting the IBNR estimate. The following table illustrates the sensitivity of these factors and the estimated potential impact on our operating results caused by changes in these factors based on December 31, 2018 data:

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Completion Factors: [1]		Cost Trend Factors: [2]	
(Decrease) Increase in Factors	Increase (Decrease) in Medical Claims Liabilities (in millions)	(Decrease) Increase in Factors	Increase (Decrease) in Medical Claims Liabilities (in millions)
(1.00)%	$ 294	(1.00)%	$ (77)
(0.75)	220	(0.75)	(58)
(0.50)	146	(0.50)	(39)
(0.25)	73	(0.25)	(19)
0.25	(73)	0.25	19
0.50	(145)	0.50	39
0.75	(217)	0.75	58
1.00	(288)	1.00	77

(1) Reflects estimated potential changes in medical claims liability caused by changes in completion factors.

(2) Reflects estimated potential changes in medical claims liability caused by changes in cost trend factors for the most recent periods.

While we believe our estimates are appropriate, it is possible future events could require us to make significant adjustments for revisions to these estimates. For example, a 1% increase or decrease in our estimated medical claims liability would have affected net earnings by $45 million for the year ended December 31, 2018, excluding the effect of any return of premium, risk corridor, or minimum MLR programs. The estimates are based on our historical experience, terms of existing contracts, our observance of trends in the industry, information provided by our providers and information available from other outside sources.

The change in medical claims liability is summarized as follows (in millions):

	Year Ended December 31,		
	2018	2017	2016
Balance, January 1,	$4,286	$3,929	$2,298
Less: reinsurance recoverable	18	5	—
Balance, January 1, net	4,268	3,924	2,298
Acquisitions	1,204	—	1,482
Less: acquired reinsurance recoverable	8	—	—
Incurred related to:			
Current year	46,484	38,225	30,946
Prior years	(427)	(374)	(310)
Total incurred	46,057	37,851	30,636
Paid related to:			
Current year	41,161	34,196	28,532

Prior years	3,556	3,311	1,960
Total paid	44,717	37,507	30,492
Balance, December 31, net	6,804	4,268	3,924
Plus: reinsurance recoverable	27	18	5
Balance, December 31,	$6,831	$4,286	$3,929
Days in claims payable [1]	48	41	42

(1) Days in claims payable is a calculation of medical claims liability at the end of the period divided by average expense per calendar day for the fourth quarter of each year.

Medical claims are usually paid within a few months of the member receiving service from the physician or other healthcare provider. As a result, the liability generally is described as having a “short-tail,” which causes less than 5% of our medical claims liability as of the end of any given year to be outstanding the following year. We believe that substantially all the development of the estimate of medical claims liability as of December 31, 2018 will be known by the end of 2019.

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Changes in estimates of incurred claims for prior years are primarily attributable to reserving under moderately adverse conditions. Additionally, as a result of minimum HBR and other return of premium programs, approximately $25 million, $1 million and $39 million of the “Incurred related to: Prior years” was recorded as a reduction to premium revenues in 2018, 2017 and 2016, respectively. Further, claims processing initiatives yielded increased claim payment recoveries and coordination of benefits related to prior year dates of service. Changes in medical utilization and cost trends and the effect of medical management initiatives may also contribute to changes in medical claim liability estimates. While we have evidence that medical management initiatives are effective on a case by case basis, medical management initiatives primarily focus on events and behaviors prior to the incurrence of the medical event and generation of a claim. Accordingly, any change in behavior, leveling of care, or coordination of treatment occurs prior to claim generation and as a result, the costs prior to the medical management initiative are not known by us. Additionally, certain medical management initiatives are focused on member and provider education with the intent of influencing behavior to appropriately align the medical services provided with the member's acuity. In these cases, determining whether the medical management initiative changed the behavior cannot be determined. Because of the complexity of our business, the number of states in which we operate, and the volume of claims that we process, we are unable to practically quantify the impact of these initiatives on our changes in estimates of IBNR.

The following are examples of medical management initiatives that may have contributed to the favorable development through lower medical utilization and cost trends:

- Appropriate leveling of care for neonatal intensive care unit hospital admissions, other inpatient hospital admissions, and observation admissions, in accordance with InterQual or other criteria.
- Management of our pre-authorization list and more stringent review of durable medical equipment and injectibles.
- Emergency department program designed to collaboratively work with hospitals to steer non-emergency care away from the costly emergency department setting (through patient education, on-site alternative urgent care settings, etc.).
- Increased emphasis on case management and clinical rounding where case managers are nurses or social workers who are employed by the health plan to assist selected patients with the coordination of healthcare services in order to meet a patient's specific healthcare needs.
- Incorporation of disease management which is a comprehensive, multidisciplinary, collaborative approach to chronic illnesses such as asthma.
- Prenatal and infant health programs utilized in our Start Smart For Your Baby outreach service.

Revenue Recognition

Our health plans generate revenues primarily from premiums received from the states in which we operate health plans, premiums received from our members and CMS for our Medicare product, and premiums from members of our commercial health plans. In addition to member premium payments, our Marketplace contracts also generate revenues from subsidies received from CMS. We generally receive a fixed premium per member per month pursuant to our contracts and recognize premium revenues during the period in which we are obligated to provide services to our members at the amount reasonably estimable. In some instances, our base premiums are subject to an adjustment, or risk score, based on the acuity of its membership. Generally, the risk score is determined by the State or CMS analyzing submissions of processed claims data to determine the acuity of our membership relative to the entire state's membership. We estimate the amount of risk adjustment based upon the processed claims data submitted and expected to be submitted to CMS and record revenues on a risk adjusted basis. Some contracts allow for additional premiums related to certain supplemental services provided such as maternity deliveries.

