UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549
Form 10-K

(Mark One)

x **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended December 31, 2018

or

o **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from to

Commission file number: 001-31826

Centene Corporation

(Exact name of registrant as specified in its charter)

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

Registrant's telephone number, including area code: (314) 725-4477

Securities registered pursuant to Section 12(b) of the Act:

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

Securities registered pursuant to Section 12(g) of the Act:

None

(Title of Each Class)

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes x No o

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes o No x

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes x No o

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit such files).

Yes x No o

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. x

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or smaller reporting company, or an emerging growth company. See the definitions of “large accelerated filer”, “accelerated filer”, “small reporting company”, and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer x	Accelerated filer o
Non-accelerated filer o	Smaller reporting company o
	Emerging growth company o

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

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

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

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

DOCUMENTS INCORPORATED BY REFERENCE

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

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

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

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

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

- our ability to accurately predict and effectively manage health benefits and other operating expenses and reserves;
- competition;
- membership and revenue declines or unexpected trends;
- changes in healthcare practices, new technologies, and advances in medicine;
- increased healthcare costs;
- changes in economic, political or market conditions;
- changes in federal or state laws or regulations, including changes with respect to income tax reform or government healthcare programs as well as changes with respect to the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act , collectively referred to as the Affordable Care Act (ACA) and any regulations enacted thereunder that may result from changing political conditions or judicial actions, including the ultimate outcome of the District Court decision in "Texas v. United States of America" regarding the constitutionality of the ACA;
- rate cuts or other payment reductions or delays by governmental payors and other risks and uncertainties affecting our government businesses;
- our ability to adequately price products on federally facilitated and state-based Health Insurance Marketplaces;
- tax matters;
- disasters or major epidemics;
- the outcome of legal and regulatory proceedings;
- changes in expected contract start dates;
- provider, state, federal and other contract changes and timing of regulatory approval of contracts;
- the expiration, suspension, or termination of our contracts with federal or state governments (including but not limited to Medicaid, Medicare, TRICARE or other customers);
- the difficulty of predicting the timing or outcome of pending or future litigation or government investigations;
- challenges to our contract awards;
- cyber-attacks or other privacy or data security incidents;
- the possibility that the expected synergies and value creation from acquired businesses, including, without limitation, the Fidelis Care Acquisition, will not be realized, or will not be realized within the expected time period;

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

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

Non-GAAP Financial Presentation

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

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

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

(1) Other adjustments include the following items:

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

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

2016 - (a) the impact of retroactive changes to the California minimum medical loss ratio (MLR) of a $195 million benefit or $0.38 per diluted share, net of an income tax expense of $0.21; (b) the charitable contribution commitment of $50 million or $0.09 per diluted share, net of an income tax benefit of $0.06; and (c) the debt extinguishment cost of $11 million or $0.02 per diluted share, net of an income tax benefit of $0.01.

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

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

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

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

PART I
ITEM 1. ***Business***

OVERVIEW

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

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

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

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

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

INDUSTRY

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

Medicaid

Established in 1965, Medicaid is the largest publicly funded program in the United States, and provides health insurance to low-income families and individuals with disabilities. Authorized by Title XIX of the Social Security Act, Medicaid is an entitlement program funded jointly by the federal and state governments and administered by the states. The majority of funding is provided at the federal level. Each state establishes its own eligibility standards, benefit packages, payment rates and program administration within federal standards. As a result, there are 56 Medicaid programs - one for each U.S. state, each U.S. territory and the District of Columbia. Eligibility is based on a combination of household income and assets, often determined by an income level relative to the federal poverty level. Historically, children have represented the largest eligibility group. Many states have selected Medicaid managed care as a means of delivering quality healthcare and controlling costs. We refer to these states as mandatory managed care states.

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

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

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

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

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

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

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

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

Commercial

We offer commercial healthcare products to individuals through the Health Insurance Marketplace and large and small employer groups. Our health maintenance organization (HMO) plans offer comprehensive benefits generally for a fixed fee or premium that does not vary with the extent or frequency of medical services actually received by the member. We offer HMO plans with differing benefit designs and varying levels of co-payments at different premium rates. These plans are offered generally through contracts with participating network physicians, hospitals and other providers. When an individual enrolls in one of our HMO plans, he or she selects a primary care physician (PCP) from among the physicians participating in our network. Our preferred provider organization (PPO) plans offer coverage for services received from any healthcare provider, with benefits generally paid at a higher level when care is received from a participating network provider. Coverage typically is subject to deductibles and copayments or coinsurance. Our point of service (POS) plans and our elect open access (EOA) plans blend the characteristics of HMO, PPO and indemnity plans. Members can have comprehensive HMO-style benefits for services received from participating network providers with lower copayments (particularly within the medical group), but also have coverage, generally at higher copayment or coinsurance levels or with coverage limitations, for services received outside the network. Our Exclusive Provider Organization (EPO) plans and Healthcare Service Plans (HSPs) similarly blend elements of traditional HMO and PPO plans.

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

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

Medicare

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

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

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

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

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

International

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

OUR COMPETITIVE STRENGTHS

Our approach is based on the following key competitive strengths:

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

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

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

- *Financial Strength and Scale.* We are a large healthcare enterprise with over $60 billion in revenue and $1.2 billion in operating cash flow in 2018. Our strong historical operating performance, size, and scale allow us to continue to grow, diversify and invest in our businesses through strategic acquisitions and investments in technology and other resources that support our business, allowing us to navigate the changing healthcare landscape. We are the leader in the four largest Medicaid states. We seek to continue to increase our Medicaid, Medicare and Health Insurance Marketplace membership through alliances with key providers, outreach efforts, development and implementation of community-specific products and acquisitions. For example, in 2018, we began providing managed care services to Illinois beneficiaries under a state-wide contract through our subsidiary, IlliniCare Health. In 2018 and 2019, we expanded our Health Insurance Marketplace and Medicare footprints in several existing markets.

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

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

MANAGED CARE

Benefits to Customers

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

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

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

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

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

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

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

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

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

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

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

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

Member Programs and Services

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

- primary and specialty physician care
- inpatient and outpatient hospital care
- emergency and urgent care
- prenatal care
- laboratory and x-ray services
- home-based primary care
- transportation assistance
- vision care
- dental care
- telehealth services
- immunizations
- prescriptions and limited over-the-counter drugs
- specialty pharmacy
- provision of durable medical equipment
- behavioral health and substance abuse services
- 24-hour nurse advice line
- therapies
- social work services
- care coordination

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

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

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

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

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

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

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

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

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

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

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

- *Community Health Record,* our patient-centric electronic database, collects patient demographic data, clinician visit records, dispensed medications, vital sign history, lab results, allergy charts, and immunization data. Providers can directly input additional or updated patient data and documentation into the database. All information is accessible anywhere, anytime to all authorized users, including health plan staff, greatly facilitating coordinated care among providers.

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

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

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

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

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

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

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

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

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

Providers

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Quality Management

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

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

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

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

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

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

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

SPECIALTY SERVICES

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

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

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

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

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

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

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

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

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

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

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

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

CORPORATE COMPLIANCE

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

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

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

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

COMPETITION

We operate in a highly competitive environment in an industry subject to ongoing significant changes, including business consolidations, new strategic alliances, market pressures, and regulatory and legislative reform both at the federal and state level. This is including but not limited to the federal and state healthcare reform legislation described under the heading "Regulation." In addition, changes to the political environment may drive additional changes to the competitive landscape.

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

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

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

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

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

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

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

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

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

REGULATION

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

Regulatory agencies generally have substantial discretion to issue regulations and interpret and enforce laws and rules. Changes in the regulatory environment and applicable laws and rules also may occur periodically, including in connection with changes in political party or administration at the state and federal or national levels. For example, the current administration and certain members of Congress have indicated that they may continue to pursue significant amendments to the ACA. Even if the ACA is not amended or repealed, the current administration could propose changes impacting implementation of the ACA. The ultimate content and timing of any legislation enacted under the current administration that would affect the ACA remains uncertain. Most recently, a December 2018 partial summary judgment ruling in Texas v. United States of America held that the ACA’s individual mandate requirement was essential to the ACA, and without it, the remainder of the ACA was invalid. This ruling is being appealed and the ACA remains in effect until the appeal is concluded. The ultimate content, timing or effect of any potential future legislation enacted under the current administration remains uncertain.

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

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

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

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

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

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

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

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

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

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

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

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

State and Federal Contracts

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

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

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

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

- eligibility, enrollment and dis-enrollment processes
- covered services
- eligible providers
- subcontractors
- record-keeping and record retention
- periodic financial and informational reporting
- quality assurance
- accreditation
- health education and wellness and prevention programs
- timeliness of claims payment
- financial standards
- safeguarding of member information
- fraud, waste and abuse detection and reporting
- grievance procedures
- organization and administrative systems

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

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

Marketplace Contracts

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

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

Privacy Regulations

We are subject to various international, federal, state and local laws and rules regarding the use, security and disclosure of protected health information, personal information, and other categories of confidential or legally protected data that our businesses handle. Such laws and rules include, without limitation, the Health Insurance Portability and Accountability Act (HIPAA), the Federal Trade Commission Act, the Gramm-Leach-Bliley Financial Modernization Act of 1999 (Gramm-Leach-Bliley Act), state privacy and security laws such as the California Confidentiality of Medical Information Act and the California Online Privacy Protection Act. Privacy and security laws and regulations often change due to new or amended legislation, regulations or administrative interpretation. A variety of state and federal regulators enforce these laws, including but not limited to the U.S. Department of Health and Human Services (HHS), the Federal Trade Commission, state attorneys general and other state regulators.

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

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

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

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

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

Other Fraud, Waste and Abuse Laws

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

EMPLOYEES

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

EXECUTIVE OFFICERS OF THE REGISTRANT

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

Name	Age	Position
Michael F. Neidorff	76	Chairman and Chief Executive Officer
Christopher D. Bowers	63	Executive Vice President, Markets
Mark J. Brooks	49	Executive Vice President and Chief Information Officer
Brandy Burkhalter	46	Executive Vice President, Operations
Jesse N. Hunter	43	Executive Vice President and Chief Strategy Officer
Christopher R. Isaak	52	Senior Vice President, Corporate Controller and Chief Accounting Officer
Jeffrey A. Schwaneke	43	Executive Vice President, Chief Financial Officer and Treasurer
Keith H. Williamson	66	Executive Vice President, General Counsel and Secretary

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

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

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

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

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

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

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

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

Available Information

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

ITEM 1A. ***Risk Factors.***

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

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

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

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

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

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

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

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

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

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

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

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

Our medical expenses include claims reported but not paid, estimates for claims incurred but not reported, and estimates for the costs necessary to process unpaid claims at the end of each period. Our development of the medical claims liability estimate is a continuous process which we monitor and refine on a monthly basis as claims receipts and payment information as well as inpatient acuity information becomes available. As more complete information becomes available, we adjust the amount of the estimate, and include the changes in estimates in medical expenses in the period in which the changes are identified. Given the uncertainties inherent in such estimates, there can be no assurance that our medical claims liability estimate will be adequate, and any adjustments to the estimate may unfavorably impact our results of operations and may be material.

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

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

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

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

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

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

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

The HHS has stated that it will consider a limited number of premium assistance demonstration proposals from states that want to privatize Medicaid expansion. States must provide a choice between at least two qualified health plans and offer very similar benefits as those available in the Health Insurance Marketplaces. Arkansas was the first state to obtain federal approval to use Medicaid funding to purchase private insurance for low-income residents, and we began operations under the program beginning January 1, 2014. As of December 31, 2018, eight states had approved Section 1115 waivers to implement the ACA's Medicaid expansion in ways that extend beyond the flexibility provided by the federal law.

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

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

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

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

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

In each of the jurisdictions in which we operate, we are regulated by the relevant insurance, health and/or human services or government departments that oversee the activities of managed care organizations providing or arranging to provide services to Medicaid, Medicare, Health Insurance Marketplace enrollees or other beneficiaries. For example, our health plan subsidiaries, as well as our applicable specialty companies, must comply with minimum statutory capital and other financial solvency requirements, such as deposit and surplus requirements.

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

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

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

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

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

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

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

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

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.

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

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

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

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

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

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

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

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

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

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

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

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.

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

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

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

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

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

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

From time to time, we are a defendant in lawsuits and regulatory actions and are subject to investigations relating to our business, including, without limitation, medical malpractice claims, claims by members alleging failure to pay for or provide healthcare, claims related to non-payment or insufficient payments for out-of-network services, claims alleging bad faith, investigations regarding our submission of risk adjuster claims, putative securities class actions, and claims related to the imposition of new taxes, including but not limited to claims that may have retroactive application. Due to the inherent uncertainties of litigation and regulatory proceedings, we cannot accurately predict the ultimate outcome of any such proceedings. An unfavorable outcome could have a material adverse impact on our business and financial position, results of operations and/or cash flows and may affect our reputation. In addition, regardless of the outcome of any litigation or regulatory proceedings, such proceedings are costly and time consuming and require significant attention from our management, and could therefore harm our business and financial position, results of operations or cash flows.

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

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

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

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

In addition, HIPAA broadened the scope of fraud and abuse laws applicable to healthcare companies. HIPAA established new enforcement mechanisms to combat fraud and abuse, including civil and, in some instances, criminal penalties for failure to comply with specific standards relating to the privacy, security and electronic transmission of protected health information. The HITECH Act expanded the scope of these provisions by mandating individual notification in instances of breaches of protected health information, providing enhanced penalties for HIPAA violations, and granting enforcement authority to states' Attorneys General in addition to the HHS Office for Civil Rights. It is possible that Congress may enact additional legislation in the future to increase penalties and to create a private right of action under HIPAA, which could entitle patients to seek monetary damages for violations of the privacy rules. HHS continued its auditing program in 2016 to assess compliance efforts by covered entities and business associates. Through a second phase of audits, which commenced for covered entities in July 2016, HHS focused on a review of policies and procedures adopted and employed by covered entities and their business associates to meet selected standards and implementation specifications of the HIPAA Privacy, Security, and Breach Notification Rules. The HHS Office for Civil Rights reported that as of February 2018, the Phase 2 desk audits of covered entities and business associates were completed, and additional comprehensive on-site audits would be conducted as a part of a permanent audit program going forward. An audit resulting in findings or allegations of noncompliance could have a material adverse effect on our results of operations, financial position and cash flows.

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

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

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

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

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

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

The market price of our common stock is generally subject to volatility, and there can be no assurances regarding the level or stability of our share price at any time. The market price of our common stock may decline as a result of acquisitions if, among other things, we are unable to achieve the expected growth in earnings, or if the operational cost savings estimates in connection with the integration of acquired businesses with ours are not realized, or if the transaction costs related to the acquisitions and integrations are greater than expected. The market price also may decline if we do not achieve the perceived benefits of the acquisitions as rapidly or to the extent anticipated by financial or industry analysts or if the effect of the acquisitions on our financial position, results of operations or cash flows is not consistent with the expectations of financial or industry analysts.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Item 1B. ***Unresolved Staff Comments***

None.

Item 2. ***Properties***

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

Item 3. *Legal Proceedings*

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

Item 4. *Mine Safety Disclosures*

Not applicable.

PART II

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

Market for Common Stock; Dividends

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

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

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

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

Issuer Purchases of Equity Securities

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

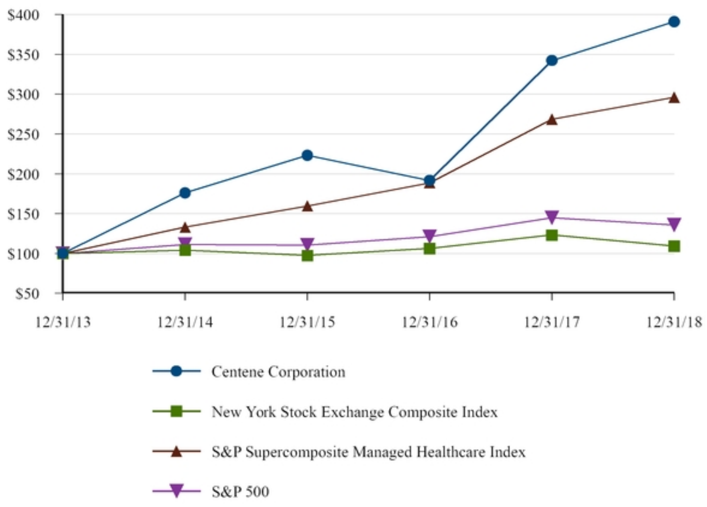
Issuer Purchases of Equity Securities
Fourth Quarter 2018
(shares in thousands)

Period	Total Number of Shares Purchased(1)	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number of Shares that May Yet Be Purchased Under the Plans or Programs(2)
October 1 – October 31, 2018	8	$ 66.95	—	6,671
November 1 – November 30, 2018	3	68.60	—	6,671
December 1 – December 31, 2018	815	65.72	—	6,671
Total	826	$ 65.74	—	6,671

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

Stock Performance Graph

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



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

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

Item 6. *Selected Financial Data*

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

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

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

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

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

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

EXECUTIVE OVERVIEW

General

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

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

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

Fidelis Care Acquisition

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

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

Acquisitions and Investments

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

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

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

Regulatory Trends and Uncertainties

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

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

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

2018 Highlights

Our financial performance for 2018 is summarized as follows:

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

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

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

(1) Other adjustments include the following items:

- 2018 - the impact of retroactive changes to the California minimum MLR of $30 million or $0.06 per diluted share, net of an income tax benefit of $0.02; and
- 2017 - (a) the Penn Treaty assessment expense of $56 million or $0.10 per diluted share, net of an income tax benefit of $0.06; (b) the cost sharing reduction (CSR) expense of $22 million or $0.04 per diluted share, net of an income tax benefit of $0.02; (c) the charitable contribution commitment of $40 million or $0.07 per diluted share, net of an income tax benefit of $0.05, and (d) the benefit associated with income tax reform of $125 million or $0.35 per diluted share.

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

- During the year ended December 31, 2018, we received 2014-2017 cost reconciliation information related to the California Medicaid in-home support services (IHSS) program, which ended December 31, 2017. As a result, our 2018 results include an estimated pre-tax benefit of $140 million related to the IHSS program reconciliation. The 2014-2016 reconciliation is expected to be finalized by early 2019, with the final 2017 reconciliation to follow.
- On September 30, 2018, our contract to provide health care coordination services to the U.S. Department of Veterans Affairs under the Patient-Centered Community Care and Veterans Choice Programs expired. In connection with the conclusion of the contract, during the year ended December 31, 2018, we recorded a pre-tax charge of $110 million for negotiated settlements and severance costs. We will continue to provide close out and transition services through 2021.
- During the year ended December 31, 2018, we recorded pre-tax expense of $30 million associated with a contribution commitment to our charitable foundation.

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

- *Arizona.* In October 2018, our Arizona subsidiary, Health Net Access, began providing physical and behavioral health care services under a new integrated contract through the Arizona Health Care Cost Containment System Complete Care program in the Central region and the Southern region. In January 2017, we continued our participation as a qualified health plan issuer in the Arizona Health Insurance Marketplace and exited the Health Net preferred provider organization offerings in Arizona.
- *Arkansas.* In February 2018, our Arkansas subsidiary, Arkansas Total Care, began managing a Medicaid special needs population comprised of people with high behavioral health needs and individuals with developmental/intellectual disabilities. Arkansas Total Care is expected to assume full-risk on this population beginning in March 2019.
- *CMG.* In March 2018, we completed the acquisition of CMG, an at-risk primary care provider serving Medicaid, Medicare Advantage, and Health Insurance Marketplace patients in Miami-Dade County, Florida.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- In July 2018, our subsidiary, Health Net Federal Services, was awarded the next generation Military & Family Life Counseling Program contract. The awarded contract is up to ten years, including multiple one-year option periods.
- In July 2018, Centurion began operating under a contract to provide healthcare services for correctional facilities in Pima County, Arizona. In addition, Centurion's contracts for correctional facilities were reprocured in Florida, New Hampshire and Tennessee.
- In May 2018, our Iowa subsidiary, Iowa Total Care, Inc., was selected to negotiate a new statewide contract for the IA Health Link Program. The contract is expected to commence on July 1, 2019.

