CENTENE CORP
Form 10-Q
April 24, 2018

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, DC 20549

FORM 10-Q

(Mark One)

[X] QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the quarterly period ended March 31, 2018
OR

[ ] 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

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: x Yes o No

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). x Yes o No

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a 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 (do not check if a smaller reporting company)	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 Exchange Act). Yes o No x

As of April 13, 2018, the registrant had 178,533,259 shares of common stock outstanding.

CENTENE CORPORATION
QUARTERLY REPORT ON FORM 10-Q
TABLE OF CONTENTS

Table of Contents

CAUTIONARY STATEMENT ON FORWARD-LOOKING STATEMENTS

All statements, other than statements of current or historical fact, contained in this filing are forward-looking statements. 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. We have attempted to identify these statements by terminology including “believe,” “anticipate,” “plan,” “expect,” “estimate,” “intend,” “seek,” “target,” “goal,” “m “would,” “could,” “should,” “can,” “continue” and other similar words or expressions (and the negative thereof) in connection with, among other things, any discussion of future operating or financial performance. In particular, these statements include without limitation statements about our market opportunity, growth strategy, competition, expected activities and future acquisitions, including our proposed acquisition of New York State Catholic Health Plan, Inc., d/b/a Fidelis Care New York (Fidelis Care) (Proposed Fidelis Acquisition or Fidelis Care Transaction), investments and the adequacy of our available cash resources. These statements may be found in the various sections of this filing, such as Part I, Item 2. “Management's Discussion and Analysis of Financial Condition and Results of Operations,” Part II, Item 1. “Legal Proceedings,” and Part II, Item 1A. “Risk Factors.” Readers are cautioned that matters subject to forward-looking statements involve known and unknown risks and uncertainties, 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, 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 and any regulations enacted thereunder that may result from changing political conditions;
- 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 or Fidelis Care's 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 or Fidelis Care's 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 acquisition (Health Net Acquisition) of Health Net, Inc. (Health Net), and the Proposed Fidelis Acquisition, will not be realized, or will not be realized within the expected time period, including, but not limited to, as a result of any
- failure to obtain any regulatory, governmental or third party consents or approvals in connection with the Proposed Fidelis Acquisition (including any such approvals under the New York Non-For-Profit Corporation Law) or any conditions, terms, obligations or restrictions imposed in connection with the receipt of such consents or approvals;
- 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 the Health Net Acquisition or the Proposed Fidelis Acquisition;

Table of Contents

- disruption caused by significant completed and pending acquisitions, including the Health Net Acquisition and the Proposed Fidelis 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 Health Net Acquisition and the Proposed Fidelis Acquisition;
- changes in expected closing dates, estimated purchase price and accretion for acquisitions;
- the risk that acquired businesses and pending acquisitions, including Health Net and Fidelis Care, will not be integrated successfully;
- the risk that the conditions to the completion of the Proposed Fidelis Acquisition may not be satisfied or completed on a timely basis, or at all;
- failure to obtain or receive any required regulatory approvals, consents or clearances for the Proposed Fidelis Acquisition, and the risk that, even if so obtained or received, regulatory authorities impose conditions on the completion of the transaction that could require the exertion of management's time and our resources, or otherwise have an adverse effect on Centene or the completion of the Proposed Fidelis Acquisition;
- business uncertainties and contractual restrictions while the Proposed Fidelis Acquisition is pending, which could adversely affect our business and operations;
- change of control provisions or other provisions in certain agreements to which Fidelis Care is a party, which may be triggered by the completion of the Proposed Fidelis Acquisition;
- loss of management personnel and other key employees due to uncertainties associated with the Proposed Fidelis Acquisition;
- the risk that, following completion of the Proposed Fidelis Acquisition, the combined company may not be able to effectively manage its expanded operations;
- restrictions and limitations that may stem from the financing arrangements that the combined company will enter into in connection with the Proposed Fidelis Acquisition;
- our ability to achieve improvement in 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 risk 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 Part II 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.

Table of Contents

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):

	Three Months Ended March 31,	
	2018	2017
GAAP net earnings	$340	$139
Amortization of acquired intangible assets	39	40
Acquisition related expenses	21	5
Penn Treaty assessment expense	—	47
Income tax effects of adjustments [1]	(14)	(34)
Adjusted net earnings	$386	$197
GAAP diluted earnings per share (EPS)	$1.91	$0.79
Amortization of acquired intangible assets [2]	0.17	0.14
Acquisition related expenses [3]	0.09	0.02
Penn Treaty assessment expense [4]	—	0.17
Adjusted Diluted EPS	$2.17	$1.12

(1) The income tax effects of adjustments are based on the effective income tax rates applicable to adjusted (non-GAAP) results.

(2) The amortization of acquired intangible assets per diluted share are net of an income tax benefit of $0.05 and $0.09 for the three months ended March 31, 2018 and 2017, respectively.

(3) Acquisition related expenses per diluted share are net of an income tax benefit of $0.03 and $0.01 for the three months ended March 31, 2018 and 2017, respectively.

(4) The Penn Treaty assessment expense per diluted share is net of an income tax benefit of $0.09 for the three months ended March 31, 2017.

	Three Months Ended March 31,	
	2018	2017
GAAP selling, general and administrative expenses	$1,316	$1,091
Acquisition related expenses	21	5
Penn Treaty assessment expense	—	47

Adjusted selling, general and administrative expenses	$1,295	$1,039

iii

Table of Contents

PART I
FINANCIAL INFORMATION

ITEM 1. Financial Statements.
CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED BALANCE SHEETS
(In millions, except shares in thousands and per share data in dollars)

	March 31, 2018 (Unaudited)	December 31, 2017
ASSETS		
Current assets:		
Cash and cash equivalents	$ 5,668	$ 4,072
Premium and trade receivables	3,648	3,413
Short-term investments	507	531
Other current assets	1,153	687
Total current assets	10,976	8,703
Long-term investments	5,535	5,312
Restricted deposits	140	135
Property, software and equipment, net	1,250	1,104
Goodwill	5,295	4,749
Intangible assets, net	1,519	1,398
Other long-term assets	455	454
Total assets	$ 25,170	$ 21,855
LIABILITIES, REDEEMABLE NONCONTROLLING INTERESTS AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims liability	$ 4,771	$ 4,286
Accounts payable and accrued expenses	4,962	4,165
Return of premium payable	515	549
Unearned revenue	638	328
Current portion of long-term debt	4	4
Total current liabilities	10,890	9,332
Long-term debt	5,172	4,695
Other long-term liabilities	1,520	952
Total liabilities	17,582	14,979
Commitments and contingencies		
Redeemable noncontrolling interests	8	12
Stockholders' equity:		
Preferred stock, $0.001 par value; authorized 10,000 shares; no shares issued or outstanding at March 31, 2018 and December 31, 2017	—	—
Common stock, $0.001 par value; authorized 400,000 shares; 180,643 issued and 176,795 outstanding at March 31, 2018, and 180,379 issued and 173,437 outstanding at December 31, 2017	—	—
Additional paid-in capital	4,592	4,349
Accumulated other comprehensive (loss)	(54)	(3)
Retained earnings	3,104	2,748
Treasury stock, at cost (3,848 and 6,942 shares, respectively)	(139)	(244)

Total Centene stockholders' equity	7,503	6,850
Noncontrolling interest	77	14
Total stockholders' equity	7,580	6,864
Total liabilities, redeemable noncontrolling interests and stockholders' equity	$ 25,170	$ 21,855

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

Table of Contents

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

	Three Months Ended March 31,	
	2018	2017
Revenues:		
Premium	$11,903	$10,638
Service	653	527
Premium and service revenues	12,556	11,165
Premium tax and health insurer fee	638	559
Total revenues	13,194	11,724
Expenses:		
Medical costs	10,039	9,322
Cost of services	543	441
Selling, general and administrative expenses	1,316	1,091
Amortization of acquired intangible assets	39	40
Premium tax expense	546	590
Health insurer fee expense	171	—
Total operating expenses	12,654	11,484
Earnings from operations	540	240
Other income (expense):		
Investment and other income	41	41
Interest expense	(68)	(62)
Earnings from operations, before income tax expense	513	219
Income tax expense	175	87
Net earnings	338	132
Loss attributable to noncontrolling interests	2	7
Net earnings attributable to Centene Corporation	$340	$139
Net earnings per common share attributable to Centene Corporation:		
Basic earnings per common share	$1.95	$0.81
Diluted earnings per common share	$1.91	$0.79

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

Table of Contents

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

	Three Months Ended March 31,	
	2018	2017
Net earnings	$338	$132
Reclassification adjustment, net of tax	—	—
Change in unrealized gain (loss) on investments, net of tax	(52)	14
Foreign currency translation adjustments	1	1
Other comprehensive earnings (loss)	(51)	15
Comprehensive earnings	287	147
Comprehensive loss attributable to noncontrolling interests	2	7
Comprehensive earnings attributable to Centene Corporation	$289	$154

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

Table of Contents

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

Three Months Ended March 31, 2018

	Centene Stockholders' Equity								
	Common Stock $.001 Par Value Shares	Amt	Additional Paid-in Capital	Accumulated Other Comprehensive Loss	Retained Earnings	Treasury Stock $.001 Par Value Shares	Amt	Non-controlling Interest	Total
Balance, December 31, 2017	180,379	$ —	$ 4,349	$ (3)	$ 2,748	6,942	$ (244)	$ 14	$ 6,864
Comprehensive Earnings:									
Net earnings	—	—	—	—	340	—	—	1	341
Other comprehensive loss, net of ($16) tax	—	—	—	(51)	—	—	—	—	(51)
Common stock issued for acquisitions	—	—	210	—	—	(3,176)	114	—	324
Common stock issued for employee benefit plans	264	—	4	—	—	—	—	—	4
Common stock repurchases	—	—	—	—	—	82	(9)	—	(9)
Stock compensation expense	—	—	33	—	—	—	—	—	33
Cumulative-effect of adopting new accounting guidance	—	—	—	—	16	—	—	—	16
Purchase of noncontrolling interest	—	—	(4)	—	—	—	—	—	(4)
Acquisition resulting in noncontrolling interest	—	—	—	—	—	—	—	62	62
Balance, March 31, 2018	180,643	$ —	$ 4,592	$ (54)	$ 3,104	3,848	$ (139)	$ 77	$ 7,580

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

Table of Contents

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

	Three Months Ended March 31,	
	2018	2017
Cash flows from operating activities:		
Net earnings	$338	$132
Adjustments to reconcile net earnings to net cash provided by operating activities		
Depreciation and amortization	104	86
Stock compensation expense	33	32
Deferred income taxes	30	(51)
Changes in assets and liabilities		
Premium and trade receivables	(176)	59
Other assets	51	89
Medical claims liabilities	485	358
Unearned revenue	317	320
Accounts payable and accrued expenses	157	(237)
Other long-term liabilities	477	459
Other operating activities, net	30	1
Net cash provided by operating activities	1,846	1,248
Cash flows from investing activities:		
Capital expenditures	(218)	(83)
Purchases of investments	(765)	(582)
Sales and maturities of investments	445	343
Acquisitions, net of cash acquired	(226)	—
Other investing activities, net	—	(1)
Net cash used in investing activities	(764)	(323)
Cash flows from financing activities:		
Proceeds from long-term debt	2,015	560
Payments of long-term debt	(1,491)	(560)
Common stock repurchases	(9)	(13)
Other financing activities, net	(2)	3
Net cash provided by (used in) financing activities	513	(10)
Net increase in cash, cash equivalents and restricted cash	1,595	915
Cash, cash equivalents, and restricted cash and cash equivalents, beginning of period	4,089	3,936
Cash, cash equivalents, and restricted cash and cash equivalents, end of period	$5,684	$4,851
Supplemental disclosures of cash flow information:		
Interest paid	$73	$72
Income taxes paid	$1	$2
Equity issued in connection with acquisitions	$324	$—

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

Table of Contents

CENTENE CORPORATION AND SUBSIDIARIES
NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS
(Unaudited)

1. Organization and Operations

Basis of Presentation

The accompanying interim financial statements have been prepared under the presumption that users of the interim financial information have either read or have access to the audited financial statements included in the Form 10-K for the fiscal year ended December 31, 2017. The unaudited interim financial statements herein have been prepared pursuant to the rules and regulations of the Securities and Exchange Commission. Accordingly, footnote disclosures which would substantially duplicate the disclosures contained in the December 31, 2017 audited financial statements have been omitted from these interim financial statements, where appropriate. In the opinion of management, these financial statements reflect all adjustments, consisting only of normal recurring adjustments, which are necessary for a fair presentation of the results of the interim periods presented.