Our contracts with states may require us to maintain a minimum HBR or may require us to share profits in excess of certain levels. In certain circumstances, including commercial plans, our plans may be required to return premium to the state or policyholders in the event profits exceed established levels. We estimate the effect of these programs and

recognize reductions in revenue in the current period. Other states may require us to meet certain performance and quality metrics in order to receive additional or full contractual revenue. For performance-based contracts, we do not recognize revenue subject to refund until data is sufficient to measure performance.

Revenues are recorded based on membership and eligibility data provided by the states or CMS, which is adjusted on a monthly basis by the states or CMS for retroactive additions or deletions to membership data. These eligibility adjustments are estimated monthly and subsequent adjustments are made in the period known. We continuously review and updates those estimates as new information becomes available. It is possible that new information could require us to make additional adjustments, which could be significant, to these estimates.

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Our Medicare Advantage contracts are with CMS. CMS deploys a risk adjustment model which apportions premiums paid to all health plans according to health severity and certain demographic factors. The CMS risk adjustment model pays more for members whose medical history would indicate that they are expected to have higher medical costs. Under this risk adjustment methodology, CMS calculates the risk adjusted premium payment using diagnosis data from hospital inpatient, hospital outpatient, physician treatment settings as well as prescription drug events. We and the healthcare providers collect, compile and submit the necessary and available diagnosis data to CMS within prescribed deadlines. We estimate risk adjustment revenues based upon the diagnosis data submitted and expected to be submitted to CMS and record revenues on a risk adjusted basis.

Our specialty services generate revenues under contracts with state and federal programs, healthcare organizations and other commercial organizations, as well as from our own subsidiaries. Revenues are recognized when the related services are provided or as ratably earned over the covered period of services. We recognize revenue related to administrative services under the TRICARE government-sponsored managed care support contract on a straight-line basis over the option period, when the fees become fixed and determinable. The TRICARE contract includes various performance-based measures. For each of the measures, an estimate of the amount that has been earned is made at each interim date, and revenue is recognized accordingly.

Some states enact premium taxes, similar assessments and provider pass-through payments, collectively premium taxes, and these taxes are recorded as a separate component of both revenues and operating expenses. Additionally, our insurance subsidiaries are subject to the Affordable Care Act annual HIF. The ACA imposed the HIF in 2014, 2015, 2016 and 2018. The HIF was suspended in 2017 and 2019. If we are able to negotiate reimbursement of portions of these premium taxes or the HIF, we recognize revenue associated with the HIF on a straight-line basis when we have binding agreements for such reimbursements, including the “gross-up” to reflect the HIFs non-tax deductible nature. Collectively, this revenue is recorded as premium tax and health insurer fee revenue in the Consolidated Statements of Operations. For certain products, premium taxes, state assessments and the HIF are not pass-through payments and are recorded as premium revenue and premium tax expense or health insurer fee expense in the Consolidated Statements of Operations.

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ITEM 7A. Quantitative and Qualitative Disclosures About Market Risk

INVESTMENTS AND DEBT

As of December 31, 2018, we had short-term investments of $722 million and long-term investments of $7,416 million, including restricted deposits of $555 million. The short-term investments generally consist of highly liquid securities with maturities between three and 12 months. The long-term investments consist of municipal, corporate and U.S. Treasury securities, government sponsored obligations, life insurance contracts, asset backed securities and private equity securities and have maturities greater than one year. Restricted deposits consist of investments required by various state statutes to be deposited or pledged to state agencies. Due to the nature of the states' requirements, these investments are classified as long-term regardless of the contractual maturity date. Substantially all of our investments are subject to interest rate risk and will decrease in value if market rates increase. Assuming a hypothetical and immediate 1% increase in market interest rates at December 31, 2018, the fair value of our fixed income investments would decrease by approximately $241 million. Declines in interest rates over time will reduce our investment income.

We have interest rate swap agreements for a notional amount of $2,700 million with creditworthy financial institutions to manage the impact of market interest rates on interest expense. Our swap agreements convert a portion of our interest expense from fixed to variable rates to better match the impact of changes in market rates on our variable rate cash equivalent investments. As a result, the fair value of $2,700 million of our long-term debt varies with market interest rates. Assuming a hypothetical and immediate 1% increase in market interest rates at December 31, 2018, the fair value of our debt would decrease by approximately $102 million. An increase in interest rates decreases the fair value of the debt and conversely, a decrease in interest rates increases the value.

For a discussion of the interest rate risk that our investments are subject to, see "Risk Factors – Our investment portfolio may suffer losses which could materially and adversely affect our results of operations or liquidity."

INFLATION

Historically, the inflation rate for medical care costs has been higher than the overall inflation rate for all items. We use various strategies to mitigate the negative effects of healthcare cost inflation. Specifically, our health plans try to control medical and hospital costs through our state savings initiatives and contracts with independent providers of healthcare services. Through these contracted care providers, our health plans emphasize preventive healthcare and appropriate use of specialty and hospital services. Additionally, our contracts with states require actuarially sound premiums that include healthcare cost trend.

While we currently believe our strategies to mitigate healthcare cost inflation will continue to be successful, competitive pressures, new healthcare and pharmaceutical product introductions, demands from healthcare providers and customers, applicable regulations, an increase in the expected rate of inflation for healthcare costs or other factors may affect our ability to control the impact of healthcare cost increases.