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

- In the first quarter of 2018, Health Net of Arizona, Inc. notified the Arizona Department of Insurance of its decision to discontinue and non-renew all of its Employer Group plans for small and large business groups in Arizona beginning January 1, 2019. The effective date of coverage termination for existing groups is dependent on remaining renewals; however, coverage will no longer be provided to any group policyholders and/or members after December 31, 2019.
- We were successful in reprocuring our contract in Washington. However, we expect market share to decrease as a result of the award.

MEMBERSHIP

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

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

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

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

	December 31		
	2018	2017	2016
Dual-eligible (2)	598,200	474,500	441,400
Health Insurance Marketplace	1,459,100	959,600	537,200
Medicaid Expansion	1,262,100	1,091,500	1,080,500

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

From December 31, 2017 to December 31, 2018, our membership increased as a result of:

- the Fidelis Care Acquisition; and
- membership growth in our Health Insurance Marketplace service areas.

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

From December 31, 2016 to December 31, 2017, our membership increased as a result of:

- membership growth in our Health Insurance Marketplace service areas;
- the commencement of health plan management services for Medicaid operations in Maryland;
- an expanded statewide managed care contract in Missouri; and
- the commencement of new managed care contracts in Nebraska and Nevada.

RESULTS OF OPERATIONS

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

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

n.m.: not meaningful

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

Total Revenues

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

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

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

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

Operating Expenses

Medical Costs

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

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

Cost of Services

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

The cost of service ratio for the year ended December 31, 2018 was 85.0%, compared to 81.5% in 2017. The cost of service ratio was negatively impacted by approximately 110 basis points for the costs associated with the Veterans Affairs contract expiration. The increase in the cost of service ratio was also due to lower margins associated with our other federal services business and growth in our specialty pharmacy business due to the acquisition of Foundation Care in October 2017, which operates at a higher cost of service ratio. These increases were partially offset by growth in our correctional services business resulting from the acquisition of MHM, which operates at a lower cost of service ratio.

Selling, General and Administrative Expenses

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

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

Health Insurer Fee Expense

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

Other Income (Expense)

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

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

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

Income Tax Expense

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

Segment Results

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

	2018	2017	% Change 2017-2018
Total Revenues			
Managed Care	$ 57,099	$ 45,842	25 %
Specialty Services	12,506	12,055	4 %
Eliminations	(9,489)	(9,515)	— %
Consolidated Total	$ 60,116	$ 48,382	24 %
Earnings from Operations			
Managed Care	$ 1,310	$ 917	43 %
Specialty Services	148	282	(48)%
Consolidated Total	$ 1,458	$ 1,199	22 %

Managed Care

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

Specialty Services

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

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

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

Total Revenues

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

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

Total revenues increased 19% in the year ended December 31, 2017, over the corresponding period in 2016, primarily as a result of a full year of Health Net's results, as well as the impact of growth in the Health Insurance Marketplace business in 2017 and expansions and new programs in many of our states in 2016 and 2017. This was partially offset by the moratorium of the health insurer fee in 2017, lower membership in the commercial business in California as a result of margin improvement actions taken in 2016, and lower specialty pharmacy revenues. As a result of the health insurer fee moratorium, which suspended the health insurance provider fee for the 2017 calendar year, we did not recognize health insurer fee revenue in 2017, compared to $531 million recognized in 2016. During the year ended December 31, 2017, we received Medicaid premium rate adjustments which yielded an approximate net 1% composite rate change across all of our markets.

Operating Expenses

Medical Costs

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

Cost of Services

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

Selling, General and Administrative Expenses

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

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

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

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

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

Health Insurer Fee Expense

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

Other Income (Expense)

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

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

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

Income Tax Expense

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

Segment Results

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

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

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

Managed Care

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

Specialty Services

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

LIQUIDITY AND CAPITAL RESOURCES

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

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

Cash Flows Provided by Operating Activities

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

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

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

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

Cash Flows Used in Investing Activities

Investing activities used cash of $4.6 billion for the year ended December 31, 2018, $1.3 billion in 2017, and $2.5 billion in 2016. Cash flows used in investing activities in 2018 primarily consisted of the Fidelis Care and other acquisitions, the net additions to the investment portfolio of our regulated subsidiaries (including transfers from cash and cash equivalents to long-term investments), the investments in RxAdvance, and capital expenditures.

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

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

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

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

Cash Flows Provided by (Used in) Financing Activities

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

2018

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

2017

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

2016

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

In February 2016, our wholly owned unrestricted subsidiary (Escrow Issuer) issued $1.4 billion of 5.625% senior notes ($1.4 Billion Notes) at par due 2021 and $1.0 billion of 6.125% senior notes ($1.0 Billion Notes) at par due 2024. We used the net proceeds of the offering, together with borrowings under the our new $1.0 billion revolving credit facility and cash on hand, to fund the cash consideration for the Health Net acquisition and to pay acquisition and offering related fees and expenses. In connection with the February 2016 issuance, we entered into interest rate swap agreements for notional amounts of $600 million and $1.0 billion, at floating rates of interest based on the three month LIBOR plus 4.22% and the three month LIBOR plus 4.44%, respectively. Gains and losses due to changes in the fair value of the interest rate swaps completely offset changes in the fair value of the hedged portion of the underlying debt and are recorded as an adjustment to the $1.4 Billion Notes and $1.0 Billion Notes.

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

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

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

Liquidity Metrics

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

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

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

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

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

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

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

We have a stock repurchase program authorizing us to repurchase up to 16 million shares of common stock from time to time on the open market or through privately negotiated transactions. We have 7 million available shares remaining under the program for repurchases as of December 31, 2018. No duration has been placed on the repurchase program. We reserve the right to discontinue the repurchase program at any time. We did not make any repurchases under this plan during 2018, 2017 or 2016.

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

2019 Expectations

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

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

CONTRACTUAL OBLIGATIONS

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

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

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

Commitments

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

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

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

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

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

REGULATORY CAPITAL AND DIVIDEND RESTRICTIONS

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

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

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

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

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

As a result of the above requirements and other regulatory requirements, certain of our subsidiaries are subject to restrictions on their ability to make dividend payments, loans or other transfers of cash to their parent companies. Such restrictions, unless amended or waived or unless regulatory approval is granted, limit the use of any cash generated by these subsidiaries to pay our obligations. The maximum amount of dividends that can be paid by our insurance company subsidiaries without prior approval of the applicable state insurance departments is subject to restrictions relating to statutory surplus, statutory income and unassigned surplus. As of December 31, 2018, the amount of capital and surplus or net worth that was unavailable for the payment of dividends or return of capital to us was $3,279 million in the aggregate.

RECENT ACCOUNTING PRONOUNCEMENTS

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

CRITICAL ACCOUNTING POLICIES AND ESTIMATES

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

Goodwill and Intangible Assets

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

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

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

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

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

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

Medical Claims Liability

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

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

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

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

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

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

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

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

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

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

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

	Year Ended December 31,		
	2018	2017	2016
Balance, January 1,	$ 4,286	$ 3,929	$ 2,298
Less: reinsurance recoverable	18	5	—
Balance, January 1, net	4,268	3,924	2,298
Acquisitions	1,204	—	1,482
Less: acquired reinsurance recoverable	8	—	—
Incurred related to:			
Current year	46,484	38,225	30,946
Prior years	(427)	(374)	(310)
Total incurred	46,057	37,851	30,636
Paid related to:			
Current year	41,161	34,196	28,532
Prior years	3,556	3,311	1,960
Total paid	44,717	37,507	30,492
Balance, December 31, net	6,804	4,268	3,924
Plus: reinsurance recoverable	27	18	5
Balance, December 31,	$ 6,831	$ 4,286	$ 3,929
Days in claims payable (1)	48	41	42

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

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

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

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

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

Revenue Recognition

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

Our contracts with states may require us to maintain a minimum HBR or may require us to share profits in excess of certain levels. In certain circumstances, including commercial plans, our plans may be required to return premium to the state or policyholders in the event profits exceed established levels. We estimate the effect of these programs and recognize reductions in revenue in the current period. Other states may require us to meet certain performance and quality metrics in order to receive additional or full contractual revenue. For performance-based contracts, we do not recognize revenue subject to refund until data is sufficient to measure performance.

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

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

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

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

ITEM 7A. ***Quantitative and Qualitative Disclosures About Market Risk***

INVESTMENTS AND DEBT

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

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

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

INFLATION

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

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

Item 8. ***Financial Statements and Supplementary Data***

Report of Independent Registered Public Accounting Firm

To the Stockholders and Board of Directors
Centene Corporation:

Opinion on the Consolidated Financial Statements

We have audited the accompanying consolidated balance sheets of Centene Corporation and subsidiaries (the Company) as of December 31, 2018 and 2017, the related consolidated statements of operations, comprehensive earnings, stockholders' equity, and cash flows for each of the years in the three-year period ended December 31, 2018, and the related notes (collectively, the consolidated financial statements). In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Company as of December 31, 2018 and 2017, and the results of its operations and its cash flows for each of the years in the three-year period ended December 31, 2018, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2018, based on criteria established in *Internal Control - Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission, and our report dated February 19, 2019 expressed an unqualified opinion on the effectiveness of the Company's internal control over financial reporting.

Basis for Opinion

These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

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

/s/ KPMG LLP

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

St. Louis, Missouri
February 19, 2019

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

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

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

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

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

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

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

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

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

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

	Centene Stockholders' Equity								
	Common Stock					Treasury Stock			
	$.001 Par Value Shares	Amt	Additional Paid-in Capital	Accumulated Other Comprehensive Income (Loss)	Retained Earnings	$.001 Par Value Shares	Amt	Non controlling Interest	Total
Balance, December 31, 2015	253,710	$ —	$ 956	$ (10)	$ 1,358	13,024	$ (147)	$ 11	$ 2,168
Net earnings	—	—	—	—	562	—	—	1	563
Other comprehensive loss, net of ($14) tax	—	—	—	(26)	—	—	—	—	(26)
Common stock issued for acquisitions	96,436	—	3,074	—	—	(2,750)	31	—	3,105
Common stock issued for employee benefit plans	6,122	—	12	—	—	—	—	—	12
Common stock repurchases	—	—	—	—	—	2,156	(63)	—	(63)
Stock compensation expense	—	—	148	—	—	—	—	—	148
Contribution from noncontrolling interest	—	—	—	—	—	—	—	2	2
Balance, December 31, 2016	356,268	$ —	$ 4,190	$ (36)	$ 1,920	12,430	$ (179)	$ 14	$ 5,909
Net earnings	—	—	—	—	828	—	—	—	828
Other comprehensive earnings, net of $15 tax	—	—	—	33	—	—	—	—	33
Common stock issued for employee benefit plans	4,490	—	11	—	—	—	—	—	11
Common stock repurchases	—	—	—	—	—	1,454	(65)	—	(65)
Stock compensation expense	—	—	135	—	—	—	—	—	135
Purchase of noncontrolling interest	—	—	13	—	—	—	—	—	13
Balance, December 31, 2017	360,758	$ —	$ 4,349	$ (3)	$ 2,748	13,884	$ (244)	$ 14	$ 6,864
Net earnings	—	—	—	—	900	—	—	(2)	898
Other comprehensive loss, net of ($15) tax	—	—	—	(53)	—	—	—	—	(53)
Common stock issued for acquisitions	—	—	331	—	—	(9,787)	176	—	507
Common stock issued for stock offering	53,207	—	2,779	—	—	—	—	—	2,779
Common stock issued for employee benefit plans	3,730	—	17	—	—	—	—	—	17
Common stock repurchases	—	—	—	—	—	1,120	(71)	—	(71)
Stock compensation expense	—	—	145	—	—	—	—	—	145
Cumulative-effect of adopting new accounting guidance	—	—	—	—	15	—	—	—	15
Purchase of noncontrolling interest	—	—	(172)	—	—	—	—	(15)	(187)
Acquisition resulting in noncontrolling interest	—	—	—	—	—	—	—	99	99
Balance, December 31, 2018	417,695	$ —	$ 7,449	$ (56)	$ 3,663	5,217	$ (139)	$ 96	$ 11,013

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

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

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

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

CENTENE CORPORATION AND SUBSIDIARIES
NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS

1. Organization and Operations

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

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

2. Summary of Significant Accounting Policies

Basis of Presentation

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

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

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

Use of Estimates

The preparation of financial statements in conformity with generally accepted accounting principles in the United States (GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Future events and their effects cannot be predicted with certainty; accordingly, the accounting estimates require the exercise of judgment. The accounting estimates used in the preparation of the consolidated financial statements will change as new events occur, as more experience is acquired, as additional information is obtained and as the operating environment changes. The Company evaluates and updates its assumptions and estimates on an ongoing basis and may employ outside experts to assist in its evaluation, as considered necessary. Actual results could differ from those estimates.

Business Combinations

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

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

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

Cash and Cash Equivalents

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

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

Investments

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

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

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

Restricted Deposits

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

Fair Value Measurements

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

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

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

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

Property, Software and Equipment

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

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

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

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

Goodwill and Intangible Assets

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

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

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

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

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

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

Medical Claims Liability

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

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

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

The Company's development of the medical claims liability estimate is a continuous process which it monitors and refines on a monthly basis as additional claims receipts and payment information becomes available. As more complete claims information becomes available, the Company adjusts the amount of the estimates, and includes the changes in estimates in medical costs in the period in which the changes are identified. In every reporting period, the operating results include the effects of more completely developed medical claims liability estimates associated with previously reported periods. The Company consistently applies its reserving methodology from period to period. As additional information becomes known, it adjusts the actuarial model accordingly to establish medical claims liability estimates.

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

Revenue Recognition

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

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

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

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

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

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

Affordable Care Act

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

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

Risk Adjustment

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

Reinsurance

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

Risk Corridor

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

Minimum Medical Loss Ratio

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

Cost Sharing Reductions (CSRs)

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

Premium and Trade Receivables and Unearned Revenue

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

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

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

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

Significant Customers

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

Other Income (Expense)

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

Income Taxes

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

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

Contingencies

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

Stock Based Compensation

The fair value of the Company's employee share options and similar instruments are estimated using the Black-Scholes option-pricing model. That cost is recognized over the period during which an employee is required to provide service in exchange for the award. Excess tax benefits related to stock compensation are presented as a cash inflow from operating activities for the years ended December 31, 2018, 2017 and 2016. The Company accounts for forfeitures when they occur.

Foreign Currency Translation

The Company is exposed to foreign currency exchange risk through its international subsidiaries whose functional currencies include the Euro and British Pound. The assets and liabilities of the Company's subsidiaries are translated into United States dollars at the balance sheet date. The Company translates its proportionate share of earnings using average rates during the year. The resulting foreign currency translation adjustments are recorded as a separate component of accumulated other comprehensive income.

Recently Adopted Accounting Guidance

In August 2018, the Financial Accounting Standards Board (FASB) issued an Accounting Standards Update (ASU) which modifies the disclosure requirements on fair value measurements. The amendments in this ASU remove the requirements to disclose the amount of and reasons for transfers between Level 1 and Level 2 of the fair value hierarchy, the policy for timing of transfers between levels and the valuation processes for Level 3 fair value measurements. The amendments require public entities to disclose the changes in unrealized gains and losses for the period included in other comprehensive income for recurring Level 3 fair value measurements for instruments held at the end of the reporting period, and the range and weighted average used to develop significant inputs for Level 3 fair value measurements. For investments in certain entities that calculate net asset value, the standard requires the disclosure of the period of time over which the underlying assets might be liquidated if the investee has announced the timing publicly. The Company adopted the new guidance in the third quarter of 2018. The new guidance did not have any impact on the Company’s consolidated financial position, results of operations or cash flows.

In June 2018, the FASB issued an ASU that simplifies the accounting for share-based payment arrangements with non-employees for goods and services. Under the ASU, the guidance on such payments to non-employees is aligned with the accounting for share-based payments granted to employees, including the measurement of equity-classified awards, which is fixed at the grant date under the new guidance. The Company adopted the new guidance in the second quarter of 2018 using the modified retrospective approach with an immaterial cumulative-effect adjustment to retained earnings.

In February 2018, the FASB issued an 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 $78 million, $6 million, $17 million and $8 million as of December 31, 2015, December 31, 2016, December 31, 2017 and December 31, 2018, respectively.

In January 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.

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.

Recent Accounting Guidance Not Yet Adopted

In August 2018, the FASB issued an ASU which aligns the requirements for capitalizing implementation costs incurred in a hosting arrangement that is a service contract with the requirements for capitalizing implementation costs incurred to develop or obtain internal-use software (and hosting arrangements that include an internal use software license). The accounting for the service element of a hosting arrangement that is a service contract is not affected by the amendments in this update. The amendments in this ASU require an entity that is the customer in a hosting arrangement to follow the guidance on internal-use software to determine which implementation costs to capitalize and which costs to expense. The standard also requires an entity that is the customer to expense the capitalized implementation costs of a hosting arrangement over the term of the hosting arrangement. The new guidance requires an entity to present the expense related to the capitalized implementation costs in the same line item in the statement of income as the fees associated with the hosting element of the arrangement and classify payments for capitalized implementation costs in the statement of cash flows in the same manner as payments made for fees associated with the hosting element. The entity is also required to present the capitalized implementation costs in the statement of financial position in the same line item that a prepayment for the fees of the associated hosting arrangement would be presented. The guidance is effective for annual and interim periods beginning after December 15, 2019. Early adoption is permitted. 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 August 2017, the FASB issued an ASU which amends the hedge accounting model to enable entities to better align the economics of risk management activities and financial reporting. In addition, the new standard enhances the understandability of hedge results and simplifies the application of hedge accounting in certain situations. The Company adopted the new guidance in the first quarter of 2019. The new guidance did not have a material impact on the Company’s consolidated financial position, results of operations or cash flows.

In March 2017, the FASB issued an ASU which changes the period over which premiums on callable debt securities are amortized. The new standard requires the premiums on callable debt securities to be amortized to the earliest call date rather than to the contractual maturity date of the instrument. The new guidance more closely aligns the amortization period of premiums to expectations incorporated in the market pricing on the underlying securities. The Company adopted the new guidance in the first quarter of 2019. The new guidance did not have a material impact on the Company's consolidated financial position, results of operations or cash flows.