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

Recently Adopted Accounting Guidance

In February 2018, the Financial Accounting Standards Board (FASB) issued an Accounting Standards Update (ASU) which allows a reclassification from accumulated other comprehensive income (OCI) to retained earnings for stranded tax effects resulting from the Tax Cuts and Job Acts (TCJA). Consequently, the amendments eliminate the stranded tax effects resulting from the TCJA and will improve the usefulness of information reported to financial statement users. However, because the amendments only relate to the reclassification of the income tax effects of the TCJA, the underlying guidance that requires that the effect of a change in tax laws or rates be included in income from continuing operations is not affected. The amendments in this ASU also require certain disclosures about stranded tax effects. The Company adopted the new guidance in the first quarter of 2018 and elected to reclassify stranded tax effects as a result of the TCJA related to unrealized gains and losses on investments and defined benefit plan obligations. The Company uses the individual security approach to release income tax effects from accumulated OCI. The new guidance did not have a material impact on the Company's consolidated financial position, results of operations or cash flows.

In November 2016, the FASB issued an ASU clarifying the classification and presentation of changes in restricted cash on the statement of cash flows. The amendments in this ASU require that a statement of cash flows explain the change during the period in the total of cash, cash equivalents, and restricted cash. Therefore, amounts generally described as restricted cash should be included with cash and cash equivalents when reconciling the beginning-of-period and end-of-period total amounts shown on the statement of cash flows. The Company adopted the new guidance in the first quarter of 2018. The new guidance did not have a material impact on the Company's consolidated financial position, results of operations or cash flows. Cash, cash equivalents, and restricted cash and cash equivalents reported on the Consolidated Statements of Cash Flows includes restricted cash and cash equivalents of $6 million, $12 million, $17 million, and $16 million as of December 31, 2016, March 31, 2017, December 31, 2017 and March 31, 2018, respectively, as well as previously reported cash and cash equivalents.

In March 2016, the FASB issued an ASU which requires entities to measure equity investments at fair value and recognize any change in fair value in net income. The standard does not apply to accounting methods that result in

consolidation of the investee and those accounted for under the equity method. The standard also requires entities to record changes in instrument-specific credit risk for financial liabilities measured under the fair value option in other comprehensive income. Companies are required to record a cumulative-effect adjustment to the statement of financial position as of the beginning of the fiscal year in which the guidance is adopted, with the exception of amendments related to equity investments without readily determinable fair values, which will be applied prospectively to all investments that exist as of the date of adoption. The Company adopted the new guidance in the first quarter of 2018. The new guidance did not have a material impact on the Company's consolidated financial position, results of operations or cash flows.

Table of Contents

In May 2014, the FASB issued an ASU which supersedes existing revenue recognition standards with a single model unless those contracts are within the scope of other standards (e.g., an insurance entity's insurance contracts). Under the new standard, recognition of revenue occurs when a customer obtains control of promised goods or services in an amount that reflects the consideration which the entity expects to receive in exchange for those goods or services. In addition, the standard requires disclosure of the nature, amount, timing and uncertainty of revenue and cash flows arising from contracts with customers. The Company adopted the new guidance in the first quarter of 2018 using the modified retrospective approach with a cumulative-effect increase to retained earnings of $16 million. The Company also elected the practical expedient of applying the new guidance only to contracts that are not completed as of the date of initial application. The majority of the Company's revenues are derived from insurance contracts and are excluded from the new standard.

Accounting Guidance Not Yet Adopted

In February 2018, the FASB issued an ASU which makes technical corrections and clarifications to certain aspects of the new guidance on recognizing and measuring financial instruments. The amendment clarifies, among other things, that entities will use a prospective transition approach only for equity securities they elect to measure using the new measurement alternative. The amendments are effective for annual periods beginning in 2018 and interim periods beginning in the third quarter of 2018. The new guidance is not expected to have a material impact on the Company's consolidated financial position, results of operations or cash flows.

In February 2016, the FASB issued an ASU which introduces a lessee model that requires the majority of leases to be recognized on the balance sheet. The new standard also aligns many of the underlying principles of the new lessor model with those in Accounting Standards Codification 606, the FASB's new revenue recognition standard, and addresses other concerns related to the current lessee model. The standard also requires lessors to increase the transparency of their exposure to changes in value of their residual assets and how they manage that exposure. It is effective for annual and interim periods beginning after December 15, 2018. Early adoption is permitted. The initial standard required a modified retrospective transition approach, with application, including disclosures, in all comparative periods presented. In March 2018, the FASB tentatively approved an amendment to the new guidance that allows companies the option of using the effective date of the new standard as the date of initial application. The Company is currently evaluating the effect of the new lease guidance.

2. Fidelis Care Transaction

In September 2017, the Company signed a definitive agreement under which Fidelis Care will become the Company's health plan in New York State. Under the terms of the agreement, the Company will acquire substantially all of the assets of Fidelis Care for $3.75 billion, subject to certain adjustments.

Table of Contents

3. Short-term and Long-term Investments, Restricted Deposits

Short-term and long-term investments and restricted deposits by investment type consist of the following ($ in millions):

	March 31, 2018				December 31, 2017			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$260	$ —	$ (3)	$257	$311	$ —	$ (2)	$309
Corporate securities	2,242	5	(33)	2,214	2,208	12	(10)	2,210
Restricted certificates of deposit	4	—	—	4	4	—	—	4
Restricted cash equivalents	16	—	—	16	17	—	—	17
Municipal securities	2,187	3	(28)	2,162	2,085	12	(10)	2,087
Asset-backed securities	492	1	(3)	490	437	1	(1)	437
Residential mortgage-backed securities	345	—	(10)	335	337	1	(6)	332
Commercial mortgage-backed securities	287	—	(6)	281	272	1	(2)	271
Fair value and equity method investments	290	—	—	290	176	—	—	176
Life insurance contracts	133	—	—	133	135	—	—	135
Total	$6,256	$ 9	$ (83)	$6,182	$5,982	$ 27	$ (31)	$5,978

Table of Contents

The Company’s investments are debt securities classified as available-for-sale with the exception of life insurance contracts and certain equity method investments. The Company’s investment policies are designed to provide liquidity, preserve capital and maximize total return on invested assets with the focus on high credit quality securities. The Company limits the size of investment in any single issuer other than U.S. treasury securities and obligations of U.S. government corporations and agencies. As of March 31, 2018, 96% of the Company’s investments in rated securities carry an investment grade rating by nationally recognized statistical rating organizations. At March 31, 2018, the Company held certificates of deposit, life insurance contracts and fair value and equity method investments which did not carry a credit rating.

The Company's residential mortgage-backed securities are primarily issued by the Federal National Mortgage Association, Government National Mortgage Association or Federal Home Loan Mortgage Corporation, which carry implicit or explicit guarantees of the U.S. government. The Company's commercial mortgage-backed securities are primarily senior tranches with a weighted average rating of AA+ and a weighted average duration of 3.9 years at March 31, 2018.

In March 2018, the Company completed a 25% investment in RxAdvance, a full-service pharmacy benefit manager. The investment is accounted for using the equity method of accounting.

The fair value of available-for-sale debt securities with gross unrealized losses by investment type and length of time that individual securities have been in a continuous unrealized loss position were as follows ($ in millions):

	March 31, 2018				December 31, 2017			
	Less Than 12 Months		12 Months or More		Less Than 12 Months		12 Months or More	
	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$(2)	$171	$(1)	$85	$(1)	$222	$(1)	$79
Corporate securities	(26)	1,598	(7)	185	(6)	1,044	(4)	185
Municipal securities	(22)	1,467	(6)	171	(7)	943	(3)	175
Asset-backed securities	(2)	310	(1)	27	(1)	228	—	28
Residential mortgage-backed securities	(3)	159	(7)	161	(1)	109	(5)	171
Commercial mortgage-backed securities	(4)	172	(2)	50	(1)	112	(1)	51
Total	$(59)	$3,877	$(24)	$679	$(17)	$2,658	$(14)	$689

As of March 31, 2018, the gross unrealized losses were generated from 2,714 positions out of a total of 3,564 positions. The change in fair value of fixed income securities is primarily a result of movement in interest rates subsequent to the purchase of the security.

For each security in an unrealized loss position, the Company assesses whether it intends to sell the security or if it is more likely than not the Company will be required to sell the security before recovery of the amortized cost basis for reasons such as liquidity, contractual or regulatory purposes. If the security meets this criterion, the decline in fair value is other-than-temporary and is recorded in earnings. The Company does not intend to sell these securities prior to maturity and it is not likely that the Company will be required to sell these securities prior to maturity; therefore, there is no indication of other-than-temporary impairment for these securities.

Table of Contents

The contractual maturities of short-term and long-term investments and restricted deposits are as follows ($ in millions):

	March 31, 2018				December 31, 2017			
	Investments		Restricted Deposits		Investments		Restricted Deposits	
	Amortized Cost	Fair Value	Amortized Cost	Fair Value	Amortized Cost	Fair Value	Amortized Cost	Fair Value
One year or less	$432	$430	$45	$45	$474	$474	$48	$47
One year through five years	2,439	2,411	96	95	2,424	2,420	88	88
Five years through ten years	1,920	1,894	—	—	1,773	1,779	—	—
Greater than ten years	200	201	—	—	129	130	—	—
Asset-backed securities	1,124	1,106	—	—	1,046	1,040	—	—
Total	$6,115	$6,042	$141	$140	$5,846	$5,843	$136	$135

Actual maturities may differ from contractual maturities due to call or prepayment options. Fair value and equity method investments and life insurance contracts are included in the five years through ten years category. The Company has an option to redeem at amortized cost substantially all of the securities included in the greater than ten years category listed above.

The Company continuously monitors investments for other-than-temporary impairment. Certain investments have experienced a decline in fair value due to changes in credit quality, market interest rates and/or general economic conditions. The Company recognizes an impairment loss for fair value and equity method investments when evidence demonstrates that it is other-than-temporarily impaired. Evidence of a loss in value that is other-than-temporary may include the absence of an ability to recover the carrying amount of the investment or the inability of the investee to sustain a level of earnings that would justify the carrying amount of the investment.