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Item 8. Financial Statements and Supplementary Data

Report of Independent Registered Public Accounting Firm
To the Stockholders and Board of Directors
Centene Corporation:

Opinion on the Consolidated Financial Statements
We have audited the accompanying consolidated balance sheets of Centene Corporation and subsidiaries (the Company) as of December 31, 2018 and 2017, the related consolidated statements of operations, comprehensive earnings, stockholders' equity, and cash flows for each of the years in the three-year period ended December 31, 2018, and the related notes (collectively, the consolidated financial statements). In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Company as of December 31, 2018 and 2017, and the results of its operations and its cash flows for each of the years in the three-year period ended December 31, 2018, in conformity with U.S. generally accepted accounting principles.
We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2018, based on criteria established in Internal Control - Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission, and our report dated February 19, 2019 expressed an unqualified opinion on the effectiveness of the Company's internal control over financial reporting.
Basis for Opinion
These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the consolidated financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. We believe that our audits provide a reasonable basis for our opinion.

/s/ KPMG LLP

We have served as the Company's auditor since 2005.

St. Louis, Missouri
February 19, 2019

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CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED BALANCE SHEETS
(In millions, except shares in thousands and per share data in dollars)

	December 31, 2018	December 31, 2017
ASSETS		
Current assets:		
Cash and cash equivalents	$ 5,342	$ 4,072
Premium and trade receivables	5,150	3,413
Short-term investments	722	531
Other current assets	784	687
Total current assets	11,998	8,703
Long-term investments	6,861	5,312
Restricted deposits	555	135
Property, software and equipment, net	1,706	1,104
Goodwill	7,015	4,749
Intangible assets, net	2,239	1,398
Other long-term assets	527	454
Total assets	$ 30,901	$ 21,855
LIABILITIES, REDEEMABLE NONCONTROLLING INTERESTS AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims liability	$ 6,831	$ 4,286
Accounts payable and accrued expenses	4,051	4,165
Return of premium payable	666	549
Unearned revenue	385	328
Current portion of long-term debt	38	4
Total current liabilities	11,971	9,332
Long-term debt	6,648	4,695
Other long-term liabilities	1,259	952
Total liabilities	19,878	14,979
Commitments and contingencies		
Redeemable noncontrolling interests	10	12
Stockholders' equity:		
Preferred stock, $.001 par value; authorized 10,000 shares; no shares issued or outstanding at December 31, 2018 and December 31, 2017	—	—
Common stock, $.001 par value; authorized 800,000 shares; 417,695 issued and 412,478 outstanding at December 31, 2018, and 360,758 issued and 346,874 outstanding at December 31, 2017	—	—
Additional paid-in capital	7,449	4,349
Accumulated other comprehensive loss	(56)	(3)
Retained earnings	3,663	2,748
Treasury stock, at cost (5,217 and 13,884 shares, respectively)	(139)	(244)
Total Centene stockholders' equity	10,917	6,850
Noncontrolling interest	96	14
Total stockholders' equity	11,013	6,864
Total liabilities, redeemable noncontrolling interests and stockholders' equity	$ 30,901	$ 21,855

The accompanying notes to the consolidated financial statements are an integral part of these statements.

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CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF OPERATIONS
(In millions, except per share data in dollars)

	Year Ended December 31,		
	2018	2017	2016
Revenues:			
Premium	$53,629	$43,353	$35,399
Service	2,806	2,267	2,180
Premium and service revenues	56,435	45,620	37,579
Premium tax and health insurer fee	3,681	2,762	3,028
Total revenues	60,116	48,382	40,607
Expenses:			
Medical costs	46,057	37,851	30,636
Cost of services	2,386	1,847	1,864
Selling, general and administrative expenses	6,043	4,446	3,673
Amortization of acquired intangible assets	211	156	147
Premium tax expense	3,252	2,883	2,563
Health insurer fee expense	709	—	461
Total operating expenses	58,658	47,183	39,344
Earnings from operations	1,458	1,199	1,263
Other income (expense):			
Investment and other income	253	190	114
Interest expense	(343)	(255)	(217)
Earnings from operations, before income tax expense	1,368	1,134	1,160
Income tax expense	474	326	599
Net earnings	894	808	561
Loss attributable to noncontrolling interests	6	20	1
Net earnings attributable to Centene Corporation	$900	$828	$562
Net earnings per common share attributable to Centene Corporation:			
Basic earnings per common share	$2.31	$2.40	$1.76
Diluted earnings per common share	$2.26	$2.34	$1.71

The accompanying notes to the consolidated financial statements are an integral part of these statements.

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CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF COMPREHENSIVE EARNINGS
(In millions)

	Year Ended December 31,		
	2018	2017	2016
Net earnings	$ 894	$ 808	$ 561
Reclassification adjustment, net of tax	2	(2)	(2)
Change in unrealized (loss) gain on investments, net of tax	(52)	28	(22)
Defined benefit pension plan net gain arising during the period, net of tax	1	1	1
Foreign currency translation adjustments	(4)	6	(3)
Other comprehensive (loss) earnings	(53)	33	(26)
Comprehensive earnings	841	841	535
Comprehensive loss attributable to the noncontrolling interests	6	20	1
Comprehensive earnings attributable to Centene Corporation	$ 847	$ 861	$ 536

The accompanying notes to the consolidated financial statements are an integral part of these statements.