In January 2017, the FASB issued an ASU simplifying the test for goodwill impairment. The amendments in this ASU eliminate Step 2 from the goodwill impairment test. Thus, an entity will no longer be required to compare the implied fair value of a reporting unit's goodwill to its carrying amount. Instead, under the new guidance, an entity should perform the goodwill impairment test by comparing the fair value of a reporting unit with its carrying amount and should recognize an impairment charge for the amount by which the carrying amount exceeds the fair value. The impairment charge should be limited to the total amount of goodwill allocated to that reporting unit. Under the new guidance, an entity still has the option to first perform the qualitative assessment for a reporting unit to determine if the quantitative impairment test is necessary. The new standard is effective for an entity's annual or interim goodwill impairment tests in fiscal years beginning after December 15, 2019. Early adoption is permitted, including adoption in an interim period. 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 Company adopted the new guidance in the first quarter of 2019 using the modified retrospective transition approach and elected the transition option to recognize a cumulative-effect adjustment to the opening balance of retained earnings in the period of adoption rather than in the earliest period presented. In addition, the Company elected the package of practical expedients permitted under the transition guidance within the new standard, which allows an entity to not reassess lease classification for existing leases. Adoption of the new guidance resulted in the recognition of right-of-use (ROU) assets and lease liabilities of approximately $800 million for operating leases. The new guidance did not have a material impact on the Company's consolidated results of operations or cash flows.

The Company has determined that there are no other recently issued accounting pronouncements that will have a material impact on its consolidated financial position, results of operations or cash flows.

3. Fidelis Care Acquisition

On July 1, 2018, the Company acquired substantially all of the assets of Fidelis Care for approximately $3,604 million of cash consideration, which includes a working capital adjustment. The purchase price continues to be subject to adjustments related to changes in working capital through June 2019. The acquisition consideration was funded through the issuance of 53.2 million shares of Centene common stock as further discussed in Note 11. *Stockholders Equity* and the issuance of long-term debt as further discussed in Note 10. *Debt.* The Fidelis Care acquisition expanded the Company's scale and presence to New York State.

The acquisition of Fidelis Care was accounted for as a business combination using the acquisition method of accounting which requires assets acquired and liabilities assumed to be recognized at fair value as of the acquisition date. Any necessary adjustments from preliminary estimates will be finalized within one year from the date of acquisition. Measurement period adjustments will be recorded in the period in which they are determined, as if they had been completed at the acquisition date. The Company has completed its valuation procedures on cash and cash equivalents, restricted deposits, and property, software and equipment, but the valuation of all remaining assets and liabilities has not been finalized. The Company has performed preliminary valuation procedures on all assets acquired and liabilities assumed and accordingly has recorded provisional amounts which are subject to adjustment. The Company is waiting on additional information related to certain liabilities and performing a detailed analysis on the valuation of premium and related receivables.

The Company's preliminary allocation of the fair value of assets acquired and liabilities assumed as of the acquisition date of July 1, 2018 is as follows ($ in millions):

Assets acquired and liabilities assumed		
Cash and cash equivalents	$	2,001
Premium and related receivables		508
Other current assets		33
Restricted deposits		495
Property, software and equipment		48
Intangible assets [(a)]		922
Other long-term assets		1
Total assets acquired		4,008
Medical claims liability		1,204
Accounts payable and accrued expenses		289
Return of premium payable		124
Unearned revenue		115
Other long-term liabilities		299
Total liabilities assumed		2,031
Total identifiable net assets		1,977
Goodwill [(b)]		1,627
Total assets acquired and liabilities assumed	$	3,604

The Company has made the following preliminary fair value adjustments based on information reviewed through December 31, 2018. Significant fair value adjustments are noted as follows:

(a) The identifiable intangible assets acquired are to be measured at fair value as of the completion of the acquisition. The fair value of intangible assets is determined primarily using variations of the "income approach," which is based on the present value of the future after tax cash flows attributable to each identified intangible asset. Other valuation methods, including the market approach and cost approach, were also considered in estimating the fair value. The Company has estimated the fair value of intangible assets to be $922 million with a weighted average life of 13 years. The identifiable intangible assets include customer relationships, provider contracts, trade names and developed technology.

The fair values and weighted average useful lives for identifiable intangible assets acquired are as follows:

		Fair Value	**Weighted Average Useful Life (in years)**
Customer relationships	$	677	11
Trade name		196	20
Provider contracts		33	15
Developed technologies		16	2
Total intangible assets acquired	$	922	13

(b) The acquisition resulted in $1.6 billion of goodwill related primarily to synergies expected from the acquisition and the assembled workforce of Fidelis Care. All of the goodwill has been assigned to the Managed Care segment. The goodwill is deductible for income tax purposes.

Statement of Operations

From the acquisition date through December 31, 2018, the Company's Consolidated Statements of Operations include total Fidelis Care revenues of $5,628 million. It is impracticable to determine the effect on net income resulting from the Fidelis Care acquisition for the year ended December 31, 2018, as the Company began immediately integrating Fidelis Care into its ongoing operations.

Unaudited Pro Forma Financial Information

The unaudited pro forma total revenues for the year ended December 31, 2018 were $65,792 million. It is impracticable for the Company to determine the pro forma earnings information for the year ended December 31, 2018 due to the nature of obtaining that information as the Company began immediately integrating Fidelis Care into its ongoing operations. The following table presents supplemental pro forma information for the year ended December 31, 2017 ($ in millions, except per share data):

	Year Ended December 31, 2017
Total revenues	$ 58,275
Net earnings attributable to Centene Corporation	$ 936
Diluted earnings per share	$ 2.27

The pro forma results do not reflect any anticipated synergies, efficiencies, or other cost savings of the acquisition. Accordingly, the unaudited pro forma financial information is not indicative of the results if the acquisition had been completed on January 1, 2017 and is not a projection of future results.

The unaudited pro forma financial information reflects the historical results of Centene and Fidelis Care adjusted as if the acquisition had occurred on January 1, 2017, primarily for the following:

- Additional premium tax expense related to Fidelis Care no longer being a not-for-profit entity.
- Additional Health Insurer Fee revenue in 2018 related to Fidelis Care as some of those revenues will be subject to the Health Insurer Fee following the first year of the closing of the Fidelis Care acquisition, absent a Health Insurer Fee moratorium.
- Reduced Fidelis Care investment income to reflect lower investment balances and mix of investments associated with the acquired assets.
- Interest expense associated with debt incurred to finance the transaction.
- An adjustment to basic and diluted shares outstanding to reflect the shares issued by Centene to finance the transaction.
- An adjustment to income tax expense to reflect the tax impact of the acquisition and Fidelis Care becoming subject to income tax.
- Elimination of acquisition related costs.

Commitments

As part of the regulatory approval process, in connection with the acquisition Fidelis Care, the Company entered into certain undertakings with the New York State Department of Health. These undertakings contain various commitments by the Company effective upon completion of the Fidelis Care acquisition. One of the undertakings includes a $340 million contribution by the Company 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. As a result of the closing of the Fidelis Care acquisition, the present value of the $340 million contribution to the State of New York, approximately $328 million, was expensed during 2018.

4. 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):

	December 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	$ 362	$ 1	$ (2)	$ 361	$ 311	$ —	$ (2)	$ 309
Corporate securities	3,190	8	(52)	3,146	2,208	12	(10)	2,210
Restricted certificates of deposit	433	—	—	433	4	—	—	4
Restricted cash equivalents	8	—	—	8	17	—	—	17
Municipal securities	2,196	9	(18)	2,187	2,085	12	(10)	2,087
Asset-backed securities	686	1	(4)	683	437	1	(1)	437
Residential mortgage-backed securities	452	1	(9)	444	337	1	(6)	332
Commercial mortgage- backed securities	366	1	(6)	361	272	1	(2)	271
Private equity investments	387	—	—	387	176	—	—	176
Life insurance contracts	128	—	—	128	135	—	—	135
Total	$ 8,208	$ 21	$ (91)	$ 8,138	$ 5,982	$ 27	$ (31)	$ 5,978

The Company’s investments are debt securities classified as available-for-sale with the exception of life insurance contracts and certain private equity 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 December 31, 2018, 96% of the Company’s investments in rated securities carry an investment grade rating by nationally recognized statistical rating organizations. At December 31, 2018, the Company held certificates of deposit, life insurance contracts and private equity 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 3.7 years at December 31, 2018.

In March 2018, the Company completed a 25% investment in RxAdvance, a full-service pharmacy benefit manager. In May 2018, the Company made an additional investment, bringing the total ownership to 28%. The investment is being accounted for using the equity method of accounting. In September 2018, the Company made an additional investment in RxAdvance in the form of convertible preferred stock.

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):

	December 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	$ —	$ 59	$ (2)	$ 202	$ (1)	$ 222	$ (1)	$ 79
Corporate securities	(27)	1,389	(25)	871	(6)	1,044	(4)	185
Municipal securities	(4)	591	(14)	806	(7)	943	(3)	175
Asset-backed securities	(2)	318	(2)	168	(1)	228	—	28
Residential mortgage- backed securities	(1)	61	(8)	233	(1)	109	(5)	171
Commercial mortgage- backed securities	(2)	137	(4)	140	(1)	112	(1)	51
Total	$ (36)	$ 2,555	$ (55)	$ 2,420	$ (17)	$ 2,658	$ (14)	$ 689

As of December 31, 2018, the gross unrealized losses were generated from 3,096 positions out of a total of 4,190 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.

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

	December 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	$ 647	$ 646	$ 205	$ 205	$ 474	$ 474	$ 48	$ 47
One year through five years	3,026	2,998	351	350	2,424	2,420	88	88
Five years through ten years	2,387	2,362	—	—	1,773	1,779	—	—
Greater than ten years	88	89	—	—	129	130	—	—
Asset-backed securities	1,504	1,488	—	—	1,046	1,040	—	—
Total	$ 7,652	$ 7,583	$ 556	$ 555	$ 5,846	$ 5,843	$ 136	$ 135

Actual maturities may differ from contractual maturities due to call or prepayment options. Private equity 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 private equity 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.

5. 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.

The following table summarizes fair value measurements by level at December 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	$ 5,342	$ —	$ —	$ 5,342
Investments available for sale:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ 247	$ —	$ —	$ 247
Corporate securities	—	3,146	—	3,146
Municipal securities	—	2,187	—	2,187
Asset-backed securities	—	683	—	683
Residential mortgage-backed securities	—	444	—	444
Commercial mortgage-backed securities	—	361	—	361
Total investments	$ 247	$ 6,821	$ —	$ 7,068
Restricted deposits available for sale:				
Cash and cash equivalents	$ 8	$ —	$ —	$ 8
Certificates of deposit	—	433	—	433
U.S. Treasury securities and obligations of U.S. government corporations and agencies	114	—	—	114
Total restricted deposits	$ 122	$ 433	$ —	$ 555
Total assets at fair value	$ 5,711	$ 7,254	$ —	$ 12,965
Liabilities				
Other long-term liabilities:				
Interest rate swap agreements	$ —	$ 95	$ —	$ 95
Total liabilities at fair value	$ —	$ 95	$ —	$ 95

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 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. In addition, the aggregate carrying amount of the Company's life insurance contracts and other private equity investments, which approximates fair value, was $515 million and $311 million as of December 31, 2018, and December 31, 2017, respectively.

6. Property, Software and Equipment

Property, software and equipment consist of the following as of December 31 ($ in millions):

	2018	2017
Land	$ 201	$ 130
Building	614	367
Computer software	757	542
Computer hardware	308	248
Furniture and office equipment	335	186
Leasehold improvements	291	221
	2,506	1,694
Less accumulated depreciation	(800)	(590)
Property, software and equipment, net	$ 1,706	$ 1,104

Depreciation expense for the years ended December 31, 2018, 2017 and 2016 was $237 million, $161 million and $101 million, respectively.

7. Goodwill and Intangible Assets

The following table summarizes the changes in goodwill by operating segment ($ in millions):

	Managed Care	Specialty Services	Total
Balance as of December 31, 2016	$ 4,015	$ 697	$ 4,712
Acquisitions and purchase accounting adjustments	—	37	37
Balance as of December 31, 2017	4,015	734	4,749
Acquisitions and purchase accounting adjustments	1,671	595	2,266
Balance as of December 31, 2018	$ 5,686	$ 1,329	$ 7,015

The majority of the increase in the managed care segment goodwill was related to the acquisition and fair value allocations discussed in Note 3. *Fidelis Care Acquisition.* The majority of the increase in the specialty services segment goodwill related to other acquisitions discussed in Note 11. *Stockholders' Equity*.

Intangible assets at December 31, consist of the following ($ in millions):

			Weighted Average Life in Years	
	2018	2017	2018	2017
Purchased contract rights	$ 1,173	$ 1,173	12.6	12.6
Provider contracts	311	274	12.3	11.9
Customer relationships	769	22	10.9	8.2
Trade names	361	162	15.2	9.6
Developed technologies	180	109	5.2	5.0
Other Intangibles	5	7	2.7	2.8
Intangible assets	2,799	1,747	11.9	11.6
Less accumulated amortization:				
Purchased contract rights	(283)	(188)		
Provider contracts	(90)	(66)		
Customer relationships	(57)	(21)		
Trade names	(55)	(34)		
Developed technologies	(72)	(40)		
Other Intangibles	(3)	—		
Total accumulated amortization	(560)	(349)		
Intangible assets, net	$ 2,239	$ 1,398		

Amortization expense was $211 million, $156 million and $147 million for the years ended December 31, 2018, 2017 and 2016, respectively. Estimated total amortization expense related to intangible assets for each of the five succeeding fiscal years is as follows ($ in millions):

Year	Expense
2019	$ 252
2020	244
2021	223
2022	217
2023	214

8. Medical Claims Liability

In January 2017, the Company reclassified Cenpatico Behavioral Health of Arizona, LLC and the related Cenpatico Integrated Care health plan from the Specialty Services segment to the Managed Care segment due to a reorganization of the Arizona management structure following the Health Net integration. As a result, the financial results of Cenpatico Behavioral Health of Arizona, LLC and the related Cenpatico Integrated Care health plan have been reclassified from the Specialty Services segment to the Managed Care segment for all periods presented. Due to this change in segment reporting, the Specialty Services segment now has an insignificant amount of medical claims liability and, therefore, disclosures related to medical claims liabilities have been aggregated and are presented on a consolidated basis.

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

	Year Ended December 31,		
	2018	2017	2016
Balance, January 1	$ 4,286	$ 3,929	$ 2,298
Less: reinsurance recoverable	18	5	—
Balance, January 1, net	4,268	3,924	2,298
Acquisitions	1,204	—	1,482
Less: acquired reinsurance recoverable	8	—	—
Incurred related to:			
Current year	46,484	38,225	30,946
Prior years	(427)	(374)	(310)
Total incurred	46,057	37,851	30,636
Paid related to:			
Current year	41,161	34,196	28,532
Prior years	3,556	3,311	1,960
Total paid	44,717	37,507	30,492
Balance at December 31, net	6,804	4,268	3,924
Plus: reinsurance recoverable	27	18	5
Balance, December 31	$ 6,831	$ 4,286	$ 3,929

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

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

Information about incurred and paid claims development as of December 31, 2018 is included in the table below and is inclusive of claims incurred and paid related to the Health Net and Fidelis Care businesses prior and subsequent to their respective acquisition dates. The claims development information for all periods preceding the most recent reporting period is considered required supplementary information. Incurred and paid claims development as of December 31, 2018 is as follows ($ in millions):

	Cumulative Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance		
	For the Years Ended December 31,		
Claim Year	2016 (unaudited)	2017 (unaudited)	2018
2016	$ 42,512	$ 41,947	$ 41,890
2017		47,310	46,738
2018			51,309
		Total incurred claims	$ 139,937

	Cumulative Paid Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance		
	For the Years Ended December 31,		
Claim Year	2016 (unaudited)	2017 (unaudited)	2018
2016	$ 37,876	$ 41,679	$ 41,803
2017		41,972	46,512
2018			44,818
		Total payment of incurred claims	$ 133,133
		Medical claims liability, net of reinsurance	$ 6,804

Incurred claims and allocated claim adjustment expenses, net of reinsurance, total IBNR plus expected development on reported claims and cumulative claims data as of December 31, 2018 are included in the following table and are inclusive of the acquired Health Net and Fidelis Care businesses. For claims frequency information summarized below, a claim is defined as the financial settlement of a single medical event in which remuneration was paid to the servicing provider. 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. Information is summarized as follows (in millions):

	December 31, 2018		
	Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance	Total IBNR Plus Expected Development on Reported Claims	Cumulative Paid Claims
2016	$ 41,890	$ 3	228.8
2017	46,738	60	256.7
2018	51,309	5,092	266.8

9. 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 MLR and cost sharing reductions. Each of the three R programs are taken into consideration to determine if the Company’s estimated annual medical costs are less than the minimum loss ratio and require an adjustment to premium revenues to meet the minimum MLR.

During 2018, the Company recognized a $79 million net pre-tax benefit related to the reconciliation of the 2017 risk adjustment program, compared to a $48 million net pre-tax benefit in 2017 related to the reconciliation of the 2016 risk adjustment and reinsurance programs.

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

	December 31, 2018	December 31, 2017
Risk adjustment	$ (928)	$ (677)
Reinsurance	1	15
Risk corridor	4	6
Minimum MLR	(265)	(22)
Cost sharing reductions	(50)	(96)

10. Debt

Debt consists of the following ($ in millions):

	December 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	1,005	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
$1,800 million 5.375% Senior notes, due June 1, 2026	1,800	—
Fair value of interest rate swap agreements	(95)	(71)
Total senior notes	6,310	4,535
Revolving credit agreement	284	150
Mortgage notes payable	57	61
Construction loan payable	63	—
Capital leases and other	47	18
Debt issuance costs	(75)	(65)
Total debt	6,686	4,699
Less current portion	(38)	(4)
Long-term debt	$ 6,648	$ 4,695

Senior Notes

In May 2018, a wholly-owned unrestricted subsidiary of the Company (Escrow Issuer) issued $1,800 million in aggregate principal amount of 5.375% senior notes due 2026 at par. In connection with the closing of the Fidelis Care acquisition, the Escrow Issuer merged with and into the Company and the Company assumed the obligations of the Escrow Issuer under the 5.375% senior notes due 2026. The Company used the net proceeds of the offering to finance a portion of the cash consideration for the Fidelis Care acquisition, which closed in July 2018, to pay related fees and expenses, and for general corporate purposes, including the repayment of outstanding indebtedness.

The indentures governing the senior notes listed in the table above contain restrictive covenants of Centene Corporation. At December 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 December 31, 2018 and 2017 ($ in millions):

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 liabilities 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 one or three month LIBOR plus 3.61% adjusted monthly or quarterly, based on the terms of the individual swap agreements. At December 31, 2018, the weighted average rate was 6.19%.

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.

The fair value of the Swap Agreements excludes accrued interest and takes into consideration current interest rates and current likelihood of the swap counterparties' compliance with its contractual obligations.

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, EURIBOR rates, the Federal Funds Rate or the Prime Rate. As of December 31, 2018, the Company had $284 million of borrowings outstanding under the agreement with a weighted average interest rate of 4.42%, 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 December 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 $57 million at December 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 $162 million at December 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 December 31, 2018, the Company had $63 million in borrowings outstanding under the loan.

Letters of Credit & Surety Bonds

The Company had outstanding letters of credit of $56 million as of December 31, 2018, which were not part of the revolving credit facility. The Company also had letters of credit for $27 million (valued at December 31, 2018 conversion rate), or €24 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 0.99% as of December 31, 2018. The Company had outstanding surety bonds of $496 million as of December 31, 2018.

Aggregate maturities for the Company's debt are as follows ($ in millions):

2019	$	38
2020		4
2021		1,514
2022		1,293
2023		—
Thereafter		4,002
Total	$	6,851

The fair value of outstanding debt was approximately $6,619 million and $4,751 million at December 31, 2018 and 2017, respectively.

11. Stockholders' Equity

The Company has 10 million authorized shares of preferred stock at $.001 par value. At December 31, 2018, there were no preferred shares outstanding.