4. Fair Value Measurements

Assets and liabilities recorded at fair value in the Consolidated Balance Sheets are categorized based upon observable or unobservable inputs used to estimate fair value. Level inputs are as follows:

Level Input:	Input Definition:
Level I	Inputs are unadjusted, quoted prices for identical assets or liabilities in active markets at the measurement date.
Level II	Inputs other than quoted prices included in Level I that are observable for the asset or liability through corroboration with market data at the measurement date.
Level III	Unobservable inputs that reflect management’s best estimate of what market participants would use in pricing the asset or liability at the measurement date.

Table of Contents

The following table summarizes fair value measurements by level at March 31, 2018, for assets and liabilities measured at fair value on a recurring basis ($ in millions):

	Level I	Level II	Level III	Total
Assets				
Cash and cash equivalents	$5,668	$—	$ —	$5,668
Investments available for sale:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$137	$—	$ —	$137
Corporate securities	—	2,214	—	2,214
Municipal securities	—	2,162	—	2,162
Asset-backed securities	—	490	—	490
Residential mortgage-backed securities	—	335	—	335
Commercial mortgage-backed securities	—	281	—	281
Total investments	$137	$5,482	$ —	$5,619
Restricted deposits available for sale:				
Cash and cash equivalents	$16	$—	$ —	$16
Certificates of deposit	4	—	—	4
U.S. Treasury securities and obligations of U.S. government corporations and agencies	120	—	—	120
Total restricted deposits	$140	$—	$ —	$140
Other long-term assets: Interest rate swap agreements	$—	$—	$ —	$—
Total assets at fair value	$5,945	$5,482	$ —	$11,427
Liabilities				
Other long-term liabilities:				
Interest rate swap agreements	$—	$120	$ —	$120
Total liabilities at fair value	$—	$120	$ —	$120

11

Table of Contents

The following table summarizes fair value measurements by level at December 31, 2017, for assets and liabilities measured at fair value on a recurring basis ($ in millions):

	Level I	Level II	Level III	Total
Assets				
Cash and cash equivalents	$4,072	$—	$ —	$4,072
Investments available for sale:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$195	$—	$ —	$195
Corporate securities	—	2,210	—	2,210
Municipal securities	—	2,087	—	2,087
Asset-backed securities	—	437	—	437
Residential mortgage-backed securities	—	332	—	332
Commercial mortgage-backed securities	—	271	—	271
Total investments	$195	$5,337	$ —	$5,532
Restricted deposits available for sale:				
Cash and cash equivalents	$17	$—	$ —	$17
Certificates of deposit	4	—	—	4
U.S. Treasury securities and obligations of U.S. government corporations and agencies	114	—	—	114
Total restricted deposits	$135	$—	$ —	$135
Other long-term assets:				
Interest rate swap agreements	$—	$1	$ —	$1
Total assets at fair value	$4,402	$5,338	$ —	$9,740
Liabilities				
Other long-term liabilities:				
Interest rate swap agreements	$—	$72	$ —	$72
Total liabilities at fair value	$—	$72	$ —	$72

The Company periodically transfers U.S. Treasury securities and obligations of U.S. government corporations and agencies between Level I and Level II fair value measurements dependent upon the level of trading activity for the specific securities at the measurement date. The Company's policy regarding the timing of transfers between Level I and Level II is to measure and record the transfers at the end of the reporting period. At March 31, 2018, there were no transfers from Level I to Level II and no transfers from Level II to Level I. The Company utilizes matrix pricing services to estimate fair value for securities which are not actively traded on the measurement date. The Company designates these securities as Level II fair value measurements. The aggregate carrying amount of the Company's life insurance contracts and other non-majority owned investments, which approximates fair value, was $423 million and $311 million as of March 31, 2018 and December 31, 2017, respectively.

Table of Contents

5. Medical Claims Liability

The following table summarizes the change in medical claims liability ($ in millions):

	Three Months Ended March 31,	
	2018	2017
Balance, January 1	$4,286	$3,929
Less: Reinsurance recoverable	18	5
Balance, January 1, net	4,268	3,924
Acquisitions	—	—
Incurred related to:		
Current year	10,302	9,557
Prior years	(263)	(235)
Total incurred	10,039	9,322
Paid related to:		
Current year	6,579	5,973
Prior years	2,970	2,991
Total paid	9,549	8,964
Balance at March 31, net	4,758	4,282
Plus: Reinsurance recoverable	13	8
Balance, March 31	$4,771	$4,290

Reinsurance recoverables related to medical claims are included in premium and related receivables. Changes in estimates of incurred claims for prior years are primarily attributable to reserving under moderately adverse conditions. Additionally, as a result of development within "Incurred related to: Prior years" due to minimum HBR and other return of premium programs, we recorded $13 million and $3 million as a reduction to premium revenues in the three months ended March 31, 2018 and 2017, respectively.

Incurred but not reported (IBNR) plus expected development on reported claims as of March 31, 2018 was $3,688 million. Total IBNR plus expected development on reported claims represents estimates for claims incurred but not reported, development on reported claims, and estimates for the costs necessary to process unpaid claims at the end of each period. We estimate our 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.

6. 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 revenue to meet the minimum MLR.

Table of Contents

The Company's net receivables (payables) for each of these programs are as follows ($ in millions):

	March 31, 2018	December 31, 2017
Risk adjustment	$ (1,131)	$ (677)
Reinsurance	1	15
Risk corridor	5	6
Minimum MLR	(44)	(22)
Cost sharing reductions	(71)	(96)

7. Debt

Debt consists of the following ($ in millions):

	March 31, 2018	December 31, 2017
$1,400 million 5.625% Senior notes, due February 15, 2021	$ 1,400	$ 1,400
$1,000 million 4.75% Senior notes, due May 15, 2022	1,006	1,006
$1,000 million 6.125% Senior notes, due February 15, 2024	1,000	1,000
$1,200 million 4.75% Senior notes, due January 15, 2025	1,200	1,200
Fair value of interest rate swap agreements	(120)	(71)
Total senior notes	4,486	4,535
Revolving credit agreement	675	150
Mortgage notes payable	60	61
Capital leases and other	17	18
Debt issuance costs	(62)	(65)
Total debt	5,176	4,699
Less current portion	(4)	(4)
Long-term debt	$ 5,172	$ 4,695

Senior Notes

The indentures governing the senior notes listed in the table above contain restrictive covenants of Centene Corporation. At March 31, 2018, the Company was in compliance with all covenants.

Interest Rate Swaps

The Company uses interest rate swap agreements to convert a portion of its interest rate exposure from fixed rates to floating rates to more closely align interest expense with interest income received on its cash equivalent and variable rate investment balances. The following is a summary of the notional amounts of the Company's interest rate swap agreements as of March 31, 2018:

Expiration Date	Notional Amount
February 15, 2021	$ 600
May 15, 2022	500
February 15, 2024	1,000
January 15, 2025	600
Total	$ 2,700

The fair value of the swap agreements shown above are recorded in other long-term assets and other long-term liabilities, respectively in the Consolidated Balance Sheets. Under the swap agreements, the Company receives a fixed rate of interest and pays an average variable rate of either the three or one month LIBOR plus 3.61% adjusted monthly or quarterly, based on the terms of the individual swap agreements. At March 31, 2018, the weighted average rate was 5.44%.

Table of Contents

The swap agreements are formally designated and qualify as fair value hedges. Gains and losses due to changes in fair value of the interest rate swap agreements completely offset changes in the fair value of the hedged portion of the underlying debt. Therefore, no gain or loss has been recognized due to hedge ineffectiveness. Offsetting changes in fair value of both the interest rate swaps and the hedged portion of the underlying debt both were recognized in interest expense in the Consolidated Statements of Operations. The Company does not hold or issue any derivative instrument for trading or speculative purposes.

Revolving Credit Agreement

The Company has an unsecured $1,500 million revolving credit facility. The agreement has a maturity date of December 14, 2022. Borrowings under the agreement bear interest based upon LIBOR rates, the Federal Funds Rate or the Prime Rate. As of March 31, 2018, the Company had $675 million of borrowings outstanding under the agreement with a weighted average interest rate of 5.00%, and the Company was in compliance with all covenants.

The revolving credit facility contains non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios and maximum debt-to-EBITDA ratios. The Company is required to not exceed a maximum debt-to-EBITDA ratio of 3.5 to 1.0. As of March 31, 2018, there were no limitations on the availability under the revolving credit agreement as a result of the debt-to-EBITDA ratio.

Mortgage Notes Payable

The Company has a non-recourse mortgage note of $60 million at March 31, 2018 collateralized by its corporate headquarters building. The mortgage note is due January 1, 2021 and bears a 5.14% interest rate. The collateralized property had a net book value of $170 million at March 31, 2018.

Letters of Credit & Surety Bonds

The Company had outstanding letters of credit of $76 million as of March 31, 2018, which were not part of the revolving credit facility. The Company also had letters of credit for $47 million (valued at March 31, 2018 conversion rate), or €38 million, representing its 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 interest at 1.31% as of March 31, 2018. The Company had outstanding surety bonds of $404 million as of March 31, 2018.

Construction Loan

The Company has a $200 million non-recourse construction loan to fund the expansion of the Company's 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 the Company's revolving credit agreement. The Company has guaranteed completion of the construction project associated with the loan. As of March 31, 2018, the Company had no borrowings outstanding under the loan.

8. Stockholders' Equity

In March 2018, the Company acquired CMG and issued 1,449 thousand shares of Centene common stock to the selling shareholders, with a fair value of $149 million.

In March 2018, the Company acquired an additional 61% of Interpreta and issued 1,727 thousand shares of Centene common stock to the selling shareholders, with a fair value of $175 million.

15

Table of Contents

9. Earnings Per Share

The following table sets forth the calculation of basic and diluted net earnings per common share ($ in millions, except shares in thousands and per share data in dollars):

	Three Months Ended March 31,	
	2018	2017
Earnings attributable to Centene Corporation	$340	$ 139
Shares used in computing per share amounts:		
Weighted average number of common shares outstanding	173,921	172,074
Common stock equivalents (as determined by applying the treasury stock method)	3,769	3,762
Weighted average number of common shares and potential dilutive common shares outstanding	177,690	175,836
Net earnings per common share attributable to Centene Corporation:		
Basic earnings per common share	$1.95	$ 0.81
Diluted earnings per common share	$1.91	$ 0.79

The calculation of diluted earnings per common share for the three months ended March 31, 2018 and 2017 excludes the impact of 5 thousand and 55 thousand shares, respectively, related to anti-dilutive stock options, restricted stock and restricted stock units.

10. Segment Information

Centene operates in two segments: Managed Care and Specialty Services. The Managed Care segment consists of Centene's health plans including all of the functions needed to operate them. The Specialty Services segment consists of Centene's specialty companies offering auxiliary healthcare services and products.