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CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
(In millions, except shares in thousands and per share data in dollars)

	Centene Stockholders' Equity								
	Common Stock					Treasury Stock			
	$.001 Par Value Shares	Amt	Additional Paid-in Capital	Accumulated Other Comprehensive Income (Loss)	Retained Earnings	$.001 Par Value Shares	Amt	Non controlling Interest	Total
Balance, December 31, 2015	253,710	$ —	$ 956	$ (10)	$ 1,358	13,024	$ (147)	$ 11	$ 2,168
Net earnings	—	—	—	—	562	—	—	1	563
Other comprehensive loss, net of ($14) tax	—	—	—	(26)	—	—	—	—	(26)
Common stock issued for acquisitions	96,436	—	3,074	—	—	(2,750)	31	—	3,105
Common stock issued for employee benefit plans	6,122	—	12	—	—	—	—	—	12
Common stock repurchases	—	—	—	—	—	2,156	(63)	—	(63)
Stock compensation expense	—	—	148	—	—	—	—	—	148
Contribution from noncontrolling interest	—	—	—	—	—	—	—	2	2
Balance, December 31, 2016	356,268	$ —	$ 4,190	$ (36)	$ 1,920	12,430	$ (179)	$ 14	$ 5,909
Net earnings	—	—	—	—	828	—	—	—	828
Other comprehensive earnings, net of $15 tax	—	—	—	33	—	—	—	—	33
Common stock issued for employee benefit plans	4,490	—	11	—	—	—	—	—	11
Common stock repurchases	—	—	—	—	—	1,454	(65)	—	(65)
Stock compensation expense	—	—	135	—	—	—	—	—	135
Purchase of noncontrolling interest	—	—	13	—	—	—	—	—	13
Balance, December 31, 2017	360,758	$ —	$ 4,349	$ (3)	$ 2,748	13,884	$ (244)	$ 14	$ 6,864
Net earnings	—	—	—	—	900	—	—	(2)	898
Other comprehensive loss, net of ($15) tax	—	—	—	(53)	—	—	—	—	(53)
Common stock issued for acquisitions	—	—	331	—	—	(9,787)	176	—	507
Common stock issued for stock offering	53,207	—	2,779	—	—	—	—	—	2,779
Common stock issued for employee benefit plans	3,730	—	17	—	—	—	—	—	17
Common stock repurchases	—	—	—	—	—	1,120	(71)	—	(71)
Stock compensation expense	—	—	145	—	—	—	—	—	145
Cumulative-effect of adopting new accounting guidance	—	—	—	—	15	—	—	—	15
Purchase of noncontrolling interest	—	—	(172)	—	—	—	—	(15)	(187)
	—	—	—	—	—	—	—	99	99

Acquisition resulting in noncontrolling interest								
Balance, December 31, 2018	417,695	$ —	$ 7,449	$ (56)	$ 3,663	5,217	$ (139)	$ 96	$ 11,013

The accompanying notes to the consolidated financial statements are an integral part of this statement.

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CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CASH FLOWS
(In millions)

	Year Ended December 31,		
	2018	2017	2016
Cash flows from operating activities:			
Net earnings	$894	$808	$561
Adjustments to reconcile net earnings to net cash provided by operating activities			
Depreciation and amortization	495	361	278
Stock compensation expense	145	135	148
Debt extinguishment costs	—	—	(7)
Deferred income taxes	(129)	(108)	92
Changes in assets and liabilities			
Premium and trade receivables	(1,173)	(50)	74
Other assets	(38)	(146)	167
Medical claims liabilities	1,325	359	145
Unearned revenue	(52)	19	43
Accounts payable and accrued expenses	(533)	53	402
Other long-term liabilities	258	68	(61)
Other operating activities, net	42	(10)	9
Net cash provided by operating activities	1,234	1,489	1,851
Cash flows from investing activities:			
Capital expenditures	(675)	(422)	(306)
Purchases of investments	(3,846)	(2,656)	(2,432)
Sales and maturities of investments	1,991	1,862	1,566
Investments in acquisitions, net of cash acquired	(2,055)	(50)	(1,297)
Other investing activities, net	—	12	—
Net cash used in investing activities	(4,585)	(1,254)	(2,469)
Cash flows from financing activities:			
Proceeds from the issuance of common stock	2,779	—	—
Proceeds from borrowings	6,077	1,400	8,946
Payment of long-term debt	(4,083)	(1,353)	(6,076)
Common stock repurchases	(71)	(65)	(63)
Purchase of noncontrolling interest	(74)	(66)	(14)
Debt issuance costs	(25)	(3)	(76)
Other financing activities, net	9	5	—
Net cash provided by (used in) financing activities	4,612	(82)	2,717
Effect of exchange rate changes on cash, cash equivalents and restricted cash	—	—	(1)
Net increase in cash, cash equivalents and restricted cash	1,261	153	2,098
Cash, cash equivalents, and restricted cash and cash equivalents, beginning of period	4,089	3,936	1,838
Cash, cash equivalents, and restricted cash and cash equivalents, end of period	$5,350	$4,089	$3,936
Supplemental disclosures of cash flow information:			
Interest paid	$323	$237	$165
Income taxes paid	$448	$496	$556
Equity issued in connection with acquisitions	$507	$—	$3,105

The accompanying notes to the consolidated financial statements are an integral part of these statements.

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CENTENE CORPORATION AND SUBSIDIARIES
NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS

1. Organization and Operations

On December 12, 2018, the Board of Directors declared a two-for-one split of Centene's common stock in the form of a 100% stock dividend distributed on February 6, 2019 to stockholders of record as of December 24, 2018. All share and per share information presented in this Form 10-K has been adjusted for the two-for-one stock split.