The Company's Board of Directors has authorized a stock repurchase program for up to 16 million shares of the Company's common stock from time to time on the open market or through privately negotiated transactions. No duration has been placed on the repurchase program. The Company has 7 million available shares remaining under the program for repurchases as of December 31, 2018. The Company reserves the right to discontinue the repurchase program at any time. During the year ended December 31, 2018, the Company did not repurchase any shares through this publicly announced program.

As a component of the employee stock compensation plan, employees can use shares of stock which have vested to satisfy statutory tax withholding obligations. As part of this plan, the Company repurchased 1 million shares at an aggregate cost of $71 million in 2018 and 1 million shares at an aggregate cost of $65 million in 2017. These shares are included in the Company's treasury stock.

In May 2018, the Company completed a registered offering of 53 million shares of Centene common stock with a fair value of $2,860 million. This included the 10% over allotment option to purchase additional shares from the Company which was exercised in full by the underwriters. Net proceeds after underwriting discounts and commissions was $2,779 million. The Company used the net proceeds of the offering to finance a portion of the cash consideration in connection with the Fidelis Care acquisition, to pay related fees and expenses, and for general corporate purposes, including the repayment of outstanding indebtedness.

In April 2018, the Company acquired MHM Services Inc. (MHM) and issued 3 million shares of Centene common stock to the selling shareholders, with a fair value of $183 million.

In March 2018, the Company acquired Community Medical Holdings Corp., d/b/a Community Medical Group (CMG) and issued 3 million 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 Holdings, Inc. (Interpreta) and issued 3 million shares of Centene common stock to the selling shareholders, with a fair value of $175 million.

12. Statutory Capital Requirements and Dividend Restrictions

Various state laws require Centene's regulated subsidiaries to maintain minimum capital levels specified by each state and restrict the amount of dividends that may be paid without prior regulatory approval. At December 31, 2018 and 2017, Centene's subsidiaries had aggregate statutory capital and surplus of $7,259 million and $5,153 million, respectively, compared with the required minimum aggregate statutory capital and surplus of $3,279 million and $2,251 million, respectively. As of December 31, 2018, the amount of capital and surplus or net worth that was unavailable for the payment of dividends or return of capital to the Company was $3,279 million in the aggregate.

13. Income Taxes

The consolidated income tax expense consists of the following for the years ended December 31 ($ in millions):

	2018	2017	2016
Current provision			
Federal	$ 498	$ 421	$ 485
State and local	107	14	22
Total current provision	605	435	507
Deferred provision	(131)	(109)	92
Total income tax expense	$ 474	$ 326	$ 599

The reconciliation of the tax provision at the U.S. federal statutory rate to income tax expense for the years ended December 31 is as follows ($ in millions):

	2018	2017	2016
Earnings from operations, before income tax expense	$ 1,368	$ 1,134	$ 1,160
Loss (earnings) attributable to flow through noncontrolling interest	4	15	(8)
Earnings from operations, less noncontrolling interest, before income tax expense	1,372	1,149	1,152
Tax provision at the U.S. federal statutory rate	288	402	402
State income taxes, net of federal income tax benefit	52	11	10
Nondeductible compensation	33	58	23
ACA Health Insurer Fee	149	—	162
Income Tax Reform	—	(125)	—
Valuation Allowance	(28)	14	10
Other, net	(20)	(34)	(8)
Income tax expense	$ 474	$ 326	$ 599

The tax effects of temporary differences which give rise to deferred tax assets and liabilities are presented below for the years ended December 31 ($ in millions):

	2018	2017
Deferred tax assets:		
Medical claims liability	$ 78	$ 46
Nondeductible liabilities	128	41
Net operating loss and tax credit carryforwards	77	94
Compensation accruals	109	129
Premium and trade receivables	76	45
Other	61	11
Deferred tax assets	529	366
Valuation allowance	(53)	(81)
Net deferred tax assets	$ 476	$ 285
Deferred tax liabilities:		
Intangible assets	$ 343	$ 342
Prepaid assets	31	23
Fixed assets	132	84
Investments in joint ventures	27	20
Deferred revenue	19	26
Other	6	17
Deferred tax liabilities	558	512
Net deferred tax assets (liabilities)	$ (82)	$ (227)

Valuation allowances are provided when it is considered more likely than not that deferred tax assets will not be realized. The valuation allowances primarily relate to future tax benefits on certain federal, state and foreign net operating loss and tax credit carryforwards. The $28 million decrease in valuation allowance relates to an increase in current taxable income of a subsidiary whose annual net operating loss deduction is limited by law.

Federal net operating loss carryforwards of $19 million expire beginning in 2020 through 2038; state net operating loss and tax credit carryforwards of $44 million expire beginning in 2019 through 2038. Substantially all of the non-U.S. tax loss carryforwards have indefinite carryforward periods.

The Company maintains a reserve for uncertain tax positions that may be challenged by a tax authority. A rollforward of the beginning and ending amount of uncertain tax positions, exclusive of related interest and penalties, is as follows:

	Year Ended December 31,	
	2018	2017
Gross unrecognized tax benefits, beginning of period	$ 257	$ 102
Gross increases:		
Current year tax positions	7	43
Prior year tax positions	14	113
Gross decreases:		
Statute of limitation lapses	(1)	(1)
Gross unrecognized tax benefits, end of period	$ 277	$ 257

Uncertain tax positions increased $20 million due to various federal positions. As of December 31, 2018, $248 million of unrecognized tax benefits would impact the Company's effective tax rate in future periods, if recognized. The Company believes it is reasonably possible that its liability for unrecognized tax benefits will decrease in the next twelve months by $15 million as a result of the expiration of statutes of limitations and projected audit settlements in certain jurisdictions.

The table above excludes interest, net of related tax benefits, which is treated as income tax expense (benefit) under the Company's accounting policy. For the year ended December 31, 2018, the Company recognized net interest expense related to uncertain positions of $5 million. The Company had $14 million and $9 million of accrued interest and penalties for uncertain tax positions as of December 31, 2018 and 2017, respectively.

The Company files tax returns for federal as well as numerous state tax jurisdictions. As of December 31, 2018, Health Net is under federal examination for tax years 2011 through its final return in 2016. Additionally, Centene's tax returns for years 2014 through 2017 are subject to federal examination.

The Company has completed its accounting of the effects of the TCJA on current and deferred income taxes. No material changes were made to the tax effects recorded in 2017.

14. Stock Incentive Plans

The Company's stock incentive plans allow for the granting of restricted stock or restricted stock unit awards and options to purchase common stock. Both incentive stock options and nonqualified stock options can be awarded under the plans. However, an immaterial amount of options were granted, exercised, or outstanding in 2018. The plans have 11 million shares available for future awards. Compensation expense for stock options and restricted stock unit awards is recognized on a straight-line basis over the vesting period, generally three to five years for stock options and one to three years for restricted stock or restricted stock unit awards. Vesting is accelerated by one year for individuals who qualify under the Company's retirement eligible provisions. Certain restricted stock unit awards contain performance-based as well as service-based provisions. Certain awards provide for accelerated vesting if there is a change in control as defined in the plans. The total compensation cost that has been charged against income for the stock incentive plans was $145 million, $135 million and $148 million for the years ended December 31, 2018, 2017 and 2016, respectively. The total income tax benefit recognized in the income statement for stock-based compensation arrangements was $34 million, $50 million and $67 million for the years ended December 31, 2018, 2017 and 2016, respectively.

A summary of the Company's non-vested restricted stock and restricted stock unit shares as of December 31, 2018, and changes during the year ended December 31, 2018, is presented below (shares in thousands):

	Shares	Weighted Average Grant Date Fair Value
Non-vested balance as of December 31, 2017	8,338	$ 34.65
Granted	2,710	65.31
Vested	(3,299)	34.26
Forfeited	(384)	32.45
Non-vested balance as of December 31, 2018	7,365	$ 47.42

The total fair value of restricted stock and restricted stock units vested during the years ended December 31, 2018, 2017 and 2016, was $209 million, $174 million and $147 million, respectively.

As of December 31, 2018, there was $265 million of total unrecognized compensation cost related to non-vested share-based compensation arrangements granted under the plans; that cost is expected to be recognized over a weighted-average period of 2.3 years.

The Company maintains an employee stock purchase plan and issued 256 thousand shares, 258 thousand shares, and 236 thousand shares in 2018, 2017 and 2016, respectively.

15. Retirement Plan

Centene has a defined contribution plan which covers substantially all employees who are at least twenty-one years of age. Under the plan, eligible employees may contribute a percentage of their base salary, subject to certain limitations. Centene may elect to match a portion of the employee's contribution. Company expense related to matching contributions to the plan was $53 million, $42 million and $37 million during the years ended December 31, 2018, 2017 and 2016, respectively.

16. Commitments

Centene and its subsidiaries lease office facilities and various equipment under non-cancelable operating leases which may contain escalation provisions. The rental expense related to these leases is recorded on a straight-line basis over the lease term, including rent holidays. Tenant improvement allowances are recorded as a liability and amortized against rent expense over the term of the lease. Rent expense was $207 million, $171 million and $137 million for the years ended December 31, 2018, 2017 and 2016, respectively. Annual non-cancelable minimum lease payments over the next five years and thereafter are as follows ($ in millions):

2019	$	174
2020		176
2021		145
2022		101
2023		71
Thereafter		200
	$	867

In connection with obtaining regulatory approval of the Fidelis Care acquisition, the Company entered into certain undertakings with the New York State Department of Health in 2018. See Note 3. *Fidelis Care Acquisition* for further details. The Company also committed to certain undertakings with the California Department of Insurance and the California Department of Managed Health Care in connection with obtaining regulatory approval of the Health Net acquisition in 2016 The Health Net commitments related to the undertakings are as follows:

- invest an additional $30 million through the California Organized Investment Network over the five years following completion of the acquisition;
- build a service center in an economically distressed community in California, investing $200 million over 10 years and employing at least 300 people, of which the Company has incurred $8 million through 2018;
- contribute $65 million to improve enrollee health outcomes ($10 million over five years), support locally-based consumer assistance programs ($5 million over five years) and strengthen the healthcare delivery system ($50 million over five years), of which the Company has contributed $13 million through 2018, and;
- invest $75 million of its investment portfolio in vehicles supporting California's healthcare infrastructure, of which the Company has invested $12 million through 2018.

17. 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 (collectively, "Related Actions"). 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 and denied the motion to strike. In August 2018, the trial court stayed all the Related Actions pending determination of a writ of mandate by the California Court of Appeals in two of the Related Actions. 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.

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.

A third shareholder derivative action was filed on December 14, 2018, by plaintiffs Carpenter Pension Fund of Illinois and Iron Workers Local 11 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 third derivative action repeats many of the allegations in the securities class action and the other derivative suits and adds additional allegations asserting violations of securities laws, breach of fiduciary duty, insider trading and unjust enrichment. On January 9, 2019, the Court consolidated the three derivative suits and established a schedule for determining lead plaintiff and lead counsel.

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 Administration 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 (VA) under a contract to provide health care coordination services for veterans. The contract began in late 2014 and ended September 30, 2018. 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. This matter is separate from the negotiated settlements with the VA in connection with the contract expiration on September 30, 2018.

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. In July 2018, the plaintiff voluntarily filed a First Amended Complaint that removed Steven Milman as a plaintiff, dropped Centene Corporation and Superior Health Plan as defendants, abandoned certain claims, narrowed the putative class to Washington State only, and added Centene Management Company as a defendant. In August 2018, the Company moved to dismiss the First Amended Complaint. In response, the plaintiff voluntarily filed a Second Amended Complaint. In September 2018, the Company filed a motion to dismiss the Second Amended Complaint. On November 21, 2018, the Court granted in part and denied in part the Company’s motion to dismiss. Plaintiff Cynthia Harvey filed a Third Amended Complaint, on November 28, 2018, against Centene Management Company and Coordinated Care Corporation (“Defendants”), both subsidiaries of the Company. Defendants filed an answer on December 12, 2018 and the matter is expected to proceed. 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;

- 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.

18. Earnings Per Share

The following table sets forth the calculation of basic and diluted net earnings per common share for the years ended December 31 ($ in millions, except shares in thousands and per share data in dollars):

	2018	2017	2016
Earnings attributable to Centene Corporation	$ 900	$ 828	$ 562
Shares used in computing per share amounts:			
Weighted average number of common shares outstanding	390,248	344,853	319,135
Common stock equivalents (as determined by applying the treasury stock method)	8,258	8,551	8,816
Weighted average number of common shares and potential dilutive common shares outstanding	398,506	353,404	327,951
Net earnings per common share attributable to Centene Corporation:			
Basic earnings per common share	$ 2.31	$ 2.40	$ 1.76
Diluted earnings per common share	$ 2.26	$ 2.34	$ 1.71

The calculation of diluted earnings per common share for 2018, 2017 and 2016 excludes the impact of 58 thousand shares, 106 thousand shares and 252 thousand shares, respectively, related to anti-dilutive stock options, restricted stock and restricted stock units.

19. 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. Factors used in determining the reportable business segments include the nature of operating activities, the existence of separate senior management teams, and the type of information presented to the Company's chief operating decision-maker to evaluate all results of operations.

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

Segment information as of and for the year ended December 31, 2018, follows ($ in millions):

	Managed Care	Specialty Services	Eliminations	Consolidated Total
Total revenues from external customers	$ 56,999	$ 3,117	$ —	$ 60,116
Total revenues internal customers	100	9,389	(9,489)	—
Total revenues	$ 57,099	$ 12,506	(9,489)	$ 60,116
Earnings from operations	$ 1,310	$ 148	—	$ 1,458
Total assets	$ 27,627	$ 3,274	—	$ 30,901

Segment information as of and for the year ended December 31, 2017, follows ($ in millions):

	Managed Care	Specialty Services	Eliminations	Consolidated Total
Total revenues from external customers	$ 45,798	$ 2,584	$ —	$ 48,382
Total revenues internal customers	44	9,471	(9,515)	—
Total revenues	$ 45,842	$ 12,055	$ (9,515)	$ 48,382
Earnings from operations	$ 917	$ 282	$ —	$ 1,199
Total assets	$ 19,959	$ 1,896	$ —	$ 21,855

Segment information as of and for the year ended December 31, 2016, follows ($ in millions):

	Managed Care	Specialty Services	Eliminations	Consolidated Total
Total revenues from external customers	$ 38,182	$ 2,425	$ —	$ 40,607
Total revenues internal customers	200	5,952	(6,152)	—
Total revenues	$ 38,382	$ 8,377	$ (6,152)	$ 40,607
Earnings from operations	$ 1,080	$ 183	$ —	$ 1,263
Total assets	$ 18,423	$ 1,774	$ —	$ 20,197

20. Quarterly Selected Financial Information

Quarterly selected financial information for 2018 and 2017 is as follows:

(In millions, except per share data in dollars)
(Unaudited)

	For the Quarter Ended			
	March 31, 2018	June 30, 2018	September 30, 2018	December 31, 2018
Total revenues	$ 13,194	$ 14,181	$ 16,182	$ 16,559
Net earnings attributable to Centene Corporation	$ 340	$ 300	$ 19	$ 241
Net earnings per common share attributable to Centene Corporation:				
Basic earnings per common share	$ 0.98	$ 0.77	$ 0.05	$ 0.59
Diluted earnings per common share	$ 0.96	$ 0.75	$ 0.05	$ 0.57

	For the Quarter Ended			
	March 31, 2017	June 30, 2017	September 30, 2017	December 31, 2017
Total revenues	$ 11,724	$ 11,954	$ 11,898	$ 12,806
Net earnings attributable to Centene Corporation	$ 139	$ 254	$ 205	$ 230
Net earnings per common share attributable to Centene Corporation:				
Basic earnings per common share	$ 0.40	$ 0.74	$ 0.59	$ 0.67
Diluted earnings per common share	$ 0.39	$ 0.72	$ 0.58	$ 0.65

21. Condensed Financial Information of Registrant

Centene Corporation (Parent Company Only)
Condensed Balance Sheets
(In millions, except shares in thousands and per share data in dollars)

	December 31, 2018	December 31, 2017
ASSETS		
Current assets:		
Cash and cash equivalents	$ 6	$ 6
Short-term investments, at fair value (amortized cost $2 and $2, respectively)	2	2
Other current assets	61	46
Total current assets	69	54
Long-term investments, at fair value (amortized cost $14 and $17, respectively)	14	17
Investment in subsidiaries	17,409	11,303
Other long-term assets	278	302
Total assets	$ 17,770	$ 11,676
LIABILITIES, REDEEMABLE NONCONTROLLING INTERESTS AND STOCKHOLDERS' EQUITY		
Current liabilities	$ 109	$ 100
Long-term debt	6,521	4,624
Other long-term liabilities	117	76
Total liabilities	6,747	4,800
Redeemable noncontrolling interest	10	12
Stockholders' equity:		
Preferred stock, $.001 par value; authorized 10,000 shares; no shares issued or outstanding at December 31, 2018 and December 31, 2017	—	—
Common stock, $.001 par value; authorized 800,000 shares; 417,695 issued and 412,478 outstanding at December 31, 2018, and 360,758 issued and 346,874 outstanding at December 31, 2017	—	—
Additional paid-in capital	7,449	4,349
Accumulated other comprehensive loss	(56)	(3)
Retained earnings	3,663	2,748
Treasury stock, at cost (5,217 and 13,884 shares, respectively)	(139)	(244)
Total Centene stockholders' equity	10,917	6,850
Noncontrolling interest	96	14
Total stockholders' equity	11,013	6,864
Total liabilities, redeemable noncontrolling interests and stockholders' equity	$ 17,770	$ 11,676

See notes to condensed financial information of registrant.

Centene Corporation (Parent Company Only)
Condensed Statements of Operations
(In millions, except per share data in dollars)

	Year Ended December 31,		
	2018	**2017**	**2016**
Expenses:			
Selling, general and administrative expenses	$ 24	$ 6	$ 5
Other income (expense):			
Investment and other income	3	2	2
Interest expense	(334)	(247)	(201)
Earnings (loss) before income taxes	(355)	(251)	(204)
Income tax benefit	(64)	(114)	(76)
Net earnings (loss) before equity in subsidiaries	(291)	(137)	(128)
Equity in earnings from subsidiaries	1,185	945	689
Net earnings	894	808	561
Loss attributable to noncontrolling interests	6	20	1
Net earnings attributable to Centene	$ 900	$ 828	$ 562
Net earnings per share:			
Basic earnings per common share	$ 2.31	$ 2.40	$ 1.76
Diluted earnings per common share	$ 2.26	$ 2.34	$ 1.71

See notes to condensed financial information of registrant.

Centene Corporation (Parent Company Only)
Condensed Statements of Cash Flows
(In millions)

	Year Ended December 31,		
	2018	2017	2016
Cash flows from operating activities:			
Dividends from subsidiaries, return on investment	$ 464	$ 292	$ 25
Other operating activities, net	(317)	(132)	(71)
Net cash (used in) provided by operating activities	147	160	(46)
Cash flows from investing activities:			
Capital contributions to subsidiaries	(681)	(339)	(691)
Purchases of investments	(23)	(38)	(112)
Sales and maturities of investments	7	4	169
Dividends from subsidiaries, return of investment	11	28	100
Investments in acquisitions	(4,226)	(59)	(2,248)
Intercompany activities	215	322	(575)
Other investing activities, net	—	(1)	—
Net cash used in investing activities	(4,697)	(83)	(3,357)
Cash flows from financing activities:			
Proceeds from the issuance of common stock	2,778	—	—
Proceeds from borrowings	6,014	1,400	8,934
Payment of long-term debt	(4,080)	(1,350)	(5,377)
Common stock repurchases	(71)	(65)	(63)
Debt issuance costs	(25)	—	(76)
Purchase of noncontrolling interest	(76)	(66)	(14)
Other financing activities, net	10	5	—
Net cash provided by (used in) financing activities	4,550	(76)	3,404
Net increase in cash and cash equivalents	—	1	1
Cash and cash equivalents, beginning of period	6	5	4
Cash and cash equivalents, end of period	$ 6	$ 6	$ 5

See notes to condensed financial information of registrant.