Segment information for the three months ended March 31, 2018, follows ($ in millions):

	Managed Care	Specialty Services	Eliminations	Consolidated Total
Total revenues from external customers	$ 12,449	$ 745	$ —	$ 13,194
Total revenues from internal customers	25	2,231	(2,256)	—
Total revenues	$ 12,474	$ 2,976	$ (2,256)	$ 13,194
Earnings from operations	$ 470	$ 70	$ —	$ 540

Segment information for the three months ended March 31, 2017, follows ($ in millions):

	Managed Care	Specialty Services	Eliminations	Consolidated Total
Total revenues from external customers	$ 11,115	$ 609	$ —	$ 11,724
Total revenues from internal customers	11	2,333	(2,344)	—
Total revenues	$ 11,126	$ 2,942	$ (2,344)	$ 11,724
Earnings from operations	$ 187	$ 53	$ —	$ 240

Table of Contents

11. Contingencies

Overview

The Company records reserves and accrues costs for certain legal proceedings and regulatory matters to the extent that it determines an unfavorable outcome is probable and the amount of the loss can be reasonably estimated. While such reserves and accrued costs reflect the Company's best estimate of the probable loss for such matters, the recorded amounts may differ materially from the actual amount of any such losses. In some cases, no estimate of the possible loss or range of loss in excess of amounts accrued, if any, can be made because of the inherently unpredictable nature of legal and regulatory proceedings, which may be exacerbated by various factors, including but not limited to, they may involve indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or legal uncertainties; involve disputed facts; represent a shift in regulatory policy; involve a large number of parties, claimants or regulatory bodies; are in the early stages of the proceedings; involve a number of separate proceedings and/or a wide range of potential outcomes; or result in a change of business practices.

As of the date of this report, amounts accrued for legal proceedings and regulatory matters were not material. However, it is possible that in a particular quarter or annual period the Company’s financial condition, results of operations, cash flow and/or liquidity could be materially adversely affected by an ultimate unfavorable resolution of or development in legal and/or regulatory proceedings, including as described below. Except for the proceedings discussed below, the Company believes that the ultimate outcome of any of the regulatory and legal proceedings that are currently pending against it should not have a material adverse effect on financial condition, results of operations, cash flow or liquidity.

California

On October 20, 2015, the Company's California subsidiary, Health Net of California, Inc. (Health Net California), was named as a defendant in a California taxpayer action filed in Los Angeles County Superior Court, captioned as Michael D. Myers v. State Board of Equalization, Dave Jones, Insurance Commissioner of the State of California, Betty T. Yee, Controller of the State of California, et al., Los Angeles Superior Court Case No. BS158655. This action is brought under a California statute that permits an individual taxpayer to sue a governmental agency when the taxpayer believes the agency has failed to enforce governing law. Plaintiff contends that Health Net California, a California licensed Health Care Service Plan (HCSP), is an “insurer” for purposes of taxation despite acknowledging it is not an “insurer” under regulatory law. Under California law, “insurers” must pay a gross premiums tax (GPT), calculated as 2.35% on gross premiums. As a licensed HCSP, Health Net California has paid the California Corporate Franchise Tax (CFT), the tax generally paid by California businesses. Plaintiff contends that Health Net California must pay the GPT rather than the CFT. Plaintiff seeks a writ of mandate directing the California taxing agencies to collect the GPT, and seeks an order requiring Health Net California to pay GPT, interest and penalties for a period dating to eight years prior to the October 2015 filing of the complaint. This lawsuit is being coordinated with similar lawsuits filed against other entities. In September 2017, the Company filed a demurrer seeking to dismiss the complaint, and a motion to strike the allegations seeking retroactive relief. In March 2018, the Court overruled the Company's demurrer, denied the motion to strike, and set a status conference for May 2018. The Company intends to vigorously defend itself against these claims; however, this matter is subject to many uncertainties, and an adverse outcome in this matter could potentially have a materially adverse impact on our financial position, results of operations and cash flows.

Federal Securities Class Action

On November 14, 2016, a putative federal securities class action, Israel Sanchez v. Centene Corp., et al., was filed against the Company and certain of its executives in the U.S. District Court for the Central District of California. In

March 2017, the court entered an order transferring the matter to the U.S. District Court for the Eastern District of Missouri. The plaintiffs in the lawsuit allege that the Company's accounting and related disclosures for certain liabilities acquired in the acquisition of Health Net violated federal securities laws. In July 2017, the lead plaintiff filed a Consolidated Class Action Complaint. The Company filed a motion to dismiss this complaint in September 2017. In February 2018, the Court held a hearing on the motion to dismiss but has not yet issued a ruling.

The Company denies any wrongdoing and is vigorously defending itself against these claims. Nevertheless, this matter is subject to many uncertainties and the Company cannot predict how long this litigation will last or what the ultimate outcome will be, and an adverse outcome in this matter could potentially have a materially adverse impact on our financial position and results of operations.

Table of Contents

Additionally, on January 24, 2018, a separate derivative action was filed by plaintiff Harkesh Parekh on behalf of Centene Corporation against the Company and certain of its officers and directors in the United States District Court for the Eastern District of Missouri. Plaintiff purports to bring suit derivatively on behalf of the Company against certain officers and directors for violation of securities laws, breach of fiduciary duty, waste of corporate assets and unjust enrichment. The derivative complaint repeats many of the allegations in the federal securities class action described above and asserts that defendants made inaccurate or misleading statements, and/or failed to correct the alleged misstatements.

A second shareholder derivative action was filed on March 9, 2018, by plaintiffs Laura Wood and Peoria Police Pension Fund on behalf of Centene Corporation against the Company and certain of its officers and directors in the United States District Court for the Eastern District of Missouri. This second derivative complaint repeats many of the allegations in the securities class action and the first derivative suit. The derivative suits are expected to be consolidated and a lead plaintiff appointed for the litigation.

Medicare Parts C and D Matter

In December 2016, a Civil Investigative Demand (CID) was issued to Health Net by the United States Department of Justice regarding Health Net's submission of risk adjustment claims to CMS under Parts C and D of Medicare. The CID may be related to a federal qui tam lawsuit filed under seal in 2011 naming more than a dozen health insurers including Health Net. The lawsuit was unsealed in February 2017 when the Department of Justice intervened in the case with respect to one of the insurers (not Health Net). In subsequent pleadings, both the Department of Justice and the Relator excluded Health Net from the lawsuit. The Company is complying with the CID and will vigorously defend any lawsuits. At this point, it is not possible to determine what level of liability, if any, the Company may face as a result of this matter.

Veterans Administrative Matter

In October 2017, a CID was issued to Health Net Federal Services, LLC (HNFS) by the United States Department of Justice. The CID seeks documents and interrogatory responses concerning whether HNFS submitted, or caused to be submitted, excessive, duplicative or otherwise improper claims to the U.S. Department of Veterans Affairs under a contract to arrange health care services for veterans. The contract began in late 2014. In 2016, modifications to the contract were made to allow for possible duplicate billings with a reconciliation period at the end of the contract term. The Company is complying with the CID and believes it has been meeting its contractual obligations. At this point, it is not possible to determine what level of liability, if any, the Company may face as a result of this matter.

Ambetter Class Action

On January 11, 2018, a putative class action lawsuit was filed by Cynthia Harvey and Steven A. Milman against the Company and certain subsidiaries in the U.S. District Court for the Eastern District of Washington. The complaint alleges that the Company failed to meet federal and state requirements for provider networks and directories with regard to its Ambetter policies, denied coverage and/or refused to pay for covered benefits, and failed to address grievances adequately, causing some members to incur unexpected costs. In March 2018, the Company filed separate motions to dismiss each defendant. The Company intends to vigorously defend itself against these claims. Nevertheless, this matter is subject to many uncertainties and the Company cannot predict how long this litigation will last or what the ultimate outcome will be, and an adverse outcome in this matter could potentially have a materially adverse impact on our financial position and results of operations.

Miscellaneous Proceedings

Excluding the matters discussed above, the Company is also routinely subjected to legal and regulatory proceedings in the normal course of business. These matters can include, without limitation:

- periodic compliance and other reviews and investigations by various federal and state regulatory agencies with respect to requirements applicable to the Company's business, including, without limitation, those related to payment of out-of-network claims, submissions to CMS for risk adjustment payments or the False Claims Act, pre-authorization penalties, timely review of grievances and appeals, timely and accurate payment of claims, and the Health Insurance Portability and Accountability Act of 1996;

- litigation arising out of general business activities, such as tax matters, disputes related to healthcare benefits coverage or reimbursement, putative securities class actions and medical malpractice, privacy, real estate, intellectual property and employment-related claims;

Table of Contents

- disputes regarding reinsurance arrangements, claims arising out of the acquisition or divestiture of various assets, class actions and claims relating to the performance of contractual and non-contractual obligations to providers, members, employer groups and others, including, but not limited to, the alleged failure to properly pay claims and challenges to the manner in which the Company processes claims, and claims alleging that the Company has engaged in unfair business practices.

Among other things, these matters may result in awards of damages, fines or penalties, which could be substantial, and/or could require changes to the Company's business. The Company intends to vigorously defend itself against the miscellaneous legal and regulatory proceedings to which it is currently a party; however, these proceedings are subject to many uncertainties. In some of the cases pending against the Company, substantial non-economic or punitive damages are being sought.

Table of Contents

ITEM 2. 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 II, Item 1A. “Risk Factors” of this Form 10-Q.

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 premium 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.

Fidelis Care Transaction

In September 2017, we signed a definitive agreement under which New York State Catholic Health Plan, Inc., d/b/a Fidelis Care New York (Fidelis Care) (Proposed Fidelis Acquisition or Fidelis Care Transaction) will become the Company's health plan in New York State upon closing. Under the terms of the agreement, we will acquire substantially all of the assets of Fidelis Care for $3.75 billion, subject to certain adjustments. This transaction is expected to close on or about July 1, 2018. In April 2018, we received regulatory approvals for the Fidelis Care Transaction from the New York Department of Health and the New York Department of Financial Services. The Proposed Fidelis Acquisition remains subject to regulatory approval from the New York Attorney General and certain closing conditions. Subject to market conditions, we expect to fund the transaction with approximately $2.3 billion of new equity, including share consideration, and approximately $1.6 billion of new long-term debt.

As part of the regulatory approval process, it is expected that we will enter into certain undertakings with the New York State Department of Health. The undertakings are anticipated to contain various commitments by Centene that will be effective upon completion of the Fidelis Care Transaction. It is expected that one of the undertakings, among others, will include a $340 million contribution by Centene 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. Upon the closing of the Fidelis Care Transaction, the present value of the $340 million contribution to the State of New York, estimated to be approximately $325 million, will be expensed in SG&A.

Acquisitions and Investments

We continued to execute on our growth strategy through acquisitions and investments in the first quarter of 2018. We acquired 100% of Community Medical Holdings Corp., d/b/a Community Medical Group (CMG), an at-risk primary

care provider serving approximately 70,000 Medicaid, Medicare Advantage, and Health Insurance Marketplace patients in Miami-Dade County, Florida. CMG has a multi-payor strategy and serves our Florida health plan members. The acquisition increases Centene's scale and capabilities and creates a vertical integration opportunity with providers. 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%. Finally, we made a 25% equity method investment in RxAdvance (RxA), a full-service pharmacy benefit manager (PBM) with a best-in-class technology platform. Both the Interpreta and RxA transactions reflect our commitment to technological innovation and providing comprehensive and integrated specialty services.

In the second quarter of 2018, we acquired 100% of 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, Centene also acquired the remaining 49% ownership of Centurion, the correctional healthcare services joint venture between Centene and MHM, expanding our national footprint in the correctional healthcare sector.

Table of Contents

First Quarter 2018 Highlights

Our financial performance for the first quarter of 2018 is summarized as follows:

- Managed care membership of 12.8 million, an increase of 684,000 members, or 6% year-over-year.
- Total revenues of $13.2 billion, representing 13% growth year-over-year.
- Health benefits ratio of 84.3%, compared to 87.6% in 2017.
- SG&A expense ratio of 10.5% for the first quarter of 2018, compared to 9.8% for the first quarter of 2017.
- Adjusted SG&A expense ratio of 10.3% for the first quarter of 2018, compared to 9.3% for the first quarter of 2017.
- Operating cash flows of $1,846 million.
- Diluted earnings per share (EPS) for the first quarter of 2018 of $1.91, compared to $0.79 for the first quarter of 2017.
- Adjusted Diluted EPS for the first quarter of 2018 of $2.17, compared to $1.12 for the first quarter of 2017.