Centene Corporation, or the Company, is a diversified, multi-national healthcare enterprise operating in two segments: Managed Care and Specialty Services. The Managed Care segment provides health plan coverage to individuals through government subsidized programs, including Medicaid, the State Children's Health Insurance Program (CHIP), Long-Term Services and Supports (LTSS), Foster Care, Medicare-Medicaid Plans (MMP), which cover beneficiaries who are dually eligible for Medicare and Medicaid, the Supplemental Security Income Program, also known as the Aged, Blind or Disabled Program (ABD), Medicare, and the Health Insurance Marketplace. The Company also offers a variety of individual, small group, and large group commercial healthcare products, both to employers and directly to members in the Managed Care segment. The Specialty Services segment consists of our specialty companies offering auxiliary healthcare services and products to state programs, correctional facilities, healthcare organizations, employer groups and other commercial organizations, as well as to our own subsidiaries. The Specialty Service segment also includes the Government Contracts business which includes the Company's government-sponsored managed care support contract with the U.S. Department of Defense (DoD) under the TRICARE program, the Military Family and Life Counseling (MFLC) contract with the DoD, and other healthcare related government contracts.

2. Summary of Significant Accounting Policies

Basis of Presentation

The accompanying consolidated financial statements include the accounts of Centene Corporation and all majority owned subsidiaries and subsidiaries over which the Company exercises the power and control to direct activities significantly impacting financial performance. All material intercompany balances and transactions have been eliminated.

In January 2017, the Company reclassified Cenpatico Behavioral Health of Arizona, LLC and the related Cenpatico Integrated Care health plan from the Specialty Services segment to the Managed Care segment due to a reorganization of the Arizona management structure following the Health Net integration. As a result, the financial results of Cenpatico Behavioral Health of Arizona, LLC and the related Cenpatico Integrated Care health plan have been reclassified from the Specialty Services segment to the Managed Care segment for all periods presented.

Certain amounts in the consolidated financial statements and notes have been reclassified to conform to the 2018 presentation. These reclassifications have no effect on net earnings or stockholders' equity as previously reported.

Use of Estimates

The preparation of financial statements in conformity with generally accepted accounting principles in the United States (GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Future events and their effects cannot be predicted

with certainty; accordingly, the accounting estimates require the exercise of judgment. The accounting estimates used in the preparation of the consolidated financial statements will change as new events occur, as more experience is acquired, as additional information is obtained and as the operating environment changes. The Company evaluates and updates its assumptions and estimates on an ongoing basis and may employ outside experts to assist in its evaluation, as considered necessary. Actual results could differ from those estimates.

Business Combinations

Business combinations are accounted for using the acquisition method of accounting. The Company allocates the fair value of purchase consideration to the assets acquired and liabilities assumed based on their fair values at the acquisition date. The excess of the fair value of consideration transferred over the fair value of the net assets acquired is recorded as goodwill. Goodwill is generally attributable to the value of the synergies between the combined companies and the value of the acquired assembled workforce, neither of which qualifies for recognition as an intangible asset.

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The Company uses its best estimates and assumptions to value assets acquired and liabilities assumed at the acquisition date; however, these estimates are sometimes preliminary and, in some instances, all information required to value the assets acquired and liabilities assumed may not be available or final as of the end of a reporting period subsequent to the business combination. If the accounting for the business combination is incomplete, provisional amounts are recorded. The provisional amounts are updated during the period determined, up to one year from the acquisition date. The Company includes the results of operations of acquired businesses in the Company's consolidated results prospectively from the date of acquisition.

Acquisition related expenses and post-acquisition restructuring costs are recognized separately from the business combination and are expensed as incurred.

Cash and Cash Equivalents

Investments with original maturities of three months or less are considered to be cash equivalents. Cash equivalents consist of money market funds, bank certificates of deposit and savings accounts.

The Company maintains amounts on deposit with various financial institutions, which may exceed federally insured limits. However, management periodically evaluates the credit-worthiness of those institutions, and the Company has not experienced any losses on such deposits.

Investments

Short-term investments include securities with maturities greater than three months to one year. Long-term investments include securities with maturities greater than one year.

Short-term and long-term investments are generally classified as available for sale and are carried at fair value. Certain equity investments are recorded using the fair value or equity method. Unrealized gains and losses on debt investments available for sale are excluded from earnings and reported in accumulated other comprehensive income, a separate component of stockholders' equity, net of income tax effects. Premiums and discounts are amortized or accreted over the life of the related security using the effective interest method. The Company monitors the difference between the cost and fair value of investments. Investments that experience a decline in value that is judged to be other than temporary are written down to fair value and a realized loss is recorded in investment and other income. To calculate realized gains and losses on the sale of investments, the Company uses the specific amortized cost of each investment sold. Realized gains and losses are recorded in investment and other income.

The Company uses the equity method to account for its investments in entities that it does not control but has the ability to exercise significant influence over operating and financial policies. These investments are recorded at the lower of their cost or fair value adjusted for the Company's proportionate share of earnings or losses.

Restricted Deposits

Restricted deposits consist of investments required by various state statutes to be deposited or pledged to state agencies. These investments are classified as long-term, regardless of the contractual maturity date, due to the nature of the states' requirements. The Company is required to annually adjust the amount of the deposit pledged to certain states.

Fair Value Measurements

In the normal course of business, the Company invests in various financial assets and incurs various financial liabilities. Fair values are disclosed for all financial instruments, whether or not such values are recognized in the Consolidated Balance Sheets. Management obtains quoted market prices and other observable inputs for these disclosures. The carrying amounts reported in the Consolidated Balance Sheets for cash and cash equivalents, premium and trade receivables, medical claims liability, accounts payable and accrued expenses, unearned revenue, and certain other current assets and liabilities are carried at cost, which approximates fair value because of their short-term nature.