Notes to Condensed Financial Information of Registrant

Note A - Basis of Presentation and Significant Accounting Policies

The parent company only financial statements should be read in conjunction with Centene Corporation's audited consolidated financial statements and the notes to consolidated financial statements included in this Form 10-K.

The parent company's investment in subsidiaries is stated at cost plus equity in undistributed earnings of the subsidiaries. The parent company's share of net income of its unconsolidated subsidiaries is included in income using the equity method of accounting. Certain unrestricted subsidiaries receive monthly management fees from our restricted subsidiaries. The management and service fees received by our unrestricted subsidiaries are associated with all of the functions required to manage the restricted subsidiaries including but not limited to salaries and wages for all personnel, rent, utilities, medical management, provider contracting, compliance, member services, claims processing, information technology, cash management, finance and accounting, and other services. The management fees are based on a percentage of the restricted subsidiaries revenue.

Due to our centralized cash management function, cash flows generated by our unrestricted subsidiaries are utilized by the parent company to the extent required, primarily to repay borrowings on the parent company's revolving credit facility, make acquisitions, fund capital contributions to subsidiaries and fund its operations.

In August 2016, the FASB issued an ASU which clarifies how entities should classify certain cash receipts and cash payments on the statement of cash flows. The new guidance also clarifies how the predominance principle should be applied when cash receipts and cash payments have aspects of more than one class of cash flows. The Company early adopted the new guidance in the fourth quarter of 2017. Certain amounts in the 2016 parent company only financial statements have been reclassified to conform to the 2017 presentation, reflecting this adoption and a reclassification of intercompany activities from operating to investing cash flows. These reclassifications have no effect on net earnings or stockholders' equity as previously reported.

Certain amounts presented in the parent company only financial statements are eliminated in the consolidated financial statements of Centene Corporation.

Item 9. ***Changes in and Disagreements With Accountants on Accounting and Financial Disclosure***

None.

Item 9A. ***Controls and Procedures***

Evaluation of Disclosure Controls and Procedures - Our management, with the participation of our Chief Executive Officer and Chief Financial Officer, evaluated the effectiveness of our disclosure controls and procedures as of December 31, 2018. The term “disclosure controls and procedures,” as defined in Rules 13a-15(e) and 15d-15(e) under the Exchange Act, means controls and other procedures of a company that are designed to ensure that information required to be disclosed by a company in the reports that it files or submits under the Exchange Act is recorded, processed, summarized and reported, within the time periods specified in the SEC's rules and forms. Disclosure controls and procedures include, without limitation, controls and procedures designed to ensure that information required to be disclosed by a company in the reports that it files or submits under the Exchange Act is accumulated and communicated to the company's management, including its principal executive and principal financial officers, as appropriate to allow timely decisions regarding required disclosure. Management recognizes that any controls and procedures, no matter how well designed and operated, can provide only reasonable assurance of achieving their objectives and management necessarily applies its judgment in evaluating the cost-benefit relationship of possible controls and procedures. Based on the evaluation of our disclosure controls and procedures as of December 31, 2018, our Chief Executive Officer and Chief Financial Officer concluded that, as of such date, our disclosure controls and procedures were effective at the reasonable assurance level.

Management's Report on Internal Control Over Financial Reporting - Our management is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Exchange Act Rules 13a-15(f) and 15d-15(f). Under the supervision and with the participation of our management, including our principal executive officer and principal financial officer, we conducted an evaluation of the effectiveness of our internal control over financial reporting based on the framework in *Internal Control - Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission. Based on our evaluation under the framework in *Internal Control - Integrated Framework (2013)*, our management concluded that our internal control over financial reporting was effective at the reasonable assurance level as of December 31, 2018. Our management's assessment of the effectiveness of our internal control over financial reporting as of December 31, 2018, has been audited by KPMG LLP, an independent registered public accounting firm, as stated in their report which is included herein.

We acquired the assets of Fidelis Care on July 1, 2018. Fidelis Care had total assets representing 19% of consolidated assets, and total revenues representing approximately 9% of consolidated revenues, as of and for the year ended December 31, 2018. We excluded from our assessment of the effectiveness of our internal control over financial reporting as of December 31, 2018 the internal controls over financial reporting associated with Fidelis Care.

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 year ended December 31, 2018, that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

Report of Independent Registered Public Accounting Firm

To the Stockholders and Board of Directors
Centene Corporation:

Opinion on Internal Control Over Financial Reporting

We have audited Centene Corporation and subsidiaries' (the Company) internal control over financial reporting as of December 31, 2018, based on criteria established in *Internal Control - Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission. In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2018, based on criteria established in *Internal Control - Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated balance sheets of the Company as of December 31, 2018 and 2017, and the related consolidated statements of operations, comprehensive earnings, stockholders' equity, and cash flows for each of the years in the three-year period ended December 31, 2018, and related notes (collectively, the consolidated financial statements), and our report dated February 19, 2019 expressed an unqualified opinion on those consolidated financial statements.

The Company acquired Fidelis Care on July 1, 2018. Fidelis Care had total assets representing 19% of consolidated assets and total revenues representing 9% of consolidated revenues, as of and for the year ended December 31, 2018. Management excluded from its assessment of the effectiveness of the Company's internal control over financial reporting as of December 31, 2018, Fidelis Care's internal control over financial reporting. Our audit of internal control over financial reporting of the Company also excluded an evaluation of the internal control over financial reporting of Fidelis Care.

Basis for Opinion

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Management's Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audit also included performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control Over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ KPMG LLP

St. Louis, Missouri
February 19, 2019

Item 9B. ***Other Information***

None.

PART III

Item 10. ***Directors, Executive Officers and Corporate Governance***

(a) Directors of the Registrant

Information concerning our directors will appear in our Proxy Statement for our 2019 annual meeting of stockholders under "Proposal One: Election of Directors." This portion of the Proxy Statement is incorporated herein by reference.

(b) Executive Officers of the Registrant

Pursuant to General Instruction G(3) to Form 10-K and Instruction 3 to Item 401(b) of Regulation S-K, information regarding our executive officers is provided in Item 1 of Part I of this Annual Report on Form 10-K under the caption "Executive Officers of the Registrant."

Information concerning our executive officers' compliance with Section 16(a) of the Exchange Act will appear in our Proxy Statement for our 2019 annual meeting of stockholders under "Section 16(a) Beneficial Ownership Reporting Compliance." Information concerning our audit committee financial expert and identification of our audit committee will appear in our Proxy Statement for our 2019 annual meeting of stockholders under "Board of Directors Committees." Information concerning our code of ethics will appear in our Proxy Statement for our 2019 annual meeting of stockholders under "Corporate Governance and Risk Management." These portions of our Proxy Statement are incorporated herein by reference.

(c) Corporate Governance

Information concerning certain corporate governance matters will appear in our Proxy Statement for our 2019 annual meeting of stockholders under "Corporate Governance and Risk Management." These portions of our Proxy Statement are incorporated herein by reference.

Item 11. ***Executive Compensation***

Information concerning executive compensation will appear in our Proxy Statement for our 2019 Annual Meeting of Stockholders under "Information About Executive Compensation." Information concerning Compensation Committee interlocks and insider participation will appear in the Proxy Statement for our 2019 Annual Meeting of Stockholders under "Compensation Committee Interlocks and Insider Participation." These portions of the Proxy Statement are incorporated herein by reference.

Item 12. ***Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters***

Information concerning the security ownership of certain beneficial owners and management and our equity compensation plans will appear in our Proxy Statement for our 2019 annual meeting of stockholders under "Information About Stock Ownership" and "Equity Compensation Plan Information." These portions of the Proxy Statement are incorporated herein by reference.

Item 13. ***Certain Relationships and Related Transactions, and Director Independence***

Information concerning director independence, certain relationships and related transactions will appear in our Proxy Statement for our 2019 annual meeting of stockholders under "Corporate Governance and Risk Management" and "Related Party Transactions." These portions of our Proxy Statement are incorporated herein by reference.

Item 14. ***Principal Accountant Fees and Services***

Information concerning principal accountant fees and services will appear in our Proxy Statement for our 2019 annual meeting of stockholders under "Proposal Two: Ratification of Appointment of Independent Registered Public Accounting Firm." This portion of our Proxy Statement is incorporated herein by reference.

PART IV

Item 15. *Exhibits and Financial Statement Schedules*

(a) **Financial Statements and Schedules**

The following documents are filed under Item 8 of this report:

1. Financial Statements:

   Report of Independent Registered Public Accounting Firm
   Consolidated Balance Sheets as of December 31, 2018 and 2017
   Consolidated Statements of Operations for the years ended December 31, 2018, 2017 and 2016
   Consolidated Statements of Comprehensive Earnings for the years ended December 31, 2018, 2017 and 2016
   Consolidated Statements of Stockholders' Equity for the years ended December 31, 2018, 2017 and 2016
   Consolidated Statements of Cash Flows for the years ended December 31, 2018, 2017 and 2016
   Notes to Consolidated Financial Statements

2. Financial Statement Schedules:

   None.

3. The exhibits listed in the accompanying Exhibit Index are filed or incorporated by reference as part of this filing.

EXHIBIT INDEX

EXHIBIT NUMBER	DESCRIPTION	FILED WITH THIS FORM 10-K	INCORPORATED BY REFERENCE [1] FORM	FILING DATE WITH SEC	EXHIBIT NUMBER
2.1	Asset Purchase Agreement, dated as of September 12, 2017, between Centene Corporation and New York State Catholic Health Plan, Inc. d/b/a Fidelis Care New York, incorporated by reference to Exhibit 2.1 to the Company's Current Report on Form 8-K dated September 12, 2017.		8-K	September 12, 2017	2.1
3.1	Certificate of Incorporation of Centene Corporation		S-1	October 9, 2001	3.2
3.1a	Certificate of Amendment to Certificate of Incorporation of Centene Corporation, dated November 8, 2001		S-1/A	November 13, 2001	3.2a
3.1b	Certificate of Amendment to Certificate of Incorporation of Centene Corporation as filed with the Secretary of State of the State of Delaware		10-Q	July 26, 2004	3.1b
3.1c	Certificate of Amendment to Certificate of Incorporation of Centene Corporation as filed with the Secretary of State of the State of Delaware		S-3ASR	May 16, 2014	3.1c
3.1d	Certificate of Amendment to Certificate of Incorporation of Centene Corporation as filed with the Secretary of State of the State of Delaware		8-K	October 26, 2015	3.1
3.1e	Certificate of Amendment to Certificate of Incorporation of Centene Corporation as filed with the Secretary of State of the State of Delaware		8-K	February 7, 2019	3.1
3.2	By-laws of Centene Corporation, as amended effective as of February 5, 2018		8-K	February 9, 2018	3.1
4.1	Indenture, dated April 29, 2014, among the Company and The Bank of New York Mellon Trust Company, N.A., relating to the Company’s 4.75% Senior Notes due 2022 (including Form of Global Note as Exhibit A thereto)		8-K	April 29, 2014	4.1
4.2	Indenture, dated February 11, 2016, among Centene Escrow Corporation and The Bank of New York Mellon Trust Company, N.A., relating to the Company’s 5.625% Senior Notes due 2021 (including Form of Global Note as Exhibit A thereto)		8-K	February 11, 2016	4.1
4.3	Indenture, dated February 11, 2016, among Centene Escrow Corporation and The Bank of New York Mellon Trust Company, N.A., relating to the Company’s 6.125% Senior Notes due 2024 (including Form of Global Note as Exhibit A thereto)		8-K	February 11, 2016	4.2
4.4	Indenture, dated November 9, 2016, among Centene Escrow Corporation and The Bank of New York Mellon Trust Company, N.A., relating to the Company’s 4.75% Senior Notes due 2025 (including Form of Global Note as Exhibit A thereto)		8-K	November 9, 2016	4.1
4.5	Indenture, dated as of May 23, 2018, by and between Centene Escrow I Corporation, as issuer, and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to the Company's 5.375% Senior Notes due 2026 (including Form of Global Note attached thereto).		8-K	May 23, 2018	4.1
4.6	First Supplemental Indenture, dated as of July 1, 2018, by and between Centene Corporation and The Bank of New York Mellon Trust Company, N.A., as Trustee.		8-K	July 2, 2018	4.2

10.1	*	2000 Stock Plan of Centene Corporation		S-1	October 9, 2001	10.12
10.2	*	2002 Employee Stock Purchase Plan, As Amended and Restated	X			
10.3	*	Centene Corporation Amended and Restated 2003 Stock Incentive Plan		8-K	April 30, 2010	10.1
10.4	*	2012 Stock Incentive plan, as Amended		8-K	April 27, 2017	10.1
10.5	*	Amended and Restated Non-Employee Directors Deferred Stock Compensation Plan		10-Q	July 28, 2015	10.1
10.6	*	Amended and Restated Voluntary Nonqualified Deferred Compensation Plan	X			
10.7	*	Centene Corporation 2007 Long-Term Incentive Plan		8-K	April 26, 2007	10.2
10.8	*	Centene Corporation Short-Term Executive Compensation Plan		10-K	February 22, 2011	10.12
10.9	*	Executive Employment Agreement between Centene Corporation and Michael F. Neidorff, dated November 8, 2004		8-K	November 9, 2004	10.1
10.9a	*	Amendment No. 1 to Executive Employment Agreement between Centene Corporation and Michael F. Neidorff		10-Q	October 28, 2008	10.2
10.9b	*	Amendment No. 2 to Executive Employment Agreement between Centene Corporation and Michael F. Neidorff		10-Q	April 28, 2009	10.2
10.9c	*	Amendment No. 3 to Executive Employment Agreement between Centene Corporation and Michael F. Neidorff		10-Q	October 23, 2012	10.2
10.9d	*	Amendment No. 4 to Executive Employment Agreement between Centene Corporation and Michael F. Neidorff		8-K	May 16, 2013	10.1
10.9e	*	Amendment No. 5 to Executive Employment Agreement between Centene Corporation and Michael F. Neidorff		8-K	December 14, 2016	10.1
10.9f	*	Amendment No. 6 to Executive Employment Agreement between Centene Corporation and Michael F. Neidorff		8-K	February 4, 2019	10.1
10.10	*	Form of Executive Severance and Change in Control Agreement		10-Q	October 28, 2008	10.3
10.10a	*	Amendment No. 1 to Form of Executive Severance and Change in Control Agreement		10-Q	October 23, 2012	10.3
10.10b	*	Amendment No. 2 to Form of Executive Severance and Change in Control Agreement		10-Q	April 28, 2015	10.1
10.11	*	Form of Non-statutory Stock Option Agreement (Non-Employees)		8-K	July 28, 2005	10.3
10.12	*	Form of Non-statutory Stock Option Agreement (Employees)		10-Q	October 28, 2008	10.5
10.13	*	Form of Non-statutory Stock Option Agreement (Directors)		10-K	February 23, 2009	10.18
10.14	*	Form of Incentive Stock Option Agreement		10-Q	October 28, 2008	10.6
10.15	*	Form of Stock Appreciation Right Agreement		8-K	July 28, 2005	10.6
10.16	*	Form of Restricted Stock Agreement		10-Q	October 25, 2005	10.8
10.17	*	Form of Restricted Stock Unit Agreement #1		10-K	February 22, 2016	10.13
10.18	*	Form of Restricted Stock Unit Agreement #2		10-K	February 21, 2017	10.20

10.19	*	Form of Restricted Stock Unit Agreement #3	X			
10.20	*	Form of Performance Based Restricted Stock Unit Agreement #1		10-K	February 22, 2016	10.20
10.21	*	Form of Performance Based Restricted Stock Unit Agreement #2		10-K	February 22, 2016	10.21
10.22	*	Form of Performance Based Restricted Stock Unit Agreement #3		10-K	February 21, 2017	10.23
10.23	*	Form of Long-Term Incentive Plan Agreement #1		8-K	February 7, 2008	10.1
10.24	*	Form of Long-Term Incentive Plan Agreement #2		10-K	February 21, 2017	10.25
10.25		Credit Agreement, dated as of March 24, 2016, by and among Centene Corporation, the various financial institutions party thereto and Wells Fargo Bank, National Association		8-K	March 24, 2016	10.1
10.25a		Amended and Restated Credit Agreement, dated as of December 14, 2017, to the Credit Agreement dated as of March 24, 2016, among Centene Corporation, the lenders party thereto and Wells Fargo Bank, National Association		10-K	February 20, 2018	10.24a
21		List of subsidiaries	X			
23		Consent of Independent Registered Public Accounting Firm incorporated by reference in each prospectus constituting part of the Registration Statements on Form S-8 (File Numbers 333-217634, 333-210376, 333-197737, 333-180976, 333-108467, and 333-90976) and on Form S-3 (File Numbers 333-217636 and 333-209252)	X			
31.1		Certification Pursuant to Rule 13a-14(a) and 15d-14(a) of the Exchange Act, as Adopted Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002 (Chief Executive Officer)	X			
31.2		Certification Pursuant to Rule 13a-14(a) and 15d-14(a) of the Exchange Act, as Adopted Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002 (Chief Financial Officer)	X			
32.1		Certification Pursuant to 18 U.S.C. Section 1350 (Chief Executive Officer)	X			
32.2		Certification Pursuant to 18 U.S.C. Section 1350 (Chief Financial Officer)	X			
101.1		XBRL Taxonomy Instance Document	X			
101.2		XBRL Taxonomy Extension Schema Document	X			
101.3		XBRL Taxonomy Extension Calculation Linkbase Document	X			
101.4		XBRL Taxonomy Extension Definition Linkbase Document	X			
101.5		XBRL Taxonomy Extension Label Linkbase Document	X			
101.6		XBRL Taxonomy Extension Presentation Linkbase Document	X			

1 SEC File No. 001-31826 (for filings prior to October 14, 2003, the Registrant's SEC File No. was 000-33395).
* Indicates a management contract or compensatory plan or arrangement.

Item 16. ***Form 10-K Summary***

None.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) 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 February 19, 2019.

CENTENE CORPORATION

By: /s/ Michael F. Neidorff
Michael F. Neidorff
Chairman and Chief Executive Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities as indicated, as of February 19, 2019.