Adjusted Diluted EPS is highlighted below and additional detail is provided above under the heading "Non-GAAP Financial Presentation":

	Three Months Ended March 31,	
	2018	2017
GAAP diluted EPS	$1.91	$0.79
Amortization of acquired intangible assets	0.17	0.14
Acquisition related expenses	0.09	0.02
Penn Treaty assessment expense	—	0.17
Adjusted Diluted EPS	$2.17	$1.12

The following items contributed to our revenue and membership growth over the last year:

- 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 will assume full-risk on this population beginning in January 2019.

- Correctional. In June 2017, Centurion began operating under an expanded contract to provide correctional healthcare services for the Florida Department of Corrections in South Florida.

- 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.

- 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 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 (DCFS)/Youth in Care by the Illinois Department of Healthcare and Family Services (HFS) and Foster Care. These additional products are expected to be implemented in the fourth quarter of 2018.

- 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.

Table of Contents

- 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.

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

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

- We were successful in reprocuring our contract in Georgia. However, the Medicaid program was expanded to include additional insurers, which has reduced our market share. In addition, we are no longer serving LTSS members in Arizona or Medicaid members in Massachusetts.

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

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

- We expect to realize the full year benefit in 2018 of business commenced during 2017 in Florida, Maryland, Missouri and Nevada, as discussed above.

- In April 2018, we received regulatory approvals from the New York Department of Health and the New York Department of Financial Services for the Proposed Fidelis Acquisition. The Proposed Fidelis Acquisition remains subject to regulatory approval from the New York Attorney General and certain closing conditions.

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

- In March 2018, we completed the acquisition of CMG, an at-risk primary care provider serving approximately 70,000 Medicaid, Medicare Advantage, and Health Insurance Marketplace patients in Miami-Dade County, Florida.

- 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 March 2018, our Arizona subsidiary, Health Net Access, was selected to provide physical and behavioral health care services through the Arizona Health Care Cost Containment System Complete Care program in the Central region and the Southern region. Pending regulatory approval and successful completion of readiness review, the

three-year agreement, with the possibility of two two-year extensions, is expected to commence on October 1, 2018.

- In January 2018, our New Mexico subsidiary, Western Sky Community Care, was awarded a statewide contract in New Mexico for the Centennial Care 2.0 Program. The new contract is expected to commence membership operations in January 2019.

- In August 2017, Centurion was recommended for a contract award by the Tennessee Department of Correction to continue providing inmate health services. This contract is expected to commence in the third quarter of 2018.

Table of Contents

- In June 2017, our Mississippi subsidiary, Magnolia Health, was selected by the Mississippi Division of Medicaid to continue serving Medicaid recipients enrolled in the Mississippi Coordinated Access Network (MississippiCAN). Pending regulatory approval, the new three-year agreement, which also includes the option of two one-year extensions, is expected to commence in October 2018.

- In January 2017, we signed a joint venture agreement with the North Carolina Medical Society, working in conjunction with the North Carolina Community Health Center Association, to collaborate on a patient-focused approach to Medicaid under the reform plan enacted in the State of North Carolina. The newly created health plan, Carolina Complete Health, was created to establish, organize and operate a physician-led health plan to provide Medicaid managed care services in North Carolina.

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

- Effective July 2018, we will no longer be serving correctional healthcare members in Massachusetts. Effective October 2018, we will no longer be serving veterans under the PC3 program. 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.

In October 2017, the Centers for Medicare and Medicaid Services (CMS) published updated Medicare Star quality ratings for the 2018 rating year. The 2018 rating year will affect quality bonus payments for Medicare Advantage plans in 2019. One of Health Net of California, Inc.'s Medicare Advantage plans (H0562) moved to a 3.5 Star rating from a 4.0 Star rating for the 2018 rating year, which lowered our overall 2018 parent Star rating to 3.5 Stars. Our commitment to quality remains as strong as ever. We are working to evaluate and mitigate the potential impact on our revenue in 2019 as a result of the lowered 2018 rating and working to implement year-over-year quality improvements. We continue to work towards improving our star ratings and make efforts to return to at least a 4.0 Star parent rating in future periods.

Table of Contents

MEMBERSHIP

From March 31, 2017 to March 31, 2018, we increased our managed care membership by 684,000, or 6%. The following table sets forth the Company's membership by state:

	March 31, 2018	December 31, 2017	March 31, 2017
Arizona	639,800	640,500	684,300
Arkansas	92,300	85,700	98,100
California	2,903,600	2,877,800	2,980,100
Florida	1,090,600	848,800	872,000
Georgia	581,500	483,600	568,300
Illinois	238,400	239,500	253,800
Indiana	317,400	304,500	335,800
Kansas	151,500	129,100	133,100
Louisiana	485,900	485,500	484,100
Massachusetts	8,900	43,000	44,200
Michigan	2,800	2,500	2,100
Minnesota	9,400	9,400	9,500
Mississippi	347,600	329,900	349,500
Missouri	329,900	269,400	106,100
Nebraska	81,500	79,700	79,200
Nevada	74,600	34,900	—
New Hampshire	82,900	74,800	77,800
New Mexico	7,200	7,100	7,100
Ohio	352,800	332,700	328,900
Oregon	199,300	205,200	211,900
Pennsylvania	22,400	—	—
South Carolina	119,300	117,800	121,900
Tennessee	22,000	22,200	21,900
Texas	1,260,100	1,233,500	1,243,900
Vermont	1,600	1,600	1,600
Washington	260,800	237,800	254,400
Wisconsin	74,900	70,200	71,700
Total at-risk membership	9,759,000	9,166,700	9,341,300
TRICARE eligibles	2,851,500	2,824,100	2,804,100
Non-risk membership	218,900	216,300	—
Total	12,829,400	12,207,100	12,145,400

Table of Contents

The following table sets forth our membership by line of business:

	March 31, 2018	December 31, 2017	March 31, 2017
Medicaid:			
TANF, CHIP & Foster Care	5,776,600	5,807,300	5,714,100
ABD & LTSS	866,000	846,200	825,600
Behavioral Health	454,500	463,700	466,900
Commercial	2,161,200	1,558,300	1,864,700
Medicare & MMP [(1)]	343,400	333,700	328,100
Correctional	157,300	157,500	141,900
Total at-risk membership	9,759,000	9,166,700	9,341,300
TRICARE eligibles	2,851,500	2,824,100	2,804,100
Non-risk membership	218,900	216,300	—
Total	12,829,400	12,207,100	12,145,400

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

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

	March 31, 2018	December 31, 2017	March 31, 2017
Dual-eligible [(2)]	438,200	474,500	458,700
Health Insurance Marketplace	1,603,800	959,600	1,188,700
Medicaid Expansion	1,057,400	1,091,500	1,091,300

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

Table of Contents

RESULTS OF OPERATIONS

The following discussion and analysis is based on our Consolidated Statements of Operations, which reflect our results of operations for the three months ended March 31, 2018 and 2017, prepared in accordance with generally accepted accounting principles in the United States.

Summarized comparative financial data for the three months ended March 31, 2018 and 2017 is as follows ($ in millions, except per share data in dollars):

	Three Months Ended March 31,			
	2018	2017	% Change 2017-2018	
Premium	$11,903	$10,638	12	%
Service	653	527	24	%
Premium and service revenues	12,556	11,165	12	%
Premium tax and health insurer fee	638	559	14	%
Total revenues	13,194	11,724	13	%
Medical costs	10,039	9,322	8	%
Cost of services	543	441	23	%
Selling, general and administrative expenses	1,316	1,091	21	%
Amortization of acquired intangible assets	39	40	(3	)%
Premium tax expense	546	590	(7	)%
Health insurer fee expense	171	—	100	%
Earnings from operations	540	240	125	%
Investment and other income (expense), net	(27)	(21)	(29	)%
Earnings from operations, before income tax expense	513	219	134	%
Income tax expense	175	87	101	%
Net earnings	338	132	156	%
Loss attributable to noncontrolling interests	2	7	(71	)%
Net earnings attributable to Centene Corporation	$340	$139	145	%
Diluted earnings per common share attributable to Centene Corporation	$1.91	$0.79	142	%

Three Months Ended March 31, 2018 Compared to Three Months Ended March 31, 2017

Total Revenues

Total revenues increased 13% in the three months ended March 31, 2018 over the corresponding period in 2017 primarily due to growth in the Health Insurance Marketplace business in 2018, expansions and new programs in many of our states in 2017 and 2018, and the reinstatement of the health insurer fee in 2018. These increases were partially offset by lower revenues in California, which is a result of the removal of the IHSS program from its Medicaid contract. During the three months ended March 31, 2018, we received premium rate adjustments which yielded a net 0% 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 health benefits ratio, or HBR, represents medical costs as a percentage of premium

revenues (excluding premium tax and health insurer fee revenues) and reflects the direct relationship between the premium received and the medical services provided.

Table of Contents

The HBR for the three months ended March 31, 2018 was 84.3%, compared to 87.6% in the same period in 2017. The decrease compared to last year is primarily a result of membership growth in the Health Insurance Marketplace business, lower medical costs in our Medicaid business, and the reinstatement of the health insurer fee in 2018. These decreases were partially offset by new or expanded health plans, which initially operate at a higher HBR, and increased flu-related costs.

Cost of Services

Cost of services increased by $102 million in the three months ended March 31, 2018, compared to the corresponding period in 2017. This was primarily due to the acquisition of Foundation Care in October 2017, as well as growth in our correctional and management services businesses. The cost of service ratio for the three months ended March 31, 2018, was 83.2%, compared to 83.7% in the same period in 2017. The decrease in the cost of service ratio is primarily due to improved margins for our correctional and management services businesses.

Selling, General & Administrative Expenses

Selling, general and administrative expenses, or SG&A, increased by $225 million in the three months ended March 31, 2018, compared to the corresponding period in 2017. This was due to expansions, new programs and growth in many of our states in 2017 and 2018, including growth in the Health Insurance Marketplace business, and acquisition related expenses. These increases were partially offset by the $47 million recognized during the first quarter of 2017 for our estimated share of the undiscounted guaranty association assessment resulting from the liquidation of Penn Treaty.

The SG&A expense ratio was 10.5% for the first quarter of 2018, compared to 9.8% in the first quarter of 2017. The year-over-year increase was primarily a result of growth in the Health Insurance Marketplace business, as well as increased acquisition related expenses over the first quarter of 2017. These increases were partially offset by the impact of Penn Treaty assessment expense recognized in the first quarter of 2017.

The Adjusted SG&A expense ratio was 10.3% for the first quarter of 2018, compared to 9.3% in the first quarter of 2017. The year-over-year increase is primarily a result of growth in the Health Insurance Marketplace business, which operates at a higher SG&A expense ratio.

Health Insurer Fee Expense

Health insurance fee expense was $171 million for the three months ended March 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 three months ended March 31, 2017.

Other Income (Expense)

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

	2018	2017
Investment and other income	$41	$41
Interest expense	(68)	(62)
Other income (expense), net	$(27)	$(21)

Investment income was consistent for the three months ended March 31, 2018, compared to the corresponding period in 2017. Interest expense increased in the three months ended March 31, 2018, compared to the corresponding period

in 2017, reflecting a net increase in borrowings and the effect of our interest rate swaps.