The following methods and assumptions were used to estimate the fair value of each financial instrument:

- Available for sale investments and restricted deposits: The carrying amount is stated at fair value, based on quoted market prices, where available. For securities not actively traded, fair values were estimated using values obtained from independent pricing services or quoted market prices of comparable instruments.
- Senior unsecured notes: Estimated based on third-party quoted market prices for the same or similar issues.

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- Variable rate debt: The carrying amount of our floating rate debt approximates fair value since the interest rates adjust based on market rate adjustments.
- Interest rate swap: Estimated based on third-party market prices based on the forward 1-month or 3-month LIBOR curve.
- Contingent consideration: Estimated based on expected achievement of metrics included in the acquisition agreement considering circumstances that exist as of the acquisition date.

Property, Software and Equipment

Property, software and equipment are stated at cost less accumulated depreciation. Computer hardware and software includes certain costs incurred in the development of internal-use software, including external direct costs of materials and services and payroll costs of employees devoted to specific software development. Depreciation is calculated principally by the straight-line method over estimated useful lives. Leasehold improvements are depreciated using the straight-line method over the shorter of the expected useful life or the remaining term of the lease. Property, software and equipment are depreciated over the following periods:

Fixed Asset	Depreciation Period
Buildings and land improvements	5 - 40 years
Computer hardware and software	2 - 7 years
Furniture and equipment	3 - 10 years
Land improvements	3 - 20 years
Leasehold improvements	1 - 20 years

The carrying amounts of all long-lived assets are evaluated to determine if adjustment to the depreciation and amortization period or to the unamortized balance is warranted. Such evaluation is based principally on the expected utilization of the long-lived assets.

The Company retains fully depreciated assets in property and accumulated depreciation accounts until it removes them from service. In the case of sale, retirement, or disposal, the asset cost and related accumulated depreciation balance is removed from the respective account, and the resulting net amount, less any proceeds, is included as a component of earnings from operations in the Consolidated Statements of Operations.

Goodwill and Intangible Assets

Intangible assets represent assets acquired in purchase transactions and consist primarily of purchased contract rights, provider contracts, customer relationships, trade names, developed technologies and goodwill. Intangible assets are amortized using the straight-line method over the following periods:

Intangible Asset	Amortization Period
Purchased contract rights	5 - 15 years
Provider contracts	4 - 15 years
Customer relationships	3 - 15 years
Trade names	7 - 20 years
Developed technologies	2 - 7 years

The Company tests for impairment of intangible assets as well as long-lived assets whenever events or changes in circumstances indicate that the carrying value of an asset or asset group (hereinafter referred to as “asset group”) may not be recoverable by comparing the sum of the estimated undiscounted future cash flows expected to result from use of the asset group and its eventual disposition to the carrying value. Such factors include, but are not limited to, significant changes in membership, state funding, state contracts and provider networks and contracts. If the sum of

the estimated undiscounted future cash flows is less than the carrying value, an impairment determination is required. The amount of impairment is calculated by subtracting the fair value of the asset group from the carrying value of the asset group. An impairment charge, if any, is recognized within earnings from operations.

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The Company tests goodwill for impairment using a fair value approach. The Company is required to test for impairment at least annually, absent a triggering event, which could include a significant decline in operating performance that would require an impairment assessment. Absent any impairment indicators, the Company performs its goodwill impairment testing during the fourth quarter of each year. The Company recognizes an impairment charge for any amount by which the carrying amount of goodwill exceeds its implied fair value.

The Company first assesses qualitative factors to determine whether it is necessary to perform the two-step quantitative goodwill impairment test. The Company generally does not calculate the fair value of a reporting unit unless it determines, based on a qualitative assessment, that it is more likely than not that its fair value is less than its carrying amount. However, in certain circumstances, such as recent acquisitions, the Company may elect to perform a quantitative assessment without first assessing qualitative factors.

If the two-step quantitative test is deemed necessary, the Company determines an appropriate valuation technique to estimate a reporting unit's fair value as of the testing date. The Company utilizes either the income approach or the market approach, whichever is most appropriate for the respective reporting unit. The income approach is based on an internally developed discounted cash flow model that includes many assumptions related to future growth rates, discount factors, future tax rates, etc. The market approach is based on financial multiples of comparable companies derived from current market data. The second step of the goodwill impairment test, used to measure the amount of impairment loss, compares the implied fair value of reporting unit goodwill with the carrying amount of that goodwill. If the carrying amount of reporting unit goodwill exceeds the implied fair value of that goodwill, an impairment loss shall be recognized in an amount equal to that excess. Changes in economic and operating conditions impacting assumptions used in our analyses could result in goodwill impairment in future periods.

Medical Claims Liability

Medical claims liability includes claims reported but not yet paid, or inventory, estimates for claims incurred but not reported, or IBNR, and estimates for the costs necessary to process unpaid claims at the end of each period. The Company estimates its medical claims liability using actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. These actuarial methods consider factors such as historical data for payment patterns, cost trends, product mix, seasonality, utilization of healthcare services and other relevant factors.

Actuarial Standards of Practice generally require that the medical claims liability estimates be adequate to cover obligations under moderately adverse conditions. Moderately adverse conditions are situations in which the actual claims are expected to be higher than the otherwise estimated value of such claims at the time of estimate. In many situations, the claims amounts ultimately settled will be different than the estimate that satisfies the Actuarial Standards of Practice. The Company includes in its IBNR an estimate for medical claims liability under moderately adverse conditions which represents the risk of adverse deviation of the estimates in its actuarial method of reserving.

The Company uses its judgment to determine the assumptions to be used in the calculation of the required estimates. The assumptions it considers when estimating IBNR include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, healthcare service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to fee schedules, and the incidence of high dollar or catastrophic claims.