Signature	Title
/s/ Michael F. Neidorff **Michael F. Neidorff**	Chairman and Chief Executive Officer (principal executive officer)
/s/ Jeffrey A. Schwaneke **Jeffrey A. Schwaneke**	Executive Vice President and Chief Financial Officer (principal financial officer)
/s/ Christopher R. Isaak **Christopher R. Isaak**	Senior Vice President, Corporate Controller and Chief Accounting Officer (principal accounting officer)
/s/ Orlando Ayala **Orlando Ayala**	Director
/s/ Jessica L. Blume **Jessica L. Blume**	Director
/s/ Robert K. Ditmore **Robert K. Ditmore**	Director
/s/ Fred H. Eppinger **Fred H. Eppinger**	Director
/s/ Richard A. Gephardt **Richard A. Gephardt**	Director
/s/ John R. Roberts **John R. Roberts**	Director
/s/ David L. Steward **David L. Steward**	Director
/s/ Tommy G. Thompson **Tommy G. Thompson**	Director

EXHIBIT 10.2

2002 EMPLOYEE STOCK PURCHASE PLAN
As Amended and Restated

The purpose of this Plan is to provide eligible employees of Centene Corporation (the "Company") and certain of its subsidiaries with opportunities to purchase shares of the Company's common stock, $.001 par value (the "Common Stock"), commencing on July 1, 2002. An aggregate of 1,800,000 shares of Common Stock has been approved for this purpose. This Plan is intended to qualify as an "employee stock purchase plan" as defined in Section 423 of the Internal Revenue Code of 1986, as amended (the "Code"), and the regulations promulgated thereunder, and shall be interpreted consistently therewith. The Plan is hereby amended and restated effective January 1, 2019.

1. *Administration.* The Plan will be administered by the Company's Board of Directors (the "Board") or by a Committee appointed by the Board (the "Committee"). The Board or the Committee has authority to make rules and regulations for the administration of the Plan and its interpretation and decisions with regard thereto shall be final and conclusive.

2. *Eligibility.* All employees of the Company, including directors who are employees, and all employees of any subsidiary of the Company (as defined in Section 424(f) of the Code) designated by the Board or the Committee from time to time (a "Designated Subsidiary"), are eligible to participate in any one or more of the offerings of Options (as defined in Section 9) to purchase Common Stock under the Plan provided that:

(a) they have been employed by the Company or a Designated Subsidiary for at least ninety days prior to the offering period;

(b) they are employees of the Company or a Designated Subsidiary on the first day of the applicable Plan Period (as defined below); and

(c) they are not an intern, per diem, project based, or SPA (special professional associate) employee.

No employee may be granted an option hereunder if such employee, immediately after the option is granted, owns five percent or more of the total combined voting power or value of the stock of the Company or any subsidiary. For purposes of the preceding sentence, the attribution rules of Section 424(d) of the Code shall apply in determining the stock ownership of an employee, and all stock that the employee has a contractual right to purchase shall be treated as stock owned by the employee.

3. *Offerings.* The Company will make one or more offerings ("Offerings") to employees to purchase stock under this Plan. Offerings will begin each January 1, April 1, July 1 and October 1, or the first business day thereafter (the "Offering Commencement Dates"). Each Offering Commencement Date will begin a three-month period (a "Plan Period") during which payroll deductions will be made and held for the purchase of Common Stock at the end of the Plan Period. The Board or the Committee may, at its discretion, choose a different Plan Period of twelve months or less for subsequent Offerings.

4. *Participation.* An employee eligible during the Open Enrollment window may participate in such Offering by electronically enrolling on the Company’s stock plan administrator’s website. The electronic enrollment will authorize a regular payroll deduction from the Compensation received by the employee during the Plan Period. Unless an employee updates their electronic enrollment during the Open Enrollment window or withdraws from the Plan, the employee's deductions and purchases will continue at the same rate for future Offerings under the Plan as long as the Plan remains in effect. The term "Compensation" means the amount of money reportable on the employee's Federal Income Tax Withholding Statement, excluding incentive or bonus awards, allowances and reimbursements for expenses such as relocation allowances for travel expenses, income or gains on the exercise of Company stock options or stock appreciation rights, and similar items, whether or not shown on the employee's Federal Income Tax Withholding Statement.

5. *Deductions*. The Company will maintain payroll deduction accounts for all participating employees. With respect to any Offering made under this Plan, an employee may authorize a payroll deduction in any dollar amount equal to:

(a) from a minimum of 1.0% to a maximum of 10.0% as specified by the employee, multiplied by;

(b) the amount of Compensation the employee receives during the Plan Period, up to a maximum of $8,333.33 of Compensation per month.

6. *Deduction Changes*. An employee may decrease or discontinue the employee's payroll deduction once during any Plan Period, by updating their enrollment election on the stock plan administrator’s website at least twenty one calendar days prior to the last day of such Plan Period. An employee may not, however, increase the employee's payroll deduction during a Plan Period. If an employee elects to discontinue the employee's payroll deductions during a Plan Period, but does not elect to withdraw the employee's funds pursuant to Section 8 hereof, funds deducted prior to the employee's election to discontinue will be applied to the purchase of Common Stock on the Exercise Date (as defined below).

7. *Interest*. Interest will not be paid on any employee accounts, except to the extent that the Board or the Committee, in its sole discretion, elects to credit employee accounts with interest at such per annum rate as it may from time to time determine.

8. *Withdrawal of Funds*. An employee may at any time at least twenty one calendar days prior to the close of business on the last business day in a Plan Period and for any reason permanently draw out the balance accumulated in the employee's account and thereby withdraw from participation in an Offering. Partial withdrawals are not permitted. The employee may not begin participation again during the remainder of the Plan Period. If an employee withdraws from participation in an Offering, he or she may participate in the immediately following Offering and any Offering thereafter in accordance with terms and conditions established by the Board or the Committee.

9. *Purchase of Shares*. On the Offering Commencement Date of each Plan Period, the Company will grant to each eligible employee who is then a participant in the Plan an option (“Option”) to purchase on the last business day of such Plan Period (the “Exercise Date”), at the Option Price hereinafter provided for, the largest number of whole and fractional shares of Common Stock of the Company as does not exceed the number of shares determined by multiplying $833.33 by the number of full months in the Plan Period and dividing the result by the closing price (as defined below) on the Offering Commencement Date of such Plan Period.

Notwithstanding the above, no employee may be granted an Option (as defined in Section 9) that permits the employee’s rights to purchase Common Stock under this Plan and any other employee stock purchase plan (as defined in Section 423(b) of the Code) of the Company and its subsidiaries, to accrue at a rate that exceeds $2,500 of the fair market value of such Common Stock (determined at the Offering Commencement Date of the Plan Period) for each Plan Period in which the Option is outstanding at any time.

The purchase price for each share purchased will be 95% of the closing price of the Common Stock on the Exercise Date. Such closing price shall be (a) the closing price on any national securities exchange on which the Common Stock is listed, (b) the closing price of the Common Stock on the New York Stock Exchange or (c) the average of the closing bid and asked prices in the over-the-counter-market, whichever is applicable, as published in The Wall Street Journal. If no sales of Common Stock were made on such a day, the price of the Common Stock for purposes of clauses (a) and (b) above shall be the reported price for the next preceding day on which sales were made.

Each employee who continues to be a participant in the Plan on the Exercise Date shall be deemed to have exercised the employee’s Option at the Option Price on such date and shall be deemed to have purchased from the Company the number of full and fractional shares of Common Stock reserved for the purpose of the Plan that the employee’s accumulated payroll deductions on such date will pay for, but not in excess of the maximum number determined in the manner set forth above.

Any balance remaining in an employee’s payroll deduction account at the end of a Plan Period will be automatically refunded to the employee.

10. *Issuance of Certificates.* Certificates representing shares of Common Stock purchased under the Plan may be issued only in the name of the employee, in the name of the employee and another person of legal age as joint tenants with rights of survivorship, or (in the Company's sole discretion) in the name of a brokerage firm, bank or other nominee holder designated by the employee. The Company may, in its sole discretion and in compliance with applicable laws, authorize the use of book entry registration of shares in lieu of issuing stock certificates.

11. *Rights on Retirement, Death or Termination of Employment.* In the event of a participating employee's termination of employment prior to the last business day of a Plan Period, no payroll deduction shall be taken from any pay due and owing to an employee and the balance in the employee's account shall be paid to the employee or, in the event of the employee's death, (a) to a beneficiary previously designated in a revocable notice signed by the employee (with any spousal consent required under state law), (b) in the absence of such a designated beneficiary, to the executor or administrator of the employee's estate, or (c) if no such executor or administrator has been appointed to the knowledge of the Company, to such other person or persons as the Company may, in its discretion, designate. If, prior to the last business day of the Plan Period, the Designated Subsidiary by which an employee is employed shall cease to be a subsidiary of the Company, or if the employee is transferred to a subsidiary of the Company that is not a Designated Subsidiary, the employee shall be deemed to have terminated employment for the purposes of this Plan.

12. *Optionees Not Stockholders.* Neither the granting of an Option to an employee nor the deductions from the employee's pay shall constitute such employee a stockholder of the shares of Common Stock covered by an Option under this Plan until such shares have been purchased by and issued to the employee.

13. *Rights Not Transferable.* Rights under this Plan are not transferable by a participating employee other than by will or the laws of descent and distribution, and are exercisable during the employee's lifetime only by the employee.

14. *Application of Funds.* All funds received or held by the Company under this Plan may be combined with other corporate funds and may be used for any corporate purpose.

15. *Adjustment in Case of Changes Affecting Common Stock.* In the event of a subdivision of outstanding shares of Common Stock, or the payment of a dividend in Common Stock, the number of shares approved for this Plan, and the share limitation set forth in Section 9, shall be increased proportionately, and such other adjustment shall be made as may be deemed equitable by the Board or the Committee. In the event of any other change affecting the Common Stock, such adjustment shall be made as may be deemed equitable by the Board or the Committee to give proper effect to such event.

16. *Holding Period.* By purchasing shares hereunder, absent written consent from the Company to the contrary, the employee agrees not to sell, contract to sell, make any short sale of, grant any option for the purchase of or otherwise dispose of any of said shares during the 90 day period following the Exercise Date of the Plan Period pursuant to which the shares were purchased.

17. *Merger.* If the Company shall at any time merge or consolidate with another corporation and the holders of the capital stock of the Company immediately prior to such merger or consolidation continue to hold at least 80% by voting power of the capital stock of the surviving corporation ("Continuity of Control"), the holder of each Option then outstanding will thereafter be entitled to receive at the next Exercise Date upon the exercise of such Option for each share as to which such Option shall be exercised the securities or property that a holder of one share of the Common Stock was entitled to upon and at the time of such merger or consolidation, and the Board or the Committee shall take such steps in connection with such merger or consolidation as the Board or the Committee shall deem necessary to assure that the provisions of Section 15 shall thereafter be applicable, as nearly as reasonably may be, in relation to the said securities or property as to which such holder of such Option might thereafter be entitled to receive thereunder.

In the event of a merger or consolidation of the Company with or into another corporation that does not involve Continuity of Control, or of a sale of all or substantially all of the assets of the Company while unexercised Options remain outstanding under the Plan: (a) subject to the provisions of clauses (b) and (c), after the effective date of such transaction, each holder of an outstanding Option shall be entitled, upon exercise of such Option, to receive in lieu of shares of Common Stock, shares of such stock or other securities as the holders of shares of Common Stock received pursuant to the terms of such transaction; (b) all outstanding Options may be cancelled by the Board or the Committee as of a date prior to the effective date of any such transaction and all payroll deductions shall be paid out to the participating employees; or (c) all outstanding Options may be cancelled by the Board or the Committee as of the effective date of any such transaction, provided that notice of such cancellation shall be given to each holder of an Option, and each holder of an Option shall have the right to exercise such Option in full based on payroll deductions then credited to the employee's account as of a date determined by the Board or the Committee, which date shall not be less than ten days preceding the effective date of such transaction.

18. *Amendment of the Plan.* The Board may at any time, and from time to time, amend this Plan in any respect, except that (a) if the approval of any such amendment by the stockholders of the Company is required by Section 423 of the Code, such amendment shall not be effected without such approval, and (b) in no event may any amendment be made that would cause the Plan to fail to comply with Section 423 of the Code.

19. *Insufficient Shares.* In the event that the total number of shares of Common Stock specified in elections to be purchased under any Offering plus the number of shares purchased under previous Offerings under this Plan exceeds the maximum number of shares issuable under this Plan, the Board or the Committee will allot the shares then available on a pro rata basis.

20. *Termination of the Plan.* This Plan may be terminated at any time by the Board. Upon termination of this Plan all amounts in the accounts of participating employees shall be promptly refunded.

21. *Governmental Regulations.* The Company's obligation to sell and deliver Common Stock under this Plan is subject to listing on a national stock exchange or quotation on The New York Stock Exchange (to the extent the Common Stock is then so listed or quoted) and the approval of all governmental authorities required in connection with the authorization, issuance or sale of such stock.

22. *Governing Law.* The Plan shall be governed by Missouri law except to the extent that such law is preempted by federal law.

23. *Issuance of Shares.* Shares may be issued upon exercise of an Option from authorized but unissued Common Stock, from shares held in the treasury of the Company, or from any other proper source.

24. *Notification upon Sale of Shares.* Each employee agrees, by entering the Plan, to promptly give the Company notice of any disposition of shares purchased under the Plan where such disposition occurs within two years after the date of grant of the Option pursuant to which such shares were purchased.

25. *Withholding.* Each employee shall, no later than the date of the event creating the tax liability, make provision satisfactory to the Board for payment of any taxes required by law to be withheld in connection with any transaction related to Options granted to or shares acquired by such employee pursuant to the Plan. The Company may, to the extent permitted by law, deduct any such taxes from any payment of any kind otherwise due to an employee.

26. Effective Date and Approval of Stockholders. The Plan took effect on April 24, 2002, and was approved by the stockholders of the Company as required by Section 423 of the Code, which approval occurred within twelve months of the adoption of the Plan by the Board. The Plan is amended by this restatement effective January 1, 2019.

EXHIBIT 10.6

Fifth Amendment and Restatement of the

Centene Corporation Voluntary

Nonqualified Deferred Compensation Plan

ARTICLE I

PURPOSE AND EFFECTIVE DATE

The purpose of the Centene Corporation Voluntary Nonqualified Deferred Compensation Plan ("Plan") is to aid Centene Corporation and its subsidiaries in retaining and attracting executive employees by providing them with tax deferred savings opportunities. The Plan provides a select group of management and highly compensated employees within the meaning of Sections 201(2), 301(a)(3) and 401(a)(1) of the Employee Retirement Income Security Act of 1974, as amended (ERISA), of Centene Corporation with the opportunity to elect to defer receipt of specified portions of compensation, and to have these deferred amounts treated as if invested in specified hypothetical investment benchmarks. The Plan is intended to conform to the requirements of Code §409A. A Participant's Account that was earned and vested prior to January 1, 2005, plus subsequent earnings thereon, shall not be subject to the terms of this Plan but shall be subject to the terms of the prior plan dated June 1, 2002. The Plan has been amended and restated on four previous occasions. The Fifth Amendment and Restatement of the Plan shall be effective January 1, 2019.

ARTICLE II

DEFINITIONS

For the purposes of this Plan, the following words and phrases shall have the meanings indicated, unless the context clearly indicates otherwise:

Section 2.01

Administrative Committee. "Administrative Committee" or “Committee” means the Company’s Head of Human Resources officer or other individuals to whom the Compensation Committee has delegated the authority to take action under the Plan.

Section 2.02

Base Salary. "Base Salary" means the base rate of cash compensation paid by the Company to or for the benefit of a Participant for services rendered or labor performed while a Participant is employed by the Company, including base pay a Participant could have received in cash in lieu of (A) deferrals pursuant to Section 4.02 and (B) contributions made on their behalf to any qualified plan maintained by the Company or to any cafeteria plan under Code Section 125 maintained by the Company.

Section 2.03

Base Salary Deferral. "Base Salary Deferral" means the amount of a Participant's Base Salary which the Participant elects to have withheld on a pre-tax basis from their Base Salary and credited to their Deferral Account pursuant to Section 4.02.

Section 2.04

Beneficiary. "Beneficiary" means the person, persons or entity designated by the Participant to receive any benefits payable under the Plan pursuant to Article VIII.

Section 2.05

Board. "Board" means the Board of Directors of Centene Corporation.

Section 2.06

Annual Bonus Compensation. “Annual Bonus Compensation” or “Bonus Compensation” means the bonus plan that is eligible for payment once per year, based on funding approval by the Board, and is determined by established metrics.

Section 2.07

Cash Long-Term Incentive Plan Deferral. "Cash Long-Term Incentive Plan Deferral" means the amount of a Participant's Cash Long-Term Incentive Plan compensation (Cash LTIP) which the Participant elects to have withheld on a pre-tax basis from their Cash LTIP Compensation and credited to their account pursuant to Section 4.02.

Section 2.08

Change of Control. For purposes of this Plan, a "Change in Control" shall be deemed to have occurred if any of the events set forth in any one of the following clauses shall occur: (A) any Person (as defined in section 3(a)(9) of the Securities Exchange Act of 1934, as amended (the "Exchange Act"), and as such term is modified in sections 13(d) and 14(d) of the Exchange Act), excluding a group of persons including Executive, is or becomes the "beneficial owner" (as defined in Rule 13(d)(3) under the Exchange Act), directly or indirectly, of securities of the Company representing forty percent (40%) or more of the combined voting power of the Company's then outstanding securities; (B) individuals who, as of the date of this Agreement, constitute the Board of Directors (the "Incumbent Board"), cease for any reason to constitute a majority thereof (provided, however, that an individual becoming a Director subsequent to the date of this Agreement whose election, or nomination for election by the Company's stockholders, was approved by at least a majority of the directors then comprising the Incumbent Board shall be included within the definition of Incumbent Board, but excluding, for this purpose, any such individual whose initial assumption of office occurs as a result of either an actual election contest (or such terms used in Rule 14a-11 of Regulation 14A promulgated under the Exchange Act) or other actual or threatened solicitation of proxies or consents by or on behalf of a person other than the Board); or (C) the stockholders of the Company consummate a merger or consolidation of the Company with any other corporation, other than a merger or consolidation which would result in the voting securities of the Company outstanding immediately prior thereto continuing to represent (either by remaining outstanding or by being converted into voting securities of the surviving entity) at least fifty percent (50%) of the combined voting power of the voting securities of the Company or such surviving entity outstanding immediately after such merger or consolidation. In order to qualify as Change in Control, the event or events must also qualify as a change in ownership or effective control of the Company or in the ownership of a substantial portion of the assets of the Company within the meaning of Code Section 409A.

Section 2.09

Code. "Code" shall mean the Internal Revenue Code of 1986, as amended. References to any provision of the Code or regulation (including a proposed regulation) thereunder shall include any successor provisions or regulations.

Section 2.10

Company. "Company" means Centene Corporation, its successors, any subsidiary or affiliated organizations authorized by the Board or the Compensation Committee to participate in the Plan and any organization into which or with which Centene Corporation may merge or consolidate or to which all or substantially all of its assets may be transferred.

Section 2.11

Compensation Committee. “Compensation Committee” means the Compensation Committee of the Board of Directors.

Section 2.12

Deferral Account. "Deferral Account" means the account maintained by the Administrative Committee for each Participant pursuant to Article VI.

Section 2.13

Deferral Period. "Deferral Period" means the period after which payment of the Deferred Amount is to be made or begin to be made.

Section 2.14

Deferred Amount. "Deferred Amount" means the amount of Eligible Compensation for the Plan Year or performance period to which the Participation Agreement relates that is to be deferred under the Plan.

Section 2.15

Designee. "Designee" shall mean the Company's senior Human Resources officer or other individuals to whom the Committee has delegated the authority to take action under the Plan. Wherever Committee is referenced in the Plan, it shall be deemed to also refer to Designee.

Section 2.16

Disability. "Disability" means eligibility for long term disability benefits under the terms of the Company's Long-Term Disability Plan.