Income Tax Expense

For the three months ended March 31, 2018, we recorded income tax expense of $175 million on pre-tax earnings of $513 million, or an effective tax rate of 34.1%. The current quarter 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 three months ended March 31, 2017, we recorded income tax expense of $87 million on pre-tax earnings of $219 million, or an effective tax rate of 39.7%, which reflects the higher corporate tax rate for 2017 and the impact of the health insurer fee moratorium.

Table of Contents

We are still analyzing certain aspects of the TCJA and are refining our calculations of existing current and deferred tax amounts. No material changes were made to the tax effects recorded in 2017, which will be provisional until the final 2017 federal tax return is filed. We do not anticipate other material changes to tax expense related to the TCJA.

Segment Results

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

	2018	2017	% Change 2017-2018	
Total Revenues				
Managed Care	$12,474	$11,126	12	%
Specialty Services	2,976	2,942	1	%
Eliminations	(2,256)	(2,344)	4	%
Consolidated Total	$13,194	$11,724	13	%
Earnings from Operations				
Managed Care	$470	$187	151	%
Specialty Services	70	53	32	%
Consolidated Total	$540	$240	125	%

Managed Care

Total revenues increased 12% in the three months ended March 31, 2018, compared to the corresponding period in 2017, primarily as a result of expansions, new programs, and growth in many of our states, particularly Florida, Georgia, Indiana, Missouri, Pennsylvania, and Texas, including growth in the Health Insurance Marketplace business. Earnings from operations increased $283 million between years primarily as a result of growth in the Health Insurance Marketplace business and the reinstatement of the health insurer fee in 2018. In addition, the first quarter of 2017 was negatively affected by the Penn Treaty assessment expense.

Specialty Services

Total revenues increased 1% in the three months ended March 31, 2018, compared to the corresponding period in 2017, resulting primarily from increased services associated with membership growth in the Managed Care segment and growth in our specialty pharmacy, correctional, and management services businesses. These revenue increases are partially offset by a decline in revenue for our behavioral health services business as a result of 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 increased $17 million in the three months ended March 31, 2018, compared to the corresponding period in 2017, primarily due to growth in our pharmacy benefits management, correctional, and management services businesses.

LIQUIDITY AND CAPITAL RESOURCES

Shown below is a condensed schedule of cash flows used in the discussion of liquidity and capital resources ($ in millions).

	Three Months Ended March 31,	
	2018	2017
Net cash provided by operating activities	$1,846	$1,248
Net cash used in investing activities	(764)	(323)

Net cash provided by (used in) financing activities	513	(10)
Net increase in cash and cash equivalents	$1,595	$915

Cash Flows Provided by Operating Activities

Normal operations are funded primarily through operating cash flows and borrowings under our revolving credit facility. Operating activities provided cash of $1,846 million in the three months ended March 31, 2018, compared to $1,248 million in the comparable period in 2017. The cash provided by operating activities in 2018 was due to net earnings, an increase in medical claims liabilities, primarily resulting from growth in the Health Insurance Marketplace business, and an increase in other long-term liabilities, driven by the recognition of risk adjustment payable for Health Insurance Marketplace in 2018. Cash provided by operations was also driven by increases in unearned revenue, due to the receipt of several April capitation payments received in March.

Table of Contents

Cash flows 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 health plan, an increase in other long-term liabilities driven by the recognition of risk adjustment payable for Health Insurance Marketplace in 2017 and an increase in unearned revenue primarily due to the receipt of several April capitation payments in March.

Cash flows from operations in each year were impacted by the timing of payments we receive from our states. As we have seen historically, 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.

Cash Flows Used in Investing Activities

Investing activities used cash of $764 million for the three months ended March 31, 2018, and $323 million in the comparable period in 2017. Cash flows used in investing activities in 2018 and 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, the acquisition of CMG, the investment in RxA, and capital expenditures.

We spent $218 million and $83 million in the three months ended March 31, 2018 and 2017, respectively, on capital expenditures for system enhancements and market and corporate headquarters expansions.

As of March 31, 2018, our investment portfolio consisted primarily of fixed-income securities with an average duration of 3.3 years. We had unregulated cash and investments of $452 million at March 31, 2018, compared to $310 million at December 31, 2017.

Cash Flows Provided by (Used in) Financing Activities

Our financing activities provided cash of $513 million in the three months ended March 31, 2018, compared to using cash of $10 million in the comparable period in 2017. During 2018, our net financing activities primarily related to increased borrowings on our revolving credit agreement.

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.

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 March 31, 2018, we had $675 million in borrowings outstanding under our revolving credit facility, and we were in compliance with all covenants. As of March 31, 2018, there were no limitations on the availability under the revolving credit agreement as a result of the debt-to-EBITDA ratio.

We had outstanding letters of credit of $76 million as of March 31, 2018, which were not part of our revolving credit facility. We also had letters of credit for $47 million (valued at the March 31, 2018 conversion rate), or €38 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 1.31% as of March 31, 2018. In addition, we had outstanding surety bonds of $404 million as of March 31, 2018.

The indentures governing our various maturities of senior notes contain restrictive covenants of Centene Corporation. As of March 31, 2018, we were in compliance with all covenants.

At March 31, 2018, we had working capital, defined as current assets less current liabilities, of $86 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 March 31, 2018, our debt to capital ratio, defined as total debt divided by the sum of total debt and total equity, was 40.6%, compared to 40.6% at December 31, 2017. Excluding the $60 million non-recourse mortgage note, our debt to capital ratio was 40.3% as of March 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.

Table of Contents

2018 Expectations

During the remainder of 2018, we expect to make net capital contributions to our insurance subsidiaries of approximately $196 million associated with our growth and spend approximately $590 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 in 2018 and borrowings on our Revolving Credit Facility. 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. In addition, as discussed above, subject to market conditions, we expect to fund the Fidelis Care transaction with approximately $2.3 billion of new equity, including share consideration, and approximately $1.6 billion of new long-term debt.

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. We expect to begin drawing on the construction loan in the second quarter of 2018.

As part of the regulatory approval process, it is expected that we will enter into certain undertakings with the New York State Department of Health. The undertakings are anticipated to contain various commitments by Centene that will be effective upon completion of the Fidelis Care Transaction. It is expected that one of the undertakings, among others, will include a $340 million contribution by Centene 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. Upon the closing of the Fidelis Care transaction, the present value of the $340 million contribution to the State of New York, estimated to be approximately $325 million, will be expensed in SG&A.

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

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 March 31, 2018, our subsidiaries had aggregate statutory capital and surplus of $5,058 million, compared with the required minimum aggregate statutory capital and surplus requirements of $2,289 million. During the three months ended March 31, 2018, we received net dividends of $9 million from our regulated 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 (excluding the interim impact of the health insurer fee).

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 health care expenditures, excluding capitated amounts. In addition, certain of our California subsidiaries have made certain undertakings to the California Department of Managed Health Care (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.

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 March 31, 2018, each of our health plans was in compliance with the risk-based capital requirements enacted in those states.

Table of Contents

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 March 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 $2,289 million in the aggregate.

RECENT ACCOUNTING PRONOUNCEMENTS

For this information, refer to Note 1, Organization and Operations, in the Notes to the Consolidated Financial Statements, included herein.

Table of Contents

ITEM 3. Quantitative and Qualitative Disclosures About Market Risk.

INVESTMENTS AND DEBT

As of March 31, 2018, we had short-term investments of $507 million and long-term investments of $5,675 million, including restricted deposits of $140 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 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 March 31, 2018, the fair value of our fixed income investments would decrease by approximately $189 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 March 31, 2018, the fair value of our debt would decrease by approximately $115 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.

ITEM 4. Controls and Procedures.

Evaluation of Disclosure Controls and Procedures - We maintain disclosure controls and procedures as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (Exchange Act) that are designed to provide reasonable assurance that information required to be disclosed by us in reports that we file or submit under the Exchange Act is (i) recorded, processed, summarized and reported within the time periods specified in SEC rules and forms; and (ii) accumulated and communicated to our management, including our principal executive officer and principal financial officer, as appropriate to allow timely decisions regarding required disclosure.

In connection with the filing of this Form 10-Q, management evaluated, under the supervision and with the participation of our Chief Executive Officer and Chief Financial Officer, the effectiveness of the design and operation of our disclosure controls and procedures as of March 31, 2018. Based upon that evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective at the reasonable assurance level as of March 31, 2018.

Changes in Internal Control Over Financial Reporting - No change in our internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act) occurred during the quarter ended March 31, 2018 that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

Table of Contents

PART II
OTHER INFORMATION

ITEM 1. Legal Proceedings.

A description of the legal proceedings to which the Company and its subsidiaries are a party is contained in Note 11 to the consolidated financial statements included in Part I of this Quarterly Report on Form 10-Q, and is incorporated herein by reference.

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. Unless the context otherwise requires, the terms the “Company,” “we,” “us,” “our” or similar terms and “Centene” (i) prior to the closing of the Proposed Fidelis Acquisition, refer to Centene Corporation, together with its consolidated subsidiaries, without giving effect to the Proposed Fidelis Acquisition, and (ii) upon and after the closing of the Proposed Fidelis Acquisition, refer to us, after giving effect to the Proposed Fidelis Acquisition.

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, VA, 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 57%. 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 government 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. 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.

Table of Contents

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.

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. As previously announced, CMS published Medicare Star ratings for the 2018 rating year. The achievement of Star ratings of four or higher for the 2018 rating year qualifies Medicare Advantage plans for quality bonus payments in 2019. One of Health Net of California, Inc.'s Medicare Advantage plans (H0562) moved to a 3.5 Star rating from a 4.0 Star rating for the 2018 rating year. The effect of this Star rating change lowered our parent Star rating for the 2018 rating year from 4.0 stars to 3.5 stars and, therefore, our plans that use the parent rating as well as the Medicare Advantage plan (H0562) will not be eligible for the quality bonus payments in 2019. These lowered Star ratings for the 2018 rating year for the Medicare Advantage plan (H0562) and the Company may reduce 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. We continue to evaluate the potential impact of the lowered ratings on our revenues and expansion efforts in 2019. 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.

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 expense exceeds 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. In addition, the 2018 marketplace for individual products may continue to be less stable than in previous years because, among other things, other health plans have changed or stopped offering their Health Insurance Marketplace products in the states we continue to serve in 2018. Also, member behavior could continue to be influenced by the uncertainty surrounding changes to the Patient Protection and Affordable Care Act and the accompanying Health Care and Education Affordability Reconciliation Act, collectively referred to as Affordable Care Act (ACA), including the repeal of the ACA's individual mandate in the Tax Cuts and Jobs Act of 2017 (TCJA).

Table of Contents

Our medical expense includes 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 expense 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.

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 states' election. The federal government pays the entire costs 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 March 31, 2018, 32 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. In February 2018, the U.S. Department of Health and Human Services (HHS) issued a proposed rule permitting the duration of short-term health insurance plans to be extended from up to three months to up to twelve months. These short-term plans, in addition to having a limited duration, 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 three Rs 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, the three Rs may not be adequately funded. Moreover, 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, require us to increase premium rates or result in funding issues under the three Rs. These potential exits and other continued volatility in this market may be further exacerbated by the conclusion of the risk corridor and reinsurance programs as of January 1, 2017. Our continued success in the exchanges is dependent on our ability to successfully respond to these changes in the market over time. Any significant variation from our expectations regarding acuity, enrollment levels, adverse selection, the three Rs, 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.