The Company's development of the medical claims liability estimate is a continuous process which it monitors and refines on a monthly basis as additional claims receipts and payment information becomes available. As more complete claims information becomes available, the Company adjusts the amount of the estimates, and includes the

changes in estimates in medical costs in the period in which the changes are identified. In every reporting period, the operating results include the effects of more completely developed medical claims liability estimates associated with previously reported periods. The Company consistently applies its reserving methodology from period to period. As additional information becomes known, it adjusts the actuarial model accordingly to establish medical claims liability estimates.

The Company periodically reviews actual and anticipated experience compared to the assumptions used to establish medical costs. The Company establishes premium deficiency reserves if actual and anticipated experience indicates that existing policy liabilities together with the present value of future gross premiums will not be sufficient to cover the present value of future benefits, settlement and maintenance costs.

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Revenue Recognition

The Company's health plans generate revenues primarily from premiums received from the states in which it operates health plans, premiums received from its members and CMS for its Medicare product, and premiums from members of its commercial health plans. In addition to member premium payments, its Marketplace contracts also generate revenues from subsidies received from CMS. The Company generally receives a fixed premium per member per month pursuant to its contracts and recognizes premium revenues during the period in which it is obligated to provide services to its members at the amount reasonably estimable. In some instances, the Company's base premiums are subject to an adjustment, or risk score, based on the acuity of its membership. Generally, the risk score is determined by the State or CMS analyzing submissions of processed claims data to determine the acuity of the Company's membership relative to the entire state's membership. The Company estimates the amount of risk adjustment based upon the processed claims data submitted and expected to be submitted to Centers for Medicare and Medicaid Services (CMS) and records revenues on a risk adjusted basis. Some contracts allow for additional premiums related to certain supplemental services provided such as maternity deliveries.

The Company's contracts with states may require us to maintain a minimum health benefits ratio (HBR) or may require us to share profits in excess of certain levels. In certain circumstances, including commercial plans, its plans may be required to return premium to the state or policyholders in the event profits exceed established levels. The Company estimates the effect of these programs and recognizes reductions in revenue in the current period. Other states may require us to meet certain performance and quality metrics in order to receive additional or full contractual revenue. For performance-based contracts, the Company does not recognize revenue subject to refund until data is sufficient to measure performance.

Revenues are recorded based on membership and eligibility data provided by the states or CMS, which is adjusted on a monthly basis by the states or CMS for retroactive additions or deletions to membership data. These eligibility adjustments are estimated monthly and subsequent adjustments are made in the period known. The Company continuously reviews and updates those estimates as new information becomes available. It is possible that new information could require us to make additional adjustments, which could be significant, to these estimates.

The Company's Medicare Advantage contracts are with CMS. CMS deploys a risk adjustment model which apportions premiums paid to all health plans according to health severity and certain demographic factors. The CMS risk adjustment model pays more for members whose medical history would indicate that they are expected to have higher medical costs. Under this risk adjustment methodology, CMS calculates the risk adjusted premium payment using diagnosis data from hospital inpatient, hospital outpatient, physician treatment settings as well as prescription drug events. The Company and the healthcare providers collect, compile and submit the necessary and available diagnosis data to CMS within prescribed deadlines. The Company estimates risk adjustment revenues based upon the diagnosis data submitted and expected to be submitted to CMS and records revenues on a risk adjusted basis.

The Company's specialty services generate revenues under contracts with state and federal programs, healthcare organizations and other commercial organizations, as well as from our own subsidiaries. Revenues are recognized when the related services are provided or as ratably earned over the covered period of services. The Company recognizes revenue related to administrative services under the TRICARE government-sponsored managed care support contract for the DoD's TRICARE program on a straight-line basis over the option period, when the fees become fixed and determinable. The TRICARE contract includes various performance-based measures. For each of the measures, an estimate of the amount that has been earned is made at each interim date, and revenue is recognized accordingly.

Some states enact premium taxes, similar assessments and provider pass-through payments, collectively premium taxes, and these taxes are recorded as a separate component of both revenues and operating expenses. Additionally, the Company's insurance subsidiaries are subject to the Affordable Care Act annual health insurer fee (HIF), absent a HIF moratorium. The ACA imposed the HIF in 2014, 2015, 2016 and 2018. The HIF was suspended in 2017 and 2019. If the Company is able to negotiate reimbursement of portions of these premium taxes or the HIF, it recognizes revenue associated with the HIF on a straight-line basis when we have binding agreements for such reimbursements, including the “gross-up” to reflect the HIFs non-tax deductible nature. Collectively, this revenue is recorded as premium tax and health insurer fee revenue in the Consolidated Statements of Operations. For certain products, premium taxes, state assessments and the HIF are not pass-through payments and are recorded as premium revenue and premium tax expense or health insurer fee expense in the Consolidated Statements of Operations.

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Affordable Care Act

The Affordable Care Act (ACA) established risk spreading premium stabilization programs effective January 1, 2014. These programs, commonly referred to as the “three Rs”, include a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridor program. Additionally, the ACA established a minimum annual medical loss ratio (MLR) and cost sharing reductions. Each of the three R programs are taken into consideration to determine if the Company's estimated annual medical costs are less than the minimum loss ratio and require an adjustment to premium revenues to meet the minimum MLR.

The Company’s accounting policies for the programs are as follows:

Risk Adjustment

The permanent risk adjustment program established by the ACA transfers funds from qualified individual and small group insurance plans with below average risk scores to those plans with above average risk scores within each state. The Company estimates the receivable or payable under the risk adjustment program based on its estimated risk score compared to the state average risk score. The Company may record a receivable or payable as an adjustment to premium revenues to reflect the year-to-date impact of the risk adjustment based on its best estimate. The Company refines its estimate as new information becomes available.