Section 2.17

Eligible Compensation. "Eligible Compensation" means any Base Salary, Annual Bonus Compensation, Incentive Compensation, and/or Cash Long-Term Incentive Plan compensation otherwise payable with respect to a Plan Year.

Section 2.18

ERISA. "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

Section 2.19

Form of Payment. "Form of Payment" means payment in one lump sum or in substantially equal annual installments of two (2) to fifteen (15) years. If the Form of Payment is substantially equal annual installments, each installment shall constitute a separate payment for purposes of Code Section 409A.

Section 2.20

Hardship Withdrawal. "Hardship Withdrawal" means the early payment of all or part of the balance in a Deferral Account(s) in the event of an Unforeseeable Emergency, as defined in Code section 409A(a)(2)(B)(ii), pursuant to Section 7.08.

Section 2.21

Hypothetical Investment Benchmark. "Hypothetical Investment Benchmark" shall mean the phantom investment benchmarks which are used to measure the return credited to a Participant's Deferral Account.

Section 2.22

Incentive Compensation. "Incentive Compensation" means the amount awarded to a Participant for a Plan Year under any incentive plan maintained by the Company, such as commission or other sales based compensation plans, as approved in the sole discretion of the Committee.

Section 2.23

Specified Employee. "Specified Employee" means a "specified employee" within the meaning of Code Section 409A(2)(8).

Section 2.24

Matching Contribution. "Matching Contribution" means the amount of any matching contribution that the Company will make to the Plan.

Section 2.25

Participant. "Participant" means any individual who is eligible or makes an election to participate in this Plan and who elects to participate by submitting a Participation Agreement as provided in Article IV.

Section 2.26

Participation Agreement. "Participation Agreement" means an agreement submitted by a Participant in accordance with Article IV.

Section 2.27

Plan Year. "Plan Year" means a twelve-month period beginning January 1 and ending the following December 31.

Section 2.28

Qualified Retirement. For participants hired on or after January 1, 2019, "Qualified Retirement" means retirement of a Participant from the Company after attaining age 55 with at least ten (10) years of service. For Participants hired prior to January 1, 2019, “Qualified Retirement” is defined as 65 or age 55 with at least five (5) years of service. Years of service will be calculated in accordance with the method adopted by the Company.

Section 2.29

Qualified Retiree. “Qualified Retiree” means a Participant who has experienced a Qualified Retirement.

Section 2.30

Separation from Service. "Separation from Service" means a reduction in a Participant’s services (regardless whether performed as an employee or independent contractor) to a rate that is reasonably anticipated to be a permanent reduction in services to 20 percent or less of the average rate of services performed prior to such reduction. If a Participant ceases or reduces services under a bona fide leave of absence, a Separation from Service occurs after the close of the six (6)-month anniversary of such leave, provided however that the Separation from Service shall be delayed to the extent that the Participant has a statutory or contractual right to reemployment. Determination of whether a Separation from Service occurs shall be made in a manner that is consistent with the principles in Reg. 1.409A-1(h).

Section 2.31

Unforeseeable Emergency. "Unforeseeable Emergency" means severe financial hardship to the Participant resulting from a sudden and unexpected illness or accident of the Participant or a dependent of the Participant, loss of the Participant's property due to casualty, or other similar extraordinary and unforeseeable circumstances arising as a result of events beyond the control of the Participant.

Section 2.32

Valuation Date. "Valuation Date" means the last day of the calendar month during which a Participant’s last deferral occurs or such other date as the Committee in its sole discretion may determine.

ARTICLE Ill

ADMINISTRATION Section 3.01

Section 3.01

Administrative Committee Duties.

The Committee shall be responsible for the administration of this Plan and shall have all powers necessary to administer this Plan, including discretionary authority to determine eligibility for benefits and to decide claims under the terms of this Plan, except to the extent that any such powers are vested in any other person administering this Plan by the Committee. The Committee may from time to time establish rules for the administration of this Plan, and it shall have the exclusive right to interpret this Plan and to decide any matters arising in connection with the administration and operation of this Plan. All rules, interpretations and decisions of the Committee shall be conclusive and binding on the Company, Participants and Beneficiaries.

The Committee may delegate responsibility for performing certain administrative functions under this Plan to certain employees of the Company or outside third parties. The Committee shall be responsible for determining issues related to eligibility, Hypothetical Investment Benchmarks, distribution of Deferred Amounts, determination of account balances, crediting of hypothetical earnings and debiting of hypothetical losses and of distributions, in service withdrawals, deferral elections and any other duties concerning the day-to day operation of this Plan. The Committee may designate one of its members as a Chairperson and may retain and supervise outside providers, third party administrators, record keepers and professionals (including in-house professionals) to perform any or all of the duties delegated to it hereunder.

Neither the Committee nor a member of the Board shall be liable for any act or action hereunder, whether of omission or commission, by any other member or employee or by any agent to whom duties in connection with the administration of this Plan have been delegated or for anything done or omitted to be done in connection with this Plan. The Committee shall keep records of all of their respective proceedings and the Committee shall keep records of all payments made to Participants or Beneficiaries and payments made for expenses or otherwise.

The Company shall, to the fullest extent permitted by law, indemnify each Director, officer or employee of the Company (including the heirs, executors, administrators and other personal representatives of such person), each member of the Committee against expenses (including attorneys' fees), judgments, fines, amounts paid in settlement, actually and reasonably incurred by such person in connection with any threatened, pending or actual suit, action or proceeding (whether civil, criminal, administrative or investigative in nature or otherwise) in which such person may be involved by reason of the fact that he or she is or was serving this Plan in any capacity at the request of the Company or the Committee.

Any expense incurred by the Company or the Committee relative to the administration of this Plan shall be paid by the Company and/or may be deducted from the Deferral Accounts of the Participants as determined by the Committee.

Section 3.02

Claim Procedure. If a Participant or Beneficiary makes a written request alleging a right to receive payments under this Plan or alleging a right to receive an adjustment in benefits being paid under this Plan, such actions shall be treated as a claim for benefits. All claims for benefits under this Plan shall be sent to the Committee. If the Committee determines that any individual who has claimed a right to receive benefits, or different benefits, under this Plan is not entitled to receive all or any part of the benefits claimed, the Committee shall inform the claimant in writing of such determination and the reasons therefore in terms calculated to be understood by the claimant. The notice shall be sent within 90 days of the claim unless the Committee determines that additional time, not exceeding 90 days, is needed and so notifies the Participant. The notice shall make specific reference to the pertinent Plan provisions on which the denial is based, and shall describe any additional material or information that is necessary. Such notice shall, in addition, inform the claimant of the procedure that the claimant should follow to take advantage of the review procedures set forth below in the event the claimant desires to contest the denial of the claim. The claimant may within 90 days thereafter submit in writing to the Committee a notice that the claimant contests the denial of their claim and desires a further review by the Committee. The Committee shall within 60 days thereafter review the claim and authorize the claimant to review pertinent documents and submit issues and comments relating to the claim to the Committee. The Committee will render a final decision on behalf of the Company with specific reasons therefor in writing and will transmit it to the claimant within 60 days of the written request for review, unless the Chairperson of the Committee determines that additional time, not exceeding 60 days, is needed, and so notifies the Participant. If the Committee fails to respond to a claim submitted in accordance with the foregoing within 60 days or any such extended period, the Company shall be deemed to have denied the claim.

ARTICLE IV PARTICIPATION

Section 4.01

Participation. Participation in the Plan shall be limited to executives who (i) meet such eligibility criteria as the Committee shall establish from time to time, and (ii) elect to participate in this Plan by submitting a Participation Agreement via the third party administrator’s website during the defined Open Enrollment period. A Participation Agreement must be submitted prior to the December 31st immediately preceding the Plan Year for which it is effective. The Committee shall have the discretion to establish special deadlines regarding the submission of Participation Agreements for Participants if it determines that such deadlines conform to the requirements of Code Section 409A.

Section 4.02

Contents of Participation Agreement. Subject to Article VII, each Participation Agreement shall set forth: (i) the amount of Eligible Compensation for the Plan Year or performance period to which the Participation Agreement relates that is to be deferred under the Plan (the "Deferred Amount"), expressed as a percentage of the Base Salary, Annual Bonus or Cash LTIP. for such Plan Year or performance period; provided, that the minimum Deferred Amount for any Plan Year or performance period shall not be less than one percent (1%) and the maximum Deferred Amount shall not exceed eighty percent (80%); (ii) the period after which payment of the Deferred Amount is to be made or begin to be made (the "Deferral Period"), which shall be the earlier of (A) a number of full years, not less than three, and (B) the period ending upon the Qualified Retirement or prior termination of employment of the Participant, and (iii) the form in which payments are to be made, which may be a lump sum or in substantially equal annual installments of one (1) to fifteen (15) years.

Section 4.03

Modification or Revocation of Election by Participant. A Participant may not change the amount of their Base Salary Deferrals during a Plan Year. However, a Participant may discontinue a Base Salary Deferral election at any time by submitting, on such forms and subject to such limitations and restrictions as the Committee may prescribe in its discretion, a revised Participation Agreement with the third party administrator. If approved by the Committee, revocation shall take effect as of the first payroll period next following its submission. If a Participant discontinues a Base Salary Deferral election during a Plan Year, they will not be permitted to elect new Deferrals of eligible compensation again until the first day of the Plan Year which immediately follows twelve (12) months from the date of discontinuance.

In addition, the Deferral Period may be extended if an amended Participation Agreement is submitted to the Committee at least one full calendar year before the Deferral Period (as in effect before such amendment) ends. As described in Section 7.11, an extension on a Deferral Period must result in a delay of payment for a minimum of five (5) years from the initial deferral period and otherwise satisfy the requirements of Code Section 409A.

ARTICLE V
DEFERRED COMPENSATION

Section 5.01

Elective Deferred Compensation. The Deferred Amount of a Participant with respect to each Plan Year of participation in the Plan shall be credited by the Committee, or designee, to the Participant's Deferral Account as and when such Deferred Amount would otherwise have been paid to the Participant. To the extent that the Company is required to withhold any taxes or other amounts from the Deferred Amount pursuant to any state, Federal or local law, such amounts shall be taken out of other compensation eligible to be paid to the Participant that is not deferred under this Plan. However, if the Participant elects to defer a large percentage of Eligible Compensation and the election does not allow enough remaining compensation for required withholdings or deductions, the withholdings and deductions will be subtracted from the eligible compensation first, followed by deferral of the remaining eligible compensation.

Section 5.02

Vesting of Deferral Account. Except as provided in Section 7.03, a Participant shall be 100% vested in their Deferral Account at all times.

ARTICLE VI
MAINTENANCE AND INVESTMENT OF ACCOUNTS Section 6.01

Section 6.01

Maintenance of Accounts. Separate Deferral Accounts shall be maintained for each Participant. More than one Deferral Account may be maintained for a Participant as necessary to reflect (a) various Hypothetical Investment Benchmarks and/or (b) separate Participation Agreements specifying different Deferral Periods and/or forms of payment. A Participant's Deferral Account(s) shall be utilized solely as a device for the measurement and determination of the amounts to be paid to the Participant pursuant to this Plan, and shall not constitute or be treated as a trust fund of any kind. The Committee, or Designee, shall determine the balance of each Deferral Account, as of each Valuation Date, by adjusting the balance of such Deferral Account as of the immediately preceding Valuation Date to reflect changes in the value of the deemed investments thereof, credits and debits pursuant to Section 5.01 and Section 6.02 and distributions pursuant to Article VII that conform to Code Section 409A with respect to such Deferral Account since the preceding Valuation Date.

Section 6.02

Hypothetical Investment Benchmarks. Each Participant shall be entitled to direct the manner in which their Deferral Accounts will be deemed to be invested, selecting among the Hypothetical Investment Benchmarks specified in Appendix A hereto, as amended by the Centene Corporation Voluntary Nonqualified Deferred Compensation Plan Committee from time to time, and in accordance with such rules, regulations and procedures as the Centene Corporation Voluntary Nonqualified Deferred Compensation Plan Committee may establish from time to time. Notwithstanding anything to the contrary herein, earnings and losses based on a Participant's investment elections shall begin to accrue as of the date such Participant's Deferral Amounts are credited to their Deferral Accounts.

Section 6.03

Statement of Accounts. Participants will have the ability to access account information via a web site provided by the designated third party administrator. Participants may also receive an account statement upon a written request to the Committee.

ARTICLE VII BENEFITS

Section 7.01

Time and Form of Payment. At the end of the Deferral Period for each Deferral Account, the Company shall pay to the Participant the balance of such Deferral Account at the time or times elected by the Participant in the applicable Participation Agreement; provided that if the Participant has elected to receive payments from a Deferral Account in a lump sum, the Company shall pay the balance in such Deferral Account (determined as of the most recent Valuation Date preceding the end of the Deferral Period) in a lump sum in cash as soon as practicable after the end of the Deferral Period. If the Participant has elected to receive payments from a Deferral Account in installments, the Company shall make annual cash only payments from such Deferral Account, each of which shall consist of an amount equal to (i) the balance of such Deferral Account as of the most recent Valuation Date preceding the payment date times (ii) a fraction, the numerator of which is one and the denominator of which is the number of remaining installments (including the installment being paid). The first such installment shall be paid as soon as practicable after the end of the Deferral Period and each subsequent installment shall be paid on or about the anniversary of such first payment. Each such installment shall be deemed to be made on a pro rata basis from each of the different deemed investments of the Deferral Account (if there is more than one such deemed investment).

Section 7.02

Matching Contribution. Each Participant who elects to make deferrals of Eligible Compensation to the Plan will be eligible to receive a Matching Contribution equal to fifty percent (50%) of the first six percent (6%) of the Participant's Eligible Compensation being deferred to the Plan for such Plan Year (excluding deferrals to the Plan from the Participant’s Cash Long-Term Incentive Plan and stock based compensation), reduced by any matching contributions made by the Company to the Centene Management Corporation Retirement Plan (401k Plan) for such Plan Year. When due, Matching Contributions shall be credited to a Participant’s account in conjunction with the Company’s regular payroll schedule.

Section 7.03

Matching Contribution Vesting. Participants will vest in Matching Contributions as set forth under the Participant's 401(k) plan. The vesting schedule is:

Less than 1 year	0%
1 year	10%
2 years	30%
3 years	60%
4 years	80%
5 years	100%

Section 7.04

Qualified Retirement. Subject to Section 7.01 and Section 7.07 hereof, if a Participant has elected to have the balance of their Deferral Account distributed upon Qualified Retirement, the account balance of the Participant (determined as of the Valuation Date immediately following the Participant’s last deferral after such Qualified Retirement) shall be distributed as soon as practicable following the Qualified Retirement in installments or a lump sum in accordance with the Plan and as elected in the Participation Agreement.

Deferral elections applicable to future Annual Bonus and/or Cash LTIP payments will be honored only for Participants who had a Qualified Retirement, as defined in Section 2.27. In addition, a Qualified Retiree will be allowed to defer Annual Bonus and/or Cash LTIP payments that are paid after Qualified Retirement. However, if a Qualified Retiree has received a full distribution and has a zero account balance at the time of the Annual Bonus or Cash LTIP payment, no deferral will be taken from such Annual Bonus or Cash LTIP payment.

Section 7.05

In-Service Distributions. Subject to Section 7.01 and Section 7.07 hereof, if a Participant has elected to defer Eligible Compensation under the Plan for a stated number of years, the account balance of the Participant (determined as of the most recent Valuation Date immediately following such Deferral Period) shall be distributed in installments or a lump sum in accordance with the Plan and as elected in the Participation Agreement.

Section 7.06

Other Than Qualified Retirement. Notwithstanding the provisions of Section 7.05 and Section 7.06 hereof and any Participation Agreement, if a Participant dies, has a Termination of Employment or Disability prior to a Qualified Retirement and prior to receiving full payment of their Deferral Account(s), the Company shall pay the remaining balance (determined as of the Valuation Date immediately following such event) to the Participant or the Participant's Beneficiary or Beneficiaries (as the case may be) in a lump sum in cash only (notwithstanding Section 7.01 hereof) as soon as practicable following the occurrence of such event, Subject to Section 6.02 hereof, the amount distributable under the preceding sentence of this Section 7.06 shall be based on the Participant's investments elections. If a Participant terminates employment for any reason other than Qualified Retirement, makes a Base Salary or Incentive Deferral from the final pay check, and the final pay check is paid after the Valuation Date, any distributions will be valued on the Valuation Date immediately following the final Base Salary or Incentive Deferral.

Section 7.07

Delay for Specified Employees. Notwithstanding this Article VII, if a Deferral Period ceases upon Separation from Service (other than for death or Disability), payments to a Participant who is a Specified Employee shall not be made until the close of the six (6) month anniversary of such Separation from Service. If during such six (6) month delay a Participant dies, payments shall be made pursuant to Section 7.06.

Section 7.08

Hardship Withdrawals. Notwithstanding the provisions of Section 7.01 and any Participation Agreement, a Participant shall be entitled to early payment of all or part of the balance in their Deferral Account(s) in the event of an Unforeseeable Emergency, in accordance with this Section 7.08. A distribution pursuant to this Section 7.08 may only be made to the extent reasonably needed to satisfy the Unforeseeable Emergency need, and may not be made if such need is or may be relieved (i) through reimbursement or compensation by insurance or otherwise, (ii) by liquidation of the Participant's assets to the extent such liquidation would not itself cause severe financial hardship, or (iii) by cessation of participation in the Plan. An application for an early payment under this Section 7.08 shall be made to the Committee in such form and in accordance with such procedures as the Committee shall determine from time to time. The determination of whether and in what amount and form a distribution will be permitted pursuant to this Section 7.08 shall be made solely by the Committee.

Section 7.09

Change of Control Election. In the event of a Separation from Service as a result of a Change of Control, the participant's account balance will be paid out as specified in their Change in Control election. This is a separate election from the Form of Payment election and this election applies to all Plan Years. The Participant can elect to have the same distribution schedule as previously elected, a lump sum payment or installments over two (2) to fifteen (15) years. The first such installment shall be paid as soon as practicable after the Change in Control and each subsequent installment shall be paid on or about the anniversary of such first payment. If there is no Change in Control election at the time a Change in Control occurs, the Participant's previous elections will be the default and will be followed. The Participant can change their Change in Control election by making a written request to the Committee. The Committee will inform the claimant in writing of the determination of the request within 90 days of the receipt of the request.

Section 7.10

Withholding of Taxes. Notwithstanding any other provision of this Plan, the Company shall withhold from payments made hereunder any amounts required to be so withheld by any applicable law or regulation.

Section 7.11

Changes in Payment Elections. A Participant may modify the time or the form of payment elections made on his or her Participation Agreement under the following circumstances: (i) any such election to modify may not take effect until at least twelve (12) months following the date of such election; (ii) if the election relates to a payment based on a Separation from Service or on a Change of Control or if the payment is at a specified time or pursuant to a fixed schedule, the election must result in payment being made not earlier than five (5) years following the date upon which the payment would otherwise would have been made; and (iii) if the election is related to payment at a specified time or pursuant to a fixed schedule, the Participant must make the election not less than twelve (12) months prior to the date the payment is scheduled to be made.

ARTICLE VIII
BENEFICIARY DESIGNATION

Section 8.01

Beneficiary Designation. Each Participant shall have the right, at any time, to designate any person, persons or entity as their Beneficiary or Beneficiaries. A Beneficiary designation shall be made, and may be amended, by the Participant by accessing the web site of the third party administrator and making such changes.

Section 8.02

No Beneficiary Designation. If a Participant fails to designate a Beneficiary as provided above, or if all designated Beneficiaries predecease the Participant, then the Participant's Beneficiary shall be deemed to be the Participant's estate.