Table of Contents

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 became 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 March 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.

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. 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 required for continued implementation of the ACA, including the promulgation of a substantial number of new and 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.

In addition, House v. Hargan (previously v. Burwell, et al., and v. Price, et al.), the suit that was brought by House Republicans, was settled in December 2017. The new administration's decision to stop the cost sharing subsidies rendered further challenge to the cost sharing subsidy payments unnecessary. Therefore, 2018 premium rates for Health Insurance Marketplace were set without factoring in the cost sharing subsidy payments from the federal government. On March 23, 2018, Congress further bolstered the new administration's position by omitting cost sharing subsidy payments from the two-year Omnibus Spending Bill. This bill, coupled with the new administration's decision to end payments, could affect our earnings.

Changes to, or repeal of, portions or the entirety of the ACA, 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 new administration could propose changes impacting implementation of the ACA, which could materially and adversely affect our financial position or operations. However, the ultimate content, timing or effect of any potential future legislation enacted under the new administration 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.

Table of Contents

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.

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. 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. 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 Foreign Corrupt Practices Act. 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.

Table of Contents

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.

Table of Contents

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' request to pay dividends, the funds available to us would be limited, which could harm our ability to implement our business strategy.

Table of Contents

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.

Table of Contents

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 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.

Table of Contents

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 and state laws and rules regarding the use and disclosure of confidential member information, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 and the Gramm-Leach-Bliley Act, 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. Additionally, 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. 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.

42

Table of Contents

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 Health Net and realize the anticipated benefits of the acquisition.

We completed the acquisition of Health Net on March 24, 2016. The success of the acquisition of Health Net will depend, in part, on our ability to successfully combine the businesses of the Company and Health Net and realize the anticipated benefits, including synergies, cost savings, growth in earnings, innovation and operational efficiencies, from the combination. 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.

Table of Contents

The integration of Health Net's business with our existing business is a complex, costly and time-consuming process. We have not previously completed a transaction comparable in size or scope to the acquisition of Health Net. The integration of the two companies 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 changes with respect to government healthcare programs, the ACA and any regulations enacted thereunder; and
- unforeseen expenses or delays associated with the acquisition and/or integration.

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.

We have incurred substantial expenses related to the completion of the acquisition of Health Net and are incurring substantial expenses related to the integration of Health Net.

We are in the process of integrating a large number of processes, policies, procedures, operations, technologies and systems, including sales, pricing, and marketing, among other things. In addition, the businesses of Centene and Health Net will continue to maintain a presence in St. Louis, Missouri and Woodland Hills, California, respectively. The substantial majority of these costs will be non-recurring expenses related to the acquisition (including financing of the acquisition), facilities and systems consolidation costs. We may incur additional costs to maintain employee morale and to retain key employees. We are also incurring 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.

Our future results may be adversely impacted if we do not effectively manage our expanded operations following the completion of our acquisition of Health Net.

The size of our business following the acquisition of Health Net is significantly larger than the size of either our or Health Net's respective businesses prior to the acquisition. 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. We will also have to manage our expanded operations in compliance with certain undertakings with regulators that were agreed to in connection with the approval of the acquisition. These undertakings require significant investments by us, may restrict or impose additional material costs on our future operations and strategic initiatives in certain geographies, and subject us to various enforcement mechanisms. There can be no assurances that we will be successful in managing our expanded operations 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 March 31, 2018, we had consolidated indebtedness of approximately $5,176 million. We may further increase our indebtedness in the future. This increased indebtedness and 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.

Table of Contents

Among other things, our revolving credit facility requires 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.

The Proposed Fidelis Acquisition may not occur, and if it does, it may not be accretive and may cause dilution to our earnings per share, which may negatively affect the market price of our common stock.

Although we currently anticipate that the Proposed Fidelis Acquisition will occur and will be accretive to earnings per share (on an adjusted earnings basis that is not pursuant to GAAP) from and after the Proposed Fidelis Acquisition, this expectation is based on assumptions about our and Fidelis Care's business and preliminary estimates, which may change materially. As a result, should the Proposed Fidelis Acquisition occur, certain other amounts to be paid in connection with the Proposed Fidelis Acquisition may cause dilution to our earnings per share or decrease or delay the expected accretive effect of the Proposed Fidelis Acquisition and cause a decrease in the market price of our common stock. The Proposed Fidelis Acquisition may not occur as a result. In addition, we could also encounter additional transaction-related costs or other factors such as the failure to realize all of the benefits anticipated in the Proposed Fidelis Acquisition, including cost and revenue synergies. All of these factors could cause dilution to our earnings per share or decrease or delay the expected accretive effect of the Proposed Fidelis Acquisition and cause a decrease in the market price of our common stock.

The Proposed Fidelis Acquisition is subject to conditions, some or all of which may not be satisfied, or completed on a timely basis, if at all. Failure to complete the Proposed Fidelis Acquisition could have material adverse effects on our business.

The completion of the Proposed Fidelis Acquisition is subject to a number of conditions, including, among others, the receipt of certain regulatory approvals, which make the completion and timing of the completion of the Proposed Fidelis Acquisition uncertain. Also, either we or Fidelis Care may terminate the asset purchase agreement if the Proposed Fidelis Acquisition has not been consummated by July 1, 2018 (or September 1, 2018 if the extension is exercised), except that this right to terminate the asset purchase agreement will not be available to any party whose failure to fulfill any obligation under the asset purchase agreement has been the cause of or resulted in the failure of the Proposed Fidelis Acquisition to be consummated on or before that date.

If the Proposed Fidelis Acquisition is not completed, our ongoing business may be materially adversely affected and, without realizing any of the benefits that we could have realized had the Proposed Fidelis Acquisition been completed, we will be subject to a number of risks, including the following:

- the market price of our common stock could decline;
- if the asset purchase agreement is terminated and our board of directors (Board) seeks another business combination, our stockholders cannot be certain that we will be able to find a party willing to enter into any transaction on terms equivalent to or more attractive than the terms that we and Fidelis Care have agreed to in the asset purchase agreement;
- time and resources committed by our management to matters relating to the Proposed Fidelis Acquisition could otherwise have been devoted to pursuing other beneficial opportunities;

- we may experience negative reactions from the financial markets or from our customers or employees; and

- we will be required to pay our costs relating to the Proposed Fidelis Acquisition, such as legal, accounting, financing, financial advisory and printing fees, whether or not the Proposed Fidelis Acquisition is completed.

In addition, if the Proposed Fidelis Acquisition is not completed, we could be subject to litigation related to any failure to complete the Proposed Fidelis Acquisition or related to any enforcement proceeding commenced against us to perform our obligations under the asset purchase agreement. If any such risk materializes, it could adversely impact our ongoing business.

Similarly, delays in the completion of the Proposed Fidelis Acquisition could, among other things, result in additional transaction costs, loss of revenue or other negative effects associated with uncertainty about completion of the Proposed Fidelis Acquisition and cause us not to realize some or all of the benefits that we expect to achieve if the Proposed Fidelis Acquisition is successfully completed within its expected timeframe. We cannot assure you that the conditions to the closing of the Proposed Fidelis Acquisition will be satisfied or waived or that the Proposed Fidelis Acquisition will be consummated.

Table of Contents

Centene and Fidelis Care are each subject to business uncertainties and contractual restrictions while the proposed acquisition is pending, which could adversely affect the business and operations of us or the combined company.

In connection with the pendency of the Proposed Fidelis Acquisition, it is possible that some customers, suppliers and other persons with whom we or Fidelis Care has a business relationship may delay or defer certain business decisions or might decide to seek to terminate, change or renegotiate their relationships with us or Fidelis Care, as the case may be, as a result of the Proposed Fidelis Acquisition, which could negatively affect our current or the combined company's future revenues, earnings and cash flows, as well as the market price of our common stock, regardless of whether the Proposed Fidelis Acquisition is completed.

Under the terms of the asset purchase agreement, Fidelis Care is subject to certain restrictions on the conduct of its business prior to completing the Proposed Fidelis Acquisition, which may adversely affect its ability to execute certain of its business strategies, including the ability in certain cases to enter into or amend contracts, acquire or dispose of assets, incur indebtedness or incur capital expenditures. Such limitations could adversely affect Fidelis Care's business and operations prior to the completion of the Proposed Fidelis Acquisition.

Each of the risks described above may be exacerbated by delays or other adverse developments with respect to the completion of the Proposed Fidelis Acquisition.

The Proposed Fidelis Acquisition is subject to the receipt of approvals, consents or clearances from regulatory authorities that may impose conditions that could have an adverse effect on us or the combined company or, if not obtained, could prevent completion of the Proposed Fidelis Acquisition.

Before the Proposed Fidelis Acquisition may be completed, any approvals, consents or clearances required in connection with the Proposed Fidelis Acquisition must have been obtained, in each case, under applicable law, including pursuant to the insurance laws, not-for-profit laws and state healthcare laws. In deciding whether to grant the required regulatory approval, consent or clearance, the relevant governmental entities will consider the effect of the Proposed Fidelis Acquisition on competition within their relevant jurisdiction. The terms and conditions of the approvals, consents and clearances that are granted may impose requirements, limitations or costs or place restrictions on the conduct of the combined company's business. Under the asset purchase agreement, we have agreed with Fidelis Care to use our reasonable best efforts to obtain such approvals, consents and clearances and therefore may be required to comply with conditions or limitations imposed by governmental authorities, except that (i) we may not be required to agree to any term, limitation, restriction or requirement that, individually or in the aggregate, (a) would have or could reasonably be expected to have a material and adverse effect on the financial condition, results of operations or business of us or Fidelis Care, in each case, as currently conducted, (b) would or could reasonably be expected to have a material and adverse effect on any lines or types of business, in the aggregate, in which we or Fidelis Care shall be permitted to engage or (c) would have or could reasonably be expected to have a material and adverse effect on the overall benefits that we reasonably expect to derive from the consummation of the Proposed Fidelis Acquisition and (ii) Fidelis Care may not be required to, among other things, agree to any term, limitation, restriction or requirement that, individually or in the aggregate, would have or could reasonably be expected to have a material and adverse effect on the overall benefits that Fidelis Care reasonably expects to derive from the consummation of the Proposed Fidelis Acquisition.

In addition, regulators may impose conditions, terms, obligations or restrictions in connection with their approval of or consent to the Proposed Fidelis Acquisition, and such conditions, terms, obligations or restrictions may delay completion of the Proposed Fidelis Acquisition or impose additional material costs on or materially limit the revenues of the combined company following the completion of the Proposed Fidelis Acquisition. Regulators may impose such conditions, terms, obligations or restrictions, and, if imposed, such conditions, terms, obligations or restrictions may

delay or lead to the abandonment of the Proposed Fidelis Acquisition.

As part of the regulatory approval process, it is expected that we will enter into certain undertakings with the New York State Department of Health. The undertakings are anticipated to contain various commitments by us that will be effective upon completion of the Proposed Fidelis Acquisition. It is expected that one of the undertakings, among others, will include 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.

Additionally, upon the closing of the Proposed Fidelis Acquisition, Fidelis Care will operate as a for-profit health insurer in New York, subject to customary premium taxes and fees, anticipated to result in not less than $160 million of additional revenues for the State of New York.