Reinsurance

The ACA established a transitional 2014 to 2016 three-year reinsurance program whereby the Company’s claims costs incurred for qualified members will be reimbursed when they exceed a specific threshold. For the 2016 benefit year, qualified member claims that exceeded $90,000 entitled the Company to reimbursement from the programs at 50% coinsurance. The Company accounts for reinsurance recoveries as a reduction of medical costs based on each individual case that exceeds the reinsurance threshold established by the program.

Risk Corridor

The temporary 2014 to 2016 three-year risk corridor program established by the ACA applied to qualified individual and small group health plans operating both inside and outside of the Health Insurance Marketplace. The risk corridor program limited the Company’s gains and losses in the Health Insurance Marketplace by comparing certain medical and administrative costs to a target amount and sharing the risk for allowable costs with the federal government. Allowable medical costs were adjusted for risk adjustment settlements, transitional reinsurance recoveries and cost sharing reductions received from the federal government. The Company recorded a risk corridor receivable or payable as an adjustment to premium revenues on a year-to-date basis based on where its estimated annual costs fall within the risk corridor range.

Minimum Medical Loss Ratio

Additionally, the ACA established a minimum annual MLR for the Health Insurance Marketplace. Each of the three R programs described above are taken into consideration to determine if the Company’s estimated annual medical costs are less than the minimum loss ratio and require an adjustment to premium revenues to meet the minimum MLR.

Cost Sharing Reductions (CSRs)

The ACA directs issuers to reduce the Company's members' cost sharing for essential health benefits for individuals with Federal Poverty Levels (FPLs) between 100% and 250% who are enrolled in a silver tier product; eliminate cost sharing for Indians/Alaska Natives with an FPL less than 300% and eliminate cost sharing for Indians/Alaska Natives regardless of FPL level when services are provided by an Indian Health Service. In order to compensate issuers for reduced cost sharing provided to enrollees, CMS pays an advance CSR payment to the Company each month based on the Company’s certification data provided at the time of the qualified health plan application. After the close of the benefit year, the Company is required to provide CMS with data on the value of the CSRs provided to enrollees based on either a ‘simplified’ or ‘standard’ approach. A reconciliation will occur in order to calculate the difference between the Company’s CSR advance payments received and the value of CSRs provided to enrollees. This reconciliation will produce either a payable or receivable to/from CMS. The Company has elected the standard methodology approach. In October 2017, the Trump Administration issued an executive order that immediately ceased payments of CSRs to issuers, and 2018 premium rates for Health Insurance Marketplace were set without factoring in the cost sharing subsidy payments from the federal government.

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Premium and Trade Receivables and Unearned Revenue

Premium and service revenues collected in advance are recorded as unearned revenue. For performance-based contracts, the Company does not recognize revenue subject to refund until data is sufficient to measure performance. Premiums and service revenues due to the Company are recorded as premium and trade receivables and are recorded net of an allowance based on historical trends and management's judgment on the collectibility of these accounts. As the Company generally receives payments during the month in which services are provided, the allowance is typically not significant in comparison to total revenues and does not have a material impact on the presentation of the financial condition or results of operations. Amounts receivable under federal contracts are comprised primarily of contractually defined billings, accrued contract incentives under the terms of the contract and amounts related to change orders for services not originally specified in the contract.

Activity in the allowance for uncollectible accounts for the years ended December 31, is summarized below ($ in millions):

	2018	2017	2016
Allowances, beginning of year	$24	$29	$10
Amounts charged to expense	134	35	33
Write-offs of uncollectible receivables	(35)	(40)	(14)
Allowances, end of year	$123	$24	$29

The increase in the amounts charged to expense in 2018 primarily relates to costs associated with the expiration of the Company's contract to provide health care coordination services to the U.S. Department of Veterans Affairs under the Patient-Centered Community Care and Veterans Choice Programs.

Significant Customers

Centene receives the majority of its revenues under contracts or subcontracts with state Medicaid managed care programs. Customers where the aggregate annual contract revenues exceeded 10% of total annual revenues included the State of California, where the percentage of the Company's total revenue was 13%, 18% and 21% for the years ended December 31, 2018, 2017 and 2016, respectively; and the State of Texas, where the percentage of the Company's total revenue was 10%, 12% and 13% for the years ended December 31, 2018, 2017 and 2016, respectively.

Other Income (Expense)

Other income (expense) consists principally of investment income, interest expense and equity method earnings from investments. Investment income is derived from the Company's cash, cash equivalents, restricted deposits and investments. Interest expense relates to borrowings under the senior notes, interest rate swaps, credit facilities, and interest on capital leases.

Income Taxes

Deferred tax assets and liabilities are recorded for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax law or tax rates is recognized in income in the period that includes the enactment date.

Valuation allowances are provided when it is considered more likely than not that deferred tax assets will not be realized. In determining if a deductible temporary difference or net operating loss can be realized, the Company considers future reversals of existing taxable temporary differences, future taxable income, taxable income in prior carryback periods and tax planning strategies.

Contingencies

The Company accrues for loss contingencies associated with outstanding litigation, claims and assessments for which it has determined it is probable that a loss contingency exists and the amount of loss can be reasonably estimated. The Company expenses professional fees associated with litigation claims and assessments as incurred.

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Stock Based Compensation

The fair value of the Company's employee share options and similar instruments are estimated using the Black-Scholes option-pricing model. That cost is recognized ov