Table of Contents

The Proposed Fidelis Acquisition remains subject to regulatory approval from, among others, the New York Attorney General, the Burdensome Condition provision of Section 7.03(c) of the Asset Purchase Agreement, and certain closing conditions. There can be no assurance that we will receive regulatory approval for the Proposed Fidelis Acquisition or that the closing of the Proposed Fidelis Acquisition will occur.

Uncertainties associated with the Proposed Fidelis Acquisition may cause a loss of management personnel and other key employees, which could adversely affect the future business and operations of the combined company.

We and Fidelis Care are each dependent on the experience and industry knowledge of their officers and other key employees to execute their business plans. The combined company's success after the completion of the Proposed Fidelis Acquisition will depend in part upon the ability of each of us and Fidelis Care to retain key management personnel and other key employees. Prior to completion of the Proposed Fidelis Acquisition, current and prospective employees of each of us and Fidelis Care may experience uncertainty about their roles within the combined company following the completion of the Proposed Fidelis Acquisition, which may have an adverse effect on the ability of each of us and Fidelis Care to attract or retain key management and other key personnel. In addition, no assurance can be given that the combined company will be able to attract or retain key management personnel and other key employees of each of us and Fidelis Care to the same extent that we and Fidelis Care have previously been able to attract or retain their own employees.

Completion of the Proposed Fidelis Acquisition may trigger change in control or other provisions in certain agreements to which Fidelis Care is a party, which may have an adverse impact on the combined company's business and results of operations.

The completion of the Proposed Fidelis Acquisition may trigger change in control and other provisions in certain agreements to which Fidelis Care is a party. If we are unable to negotiate waivers of those provisions with Fidelis Care, the counterparties may exercise their rights and remedies under the agreements, potentially terminating the agreements or seeking monetary damages. Even if we are able to negotiate waivers with Fidelis Care, the counterparties may require a fee for such waivers or seek to renegotiate the agreements on terms less favorable to Fidelis Care or the combined company. Any of the foregoing or similar developments may have an adverse impact on the combined company's business and results of operations.

The combined company may be unable to successfully integrate our business with the assets acquired in the Proposed Fidelis Acquisition and realize the anticipated benefits of the Proposed Fidelis Acquisition.

The success of the Proposed Fidelis Acquisition will depend, in part, on the combined company's ability to successfully combine our business and the assets acquired in the Proposed Fidelis Acquisition, and realize the anticipated benefits, including synergies, cost savings, innovation and operational efficiencies, from the combination. If the combined company is 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 its common stock may be harmed. Additionally, rating agencies may take negative actions against the combined company.

The Proposed Fidelis Acquisition involves the integration of certain assets of Fidelis Care with our existing business, which is expected to be 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 at one or both of the companies as a result of the devotion of management's attention to the Proposed Fidelis Acquisition;

- 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;

Table of Contents

- unanticipated changes in federal or state laws or regulations, including the ACA and any regulations enacted thereunder;

- decreases in premiums paid under government sponsored healthcare programs by any state in which the combined company operates; and

- unforeseen expenses or delays associated with the Proposed Fidelis Acquisition.

Many of these factors will be outside of the combined company's 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 the combined company's financial position, results of operations and cash flows.

The integration of Fidelis Care with our business may result in unforeseen expenses, and the anticipated benefits of the integration plan may not be realized. These integration matters could have an adverse effect on (i) each of us and Fidelis Care during this transition period and (ii) the combined company for an undetermined period after completion of the Proposed Fidelis Acquisition. In addition, any actual cost savings of the Proposed Fidelis Acquisition could be less than anticipated.

The future results of the combined company may be adversely impacted if the combined company does not effectively manage its expanded operations following the completion of the Proposed Fidelis Acquisition.

Following the completion of the Proposed Fidelis Acquisition, the size of the combined company's business will be significantly larger than the current size of our business. The combined company's ability to successfully manage this expanded business will depend, in part, upon management's ability to design and implement strategic initiatives that address not only the integration of two discrete companies, but also the increased scale and scope of the combined business with its associated increased costs and complexity. The combined company may not be successful or may not realize the expected operating efficiencies, cost savings and other benefits currently anticipated from the Proposed Fidelis Acquisition.

The combined company is expected to incur substantial expenses related to the completion of the Proposed Fidelis Acquisition and the integration of our business with Fidelis Care.

The combined company is expected to incur substantial expenses in connection with the completion of the Proposed Fidelis Acquisition and the integration of our business with substantially all of the 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 Proposed Fidelis Acquisition (including financing of the Proposed Fidelis Acquisition), facilities and systems consolidation costs. The combined company 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. Additionally, as a result of the Proposed Fidelis Acquisition, rating agencies may take negative actions with regard to the combined company's credit ratings, which may increase the combined company's costs in connection with the financing of the Proposed Fidelis Acquisition. These incremental transaction and acquisition related costs may exceed the savings the combined company expects 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.

We will incur additional indebtedness to finance the Proposed Fidelis Acquisition.

In connection with the Proposed Fidelis Acquisition, we expect to incur approximately $1.6 billion in additional indebtedness, assuming we do not use the option to fund up to $500 million of the acquisition consideration in our common stock and assuming we issue approximately $2.3 billion of new equity. The combined company will have consolidated indebtedness of approximately $6.8 billion, which is greater than our current indebtedness prior to the Proposed Fidelis Acquisition. The increased indebtedness of the combined company in comparison to ours on a historical basis could adversely affect us in a number of ways, including:

- affecting our ability to pay or refinance its debts as they become due during adverse economic, financial market and industry conditions;
- requiring us to use a larger portion of its cash flow for debt service, reducing funds available for other purposes;
- causing us to be less able to take advantage of business opportunities, such as acquisition opportunities, and to react to changes in market or industry conditions;

Table of Contents

- increasing our vulnerability to adverse economic, industry or competitive developments;
- affecting our ability to obtain additional financing;
- decreasing our profitability and/or cash flow;
- causing us to be disadvantaged compared to competitors with less leverage;
- resulting in a downgrade in our credit rating or any of our indebtedness or our subsidiaries which could increase the cost of further borrowings; and
- limiting our ability to borrow additional funds in the future to fund working capital, capital expenditures and other general corporate purposes.

The financing arrangements that the combined company will enter into in connection with the Proposed Fidelis Acquisition may, under certain circumstances, contain restrictions and limitations that could significantly impact the combined company's ability to operate its business.

We intend to incur additional indebtedness in connection with the Proposed Fidelis Acquisition. We expect that the agreements governing the indebtedness incurred in connection with the Proposed Fidelis Acquisition will contain covenants that, among other things, may, under certain circumstances, place limitations on the dollar amounts paid or other actions relating to:

- payments in respect of, or redemptions or acquisitions of, debt or equity issued by the combined company or its subsidiaries, including the payment of dividends on our common stock;
- incurring additional indebtedness;
- incurring guarantee obligations;
- paying dividends;
- creating liens on assets;
- entering into sale and leaseback transactions;
- making investments, loans or advances;
- entering into hedging transactions;
- engaging in mergers, consolidations or sales of all or substantially all of their respective assets; and
- engaging in certain transactions with affiliates.

In addition, the combined company will be required to maintain a minimum amount of excess availability as set forth in these agreements.

The combined company's ability to maintain minimum excess availability in future periods will depend on its ongoing financial and operating performance, which in turn will be subject to economic conditions and to financial, market and competitive factors, many of which are beyond the combined company's control. The ability to comply with this covenant in future periods will also depend on the combined company's ability to successfully implement its overall business strategy and realize contemplated synergies.

Various risks, uncertainties and events beyond the combined company's control could affect its ability to comply with the covenants contained in its debt agreements. Failure to comply with any of the covenants in its existing or future financing agreements could result in a default under those agreements and under other agreements containing cross-default provisions. A default would permit lenders to accelerate the maturity of indebtedness under these agreements and to foreclose upon any collateral securing such indebtedness. Under these circumstances, the combined company might not have sufficient funds or other resources to satisfy all of its obligations. In addition, the limitations imposed by financing agreements on the combined company's ability to incur additional indebtedness and to take other actions might significantly impair its ability to obtain other financing.

We have obtained commitment letters for the senior unsecured budge loan facility. However, neither the definitive loan documents, nor the terms of any debt financing in lieu of such bridge financing, have been finalized.

49

Table of Contents

Future issuances and sales of additional shares of preferred or common stock, including shares issued in connection with the Proposed Fidelis Acquisition, could reduce the market price of our shares of common stock.

Subject to market conditions, we intend to fund the purchase price for the Proposed Fidelis Acquisition with $2.3 billion of new equity, including shares paid as consideration. Any such issuances and sales of our preferred or common stock could have the effect of depressing the market price for our common stock. Further, any sale of shares to finance a portion of the purchase price for the Proposed Fidelis Acquisition will be subject to market conditions and could be negatively impacted by a decline in the market price for our common stock. In addition, in the future we may 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 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.

Table of Contents

ITEM 2. Unregistered Sales of Equity Securities and Use of Proceeds.

On March 12, 2018, the Company acquired 100% of Community Medical Holdings Corp. The transaction consideration was partially financed through an issuance of $149 million (1,449 thousand shares) of Centene common stock. On March 27, 2018, the Company acquired an additional 61% ownership in Interpreta Holdings, Inc. The transaction consideration was partially financed through an issuance of $175 million (1,727 thousand shares) of Centene common stock. The Company issued shares in both transactions in reliance upon the exemption contained in Section 4(a)(2) of the Securities Act of 1933, as amended, and/or Rule 506 promulgated thereunder, as transactions not involving a public offering.

Issuer Purchases of Equity Securities
First Quarter 2018

Period	Total Number of Shares Purchased [1]	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number of Shares that May Yet Be Purchased Under the Plans or Programs[2]
January 1 - January 31, 2018	12,166	$107.45	—	3,335,448
February 1 - February 28, 2018	51,989	101.48	—	3,335,448
March 1 - March 31, 2018	18,228	102.40	—	3,335,448
Total	82,383	$102.56	—	3,335,448

[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 3,335,448 shares. No duration has been placed on the repurchase program.

Table of Contents

ITEM 6. Exhibits.

EXHIBIT NUMBER		DESCRIPTION
10.1	*	2002 Employee Stock Purchase Plan, As Amended and Restated.
12.1		Computation of ratio of earnings to fixed charges.
31.1		Certification of Chairman and Chief Executive Officer pursuant to Rule 13(a)-14(a) under the Securities Exchange Act of 1934, as amended.
31.2		Certification of Executive Vice President and Chief Financial Officer pursuant to Rule 13(a)-14(a) under the Securities Exchange Act of 1934, as amended.
32.1		Certification of Chairman and Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2		Certification of Executive Vice President and Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.1		XBRL Taxonomy Instance Document.
101.2		XBRL Taxonomy Extension Schema Document.
101.3		XBRL Taxonomy Extension Calculation Linkbase Document.
101.4		XBRL Taxonomy Extension Definition Linkbase Document.
101.5		XBRL Taxonomy Extension Label Linkbase Document.
101.6		XBRL Taxonomy Extension Presentation Linkbase Document.

* Indicates a management contract or compensatory plan or arrangement.

Table of Contents

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized as of April 24, 2018.

CENTENE CORPORATION

By: /s/ MICHAEL F. NEIDORFF
Chairman and Chief Executive Officer
(principal executive officer)

By: /s/ JEFFREY A. SCHWANEKE
Executive Vice President and Chief Financial Officer
(principal financial officer)

By: /s/ CHRISTOPHER R. ISAAK
Senior Vice President, Corporate Controller and Chief Accounting Officer
(principal accounting officer)