ARTICLE IX
AMENDMENT AND TERMINATION OF PLAN

Section 9.01

Amendment. The Board or the Committee may at any time amend this Plan in whole or in part, provided, however, that no amendment shall be effective to decrease the balance in any Deferral Account as accrued at the time of such amendment, nor shall any amendment otherwise have a retroactive effect. Interpretation of the Plan by the Board or the Committee shall be made in a manner that is consistent with the intent that the Plan conform to the requirements of Code Section 409A.

Section 9.02

Company's Right to Terminate. The Board or the Committee may at any time terminate the Plan with respect to future Participation Agreements. The Board or the Committee may also terminate the Plan in its entirety at any time for any reason, including without limitation if, in its judgment, the continuance of the Plan, the tax, accounting, or other effects thereof, or potential payments thereunder would not be in the best interests of the Company, and upon any such termination, the Company shall immediately pay to each Participant in a lump sum the accrued balance in their Deferral Account (determined as of the most recent Valuation Date preceding the termination date). Such termination, however, shall be made in a manner that conforms to the requirements of Code Section 409A.

ARTICLE X MISCELLANEOUS

Section 10.01

Unfunded Plan. This Plan is intended to be an unfunded plan maintained primarily for the purpose of providing deferred compensation for a select group of management or highly compensated employees, within the meaning of Sections 201, 301 and 401 of ERISA. All payments pursuant to the Plan shall be made from the general funds of the Company and no special or separate fund shall be established or other segregation of assets made to assure payment. No Participant or other person shall have under any circumstances any interest in any particular property or assets of the Company as a result of participating in the Plan. Notwithstanding the foregoing, the Company may (but shall not be obligated to) create one or more grantor trusts, the assets of which are subject to the claims of the Company's creditors, to assist it in accumulating funds to pay its obligations under the Plan.

Section 10.02

No Assignability. Except as specifically set forth in the Plan with respect to the designation of Beneficiaries, neither a Participant nor any other person shall have any right to commute, sell, assign, transfer, pledge, anticipate, mortgage or otherwise encumber, transfer, hypothecate or convey in advance of actual receipt the amounts, if any, payable hereunder, or any part thereof, which are, and all rights to which are, expressly declared to be unassignable and non-transferable. No part of the amounts payable shall, prior to actual payment, be subject to seizure or sequestration for the payment of any debts, judgments, alimony or separate maintenance owed by a Participant or any other person, nor be transferable by operation of law in the event of a Participant's or any other person's bankruptcy or insolvency.

Section 10.03

Hypothetical Investment Benchmarks. (a) Each Participant shall be entitled to direct the manner in which their Deferral Accounts will be deemed to be invested, selecting among the Hypothetical Investment Benchmarks specified in Appendix A hereto, as amended by the Committee from time to time, and in accordance with such rules, regulations and procedures as the Committee may establish from time to time. Notwithstanding anything to the contrary herein, earnings and losses based on a Participant's investment elections shall begin to accrue as of the date such Participant's Deferral Amounts are credited to their Deferral Accounts.

Section 10.04

Validity and Severability. The invalidity or unenforceability of any provision of this Plan shall not affect the validity or enforceability of any other provision of this Plan, which shall remain in full force and effect, and any prohibition or unenforceability in any jurisdiction, shall not invalidate or render unenforceable such provision in any other jurisdiction.

Section 10.05

Governing Law. The validity, interpretation, construction and performance of this Plan shall in all respects be governed by the laws of the State of Missouri, without reference to principles of conflict of law, except to the extent preempted by federal law.

Section 10.06

Employment Status. This Plan does not constitute a contract of employment or impose on the Participant or the Company any obligation for the Participant to remain an employee of the Company or change the status of the Participant's employment or the policies of the Company and its affiliates regarding termination of employment.

Section 10.07

Underlying Incentive Plans and Programs. Nothing in this Plan shall prevent the Company from modifying, amending or terminating any Eligible Compensation arrangement or the incentive plans and programs pursuant to which cash awards are earned and which are deferred under this Plan.

Section 10.08

Section 409A. Notwithstanding any other provisions of the Plan or any Participation Agreement to the contrary, no payment shall be granted, deferred, accelerated, extended, made or modified under this Plan in a manner that would result in the imposition of an additional tax under Code Section 409A upon a Participant. In the event that it is reasonably determined by the Committee that, as a result of Code Section 409A, payments under the Plan may not be made at the time contemplated by the terms of the Plan or the relevant Participation Agreement, as the case may be, without causing the Participant receiving such payment to be subject to taxation under Code Section 409A, the Company will make such payment on the first day that would not result in the Participant incurring any tax liability under Code Section 409A; which, if the Participant is a Specified Employee within the meaning of the Code Section 409A, shall be the first day following the six-month period beginning on the date of Participant’s termination of employment. The Company shall use commercially reasonable efforts to implement the provisions of this Section 10.09 in good faith; provided that neither the Company, the Committee nor any of the Company’s employees, directors or representatives shall have any liability to a Participant with respect to this Section 10.09.

IN WITNESS WHEREOF, the Company has caused this Amendment and Restatement of the Plan to be executed by its duly authorized officer or representative.

CENTENE CORPORATION

By: /s/ H. Robert Sanders

H. Robert Sanders

Senior Vice President, Human Resources

APPENDIX A

Centene Corporation Common Stock (CNC)

MainStay VP U.S. Government Money Market - Initial Class

MFS® Value Series - Initial Class

Fidelity® VIP Index 500 Portfolio - Initial Class

Fidelity® VIP Growth Portfolio - Initial Class

Fidelity® VIP Contrafund® Portfolio - Initial Class

Janus Henderson VIT Enterprise Portfolio - Institutional Class

T. Rowe Price New America Growth Portfolio

T. Rowe Price International Stock Portfolio

PIMCO VIT Total Return Portfolio-Administrative Class Shares

Janus Henderson VIT Enterprise Portfolio - Institutional Class

T. Rowe Price Blue Chip Growth Portfolio

Lord Abbett Series - Mid-Cap Stock Portfolio - Class VC

VOYA Russell Mid Cap Index Portfolio - Initial Class

Delaware VIP® Small Cap Value Series-Standard Class

MainStay VP Eagle Small Cap Growth Portfolio - Initial Class

MainStay VP Small Cap Core - Initial Class

LVIP Baron Growth Opportunities Fund - Service Class

MainStay VP Emerging Markets Equity - Initial Class

Moody's Corporate Bond Average

Fidelity VIP Freedom 2010 Portfolio - Initial Class

Fidelity VIP Freedom 2020 Portfolio - Initial Class

Fidelity® VIP Freedom 2030 Portfolio - Initial Class

Fidelity® VIP Freedom 2040 Portfolio - Initial Class

Fidelity® VIP Freedom 2050 Portfolio - Initial Class

EXHIBIT 10.19

CENTENE CORPORATION

Restricted Stock Unit Agreement Granted Under

2012 Stock Incentive Plan, As Amended

THIS AGREEMENT is entered into by Centene Corporation, a Delaware corporation (hereinafter the “Company”), and the undersigned employee of the Company (hereinafter the “Participant”).

WHEREAS, the Participant renders important services to the Company and acquires access to Confidential Information (as defined below) of the Company in connection with the Participant’s relationship with the Company; and

WHEREAS, the Company desires to align the long-term interests of its valued employees with those of the Company by providing the ownership interest granted herein and to prevent former employees whose interest may become adverse to the Company from maintaining an ownership interest in the Company;

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements herein contained, the parties hereto hereby agree as follows:

1. Grant of RSUs.

This Agreement evidences the grant by the Company on the Grant Date (or the “Grant Date”) to Participant Name of Number of Awards Granted restricted stock units (each an “RSU,” and collectively the “RSUs”) pursuant to the Company’s 2012 Stock Incentive Plan, As Amended (the “Plan”). Each RSU represents the right to receive one share of the common stock, $.001 par value per share, of the Company (“Common Stock”) as provided in this Agreement. The shares of Common Stock that are issuable upon vesting of the RSUs are referred to in this Agreement as “Shares.”

2. Vesting.

Subject to Section 3 of this Agreement, the RSUs shall vest as to ___ of the original number of RSUs on the ___ anniversary of the Grant Date and as to an additional ____ of the original number of RSUs at the end of each successive ____ period following the first anniversary of the Grant Date until the ____ anniversary of the Grant Date. The Participant must hold vested shares for one year from the vesting date, less shares valued at an amount equivalent to the Participant’s tax liability applicable to the vested shares at the Participant’s marginal tax rate. The Participant’s tax liability may exceed the minimum statutory withholding.

3. Reorganization Event.

Upon the occurrence of a “Change in Control,” all of the RSUs that (but for the application of this clause) are not vested at the time of the occurrence of such Change in Control event shall vest. The shares represented by the RSUs so vested shall not be subject to the one-year additional holding requirement under Section 2. A “Change in Control” shall be deemed to have occurred if any of the events set forth in any one of the following clauses shall occur: (i) any Person (as defined in section 3(a)(9) of the Securities Exchange Act of 1934, as amended (the “Exchange Act”), and as such term is modified in sections 13(d) and 14(d) of the Exchange Act), excluding a group of persons including the Participant, is or becomes the “beneficial owner” (as defined in Rule 13(d)(3) under the Exchange Act), directly or indirectly, of securities of the Company representing forty percent or more of the combined voting power of the Company’s then-outstanding securities; (ii) individuals who, as of the Grant Date, constitute the Board of Directors of the Company (the “Incumbent Board”), cease for any reason to constitute a majority thereof (*provided, however,* that an individual becoming a director subsequent to the Grant Date whose election, or nomination for election by the Company’s stockholders, was approved by at least a majority of the directors then comprising the Incumbent Board shall be included within the definition of Incumbent Board, but excluding, for this purpose, any such individual whose initial assumption of office occurs as a result of either an actual election contest (or such terms used in Rule 14a-11 of Regulation 14A promulgated under the Exchange Act) or other actual or threatened solicitation of proxies or consents by or on behalf of a person other than the Board of Directors of the Company); or (iii) the stockholders of the Company consummate a merger or consolidation of the Company with any other corporation, other than a merger or consolidation that would result in the voting securities of the Company outstanding immediately prior thereto continuing to represent (either by remaining outstanding or by being converted into voting securities of the surviving entity) at least fifty percent of the combined voting power of the voting securities of the Company or such surviving entity outstanding immediately after such merger or consolidation.

4. Distribution of Shares.

(a) Timing of Distribution. The Company will distribute to the Participant (or to the Participant's beneficiary in the event of the death of the Participant occurring after a vesting date but before distribution of the corresponding Shares), as soon as administratively practicable after each vesting date, the Shares represented by RSUs that vested on such vesting date.

(b) No Fractional Shares. No fractional Shares shall be issuable pursuant to any RSU. In lieu of any fractional shares to which the Participant would otherwise be entitled, the Company shall pay cash in an amount equal to such fraction multiplied by the Fair Market Value (as defined in the Plan) of a share of Common Stock.

(c) Termination of Employment. In the event that the Participant's employment with the Company (and any parent or subsidiary thereof) is terminated for any reason by the Company or by the Participant other than by reason of death or disability (within the meaning of Section 22(e)(3) of the Internal Revenue Code of 1986, as amended (the "Code")), the RSUs shall cease vesting as of the date of termination. In the event the Participant's employment with the Company (and any parent or subsidiary thereof) is terminated by reason of death or disability (as defined previously in this Section 4(c)), the pro-rata amount of RSUs, attributable to the number of completed months employed between the grant date and the termination date shall immediately vest, and fractional shares will be rounded down to the nearest full share and will not be distributed or paid in cash.

(d) Compliance Restrictions. The Company shall not be obligated to issue to the Participant the Shares upon the vesting of any RSU (or otherwise) unless (i) the Participant has complied with covenants set forth in Section 10 of this Agreement and (ii) the issuance and delivery of such Shares shall comply with all relevant provisions of law and other legal requirements including any applicable federal, state or national securities laws and the requirements of any stock exchange or quotation system upon which Common Stock may then be listed or quoted.

5. Restrictions on Transfer.

The RSUs may not be sold, assigned, transferred, pledged or otherwise encumbered by the Participant, either voluntarily or by operation of law, except to the Participant's beneficiary as provided in Section 4(a) in the event of the Participant's death. The Participant's beneficiary can be designated and recorded with the Company's stock plan administrator or, if no election is made with the stock plan administrator, Shares will be distributed to the Participant's beneficiary under the Centene Management Corporation Retirement Plan. In the absence of any such beneficiary designation, benefits remaining unpaid at the Participant's death shall be paid to the Participant's executor, administrator, or legal representative.

6. No Rights as Stockholder.

Except as set forth in the Plan, neither the Participant nor any person claiming under or through the Participant shall be, or shall have any rights or privileges of, a stockholder of the Company in respect of any Share issuable pursuant to the RSUs granted hereunder until such Share has been delivered to the Participant.

7. Withholding Taxes.

(a) No Shares will be delivered pursuant to the vesting of an RSU unless and until the Participant pays to the Company, or makes provision satisfactory to the Company for payment of, the amount (with respect to such vesting, the "Withholding Amount") of the Company's minimum statutory withholding obligations with respect to the income recognized by the Participant upon such vesting, based on minimum statutory withholding rates for all tax purposes, including (without limitation) payroll taxes and social security contributions, that are applicable to such income.

(b) By accepting the grant of RSUs, the Participant agrees that the Company or any group company may withhold some or all of any Withholding Amount from any payment due to the Participant at any time or may require immediate payment of such Withholding Amount by the Participant on demand in cleared funds.

(c) The Participant acknowledges that no election under any local tax code or acts may be filed with respect to the RSUs.

8. Automatic Sale Upon Vesting.

(a) Upon any vesting of RSUs pursuant to Section 2 hereof, the Company may sell, or arrange for the sale of, such number of the Shares issuable pursuant to such vested RSU under Section 2 as is sufficient to generate net proceeds to satisfy the Company's minimum statutory withholding obligations with respect to the income recognized by the Participant upon vesting (based on minimum statutory withholding rates for all tax purposes, including (without limitation) payroll taxes and social security contributions, that are applicable to such income), and the Company shall retain such net proceeds in satisfaction of such tax withholding obligations.

(b) The Participant hereby appoints the Company's Secretary as his or her attorney-in-fact and agent to sell the Shares in accordance with this Section 8. The Participant agrees to execute and deliver such documents, instruments and certificates as may reasonably be required in connection with the sale of the Shares pursuant to this Section 8.

(c) It is understood that the Participant and the Company may agree from time to time, subject to compliance with applicable laws, to procedures to be implemented, in lieu of the procedures set forth in paragraphs (a) and (b) of this Section 8, to fund the Withholding Amount.

9. Provisions of the Plan.

The RSUs are subject to the provisions of the Plan, a copy of which is being furnished to the Participant with this Agreement. Capitalized terms defined in this Agreement have the same meanings as the Plan. In the event of any conflict between the provisions of this Agreement and the Plan, the terms of the Plan shall prevail.

10. Participant's Covenants.

For and in consideration of the delivery of this Agreement, the Participant agrees to the provisions of this Section 10.

(a) Confidential Information. As used in this Agreement, "Confidential Information" shall mean the Company's trade secrets and other non-public proprietary information relating to the Company or the business of the Company, including information relating to financial statements, customer lists and identities, potential customers, customer contacts, employee skills and compensation, employee data, suppliers, acquisition targets, servicing methods, equipment, programs, strategies and information, analyses, marketing plans and strategies, profit margins, financial, promotional, marketing, training or operational information, and other information developed or used by the Company that is not known generally to the public or the industry. Confidential Information shall not include any information that is in the public domain or becomes known in the public domain through no wrongful act on the part of the Participant.

(b) Non-Disclosure. The Participant agrees that the Confidential Information is a valuable, special and unique asset of the Company's business, that such Confidential Information is important to the Company and the effective operation of the Company's business, and that during employment with the Company and at all times thereafter, the Participant shall not, directly or indirectly, disclose to any competitor or other person or entity (other than current employees of the Company) any Confidential Information that the Participant obtains while performing services for the Company, except as may be required in the Participant's reasonable judgment to fulfill his or her duties hereunder or to comply with any applicable legal obligation.

(c) Non-Competition; Non-Solicitation.

(i) During Participant's employment with the Company and for the period of six (6) months immediately after the termination of Participant's employment with the Company (including any parent, subsidiary, affiliate or division of the Company) for any reason whatsoever, and whether voluntary or involuntary, Participant shall not invest in (other than in a publicly traded company with a maximum investment of no more than 1% of outstanding shares), counsel, advise, consult, be employed or otherwise engaged by or with any entity or enterprise ("Competitor") that competes with (A) the Company's business of providing Medicaid managed care services, Medicaid-related services, behavioral health, nurse triage or pharmacy compliance specialty services or (B) any other business in which, after the date of this Agreement, the Company (or any parent, subsidiary, affiliate or division of the Company) becomes engaged (or has taken substantial steps in which to become engaged) on or prior to the date of termination of Participant's employment. For purposes of paragraph 10, Participant agrees that this agreement not to compete applies to any Competitor that does business within the state of Missouri or and any other state in which Centene does business, and that such geographical limitation is reasonable.

(ii) During the Participant's employment with the Company (or any parent, subsidiary, affiliate or division of the Company) and for the period of twelve months immediately after the termination of the Participant's employment with the Company (or any parent, subsidiary, affiliate or division of the Company) for any cause whatsoever, and whether voluntary or involuntary ("Restricted Period"), the Participant will not, either directly or indirectly, either for himself or for any other person, firm, company or corporation, call upon, solicit, divert, or take away, or attempt to solicit, divert or take away any of the customers, prospective customers, business, vendors or suppliers of the Company that the Participant had dealings with, or responsibility for, or as to which the Participant had access to confidential information.

(iii) The Participant shall not, at any time during the Restricted Period, without the prior written consent of the Company, (i) directly or indirectly, solicit, recruit or employ (whether as an employee, officer, director, agent, consultant or independent contractor) any person who was or is at any time during the previous six months an employee, representative, officer or director of the Company (or any parent, subsidiary, affiliate or division of the Company); or (ii) take any action to encourage or induce any employee, representative, officer or director of the Company (or any parent, subsidiary, affiliate or division of the

Company) to cease their relationship with the Company (or any parent, subsidiary, affiliate or division of the Company) for any reason.

(iv) This Section 10(c) shall not apply if a "Change in Control" (as defined in Section 3) occurs under Section 3(ii) thereof, or if such Change in Control occurs under Section 3(i) or 3(iii) thereof without the prior approval, recommendation or consent of the Board of Directors of the Corporation.

(d) Enforcement. If any of the provisions or subparts of this Section 10 shall be held to be invalid or unenforceable by a court of competent jurisdiction, the remaining provisions or subparts thereof shall nevertheless continue to be valid and enforceable according to their terms. Further, if any restriction contained in the provisions or subparts of this Section 10 is held to be overbroad or unreasonable as written, the parties agree that the applicable provision should be considered to be amended to reflect the maximum period, scope or geographical area deemed reasonable and enforceable by the court and enforced as amended.

(e) Remedy for Breach.

(i) Because the Participant's services are unique and because the Participant has access to the Company's Confidential Information, the parties agree that any breach or threatened breach of this Section 10 will cause irreparable harm to the Company and that money damages alone would be an inadequate remedy. The parties therefore agree that, in the event of any breach or threatened breach of this Section 10, and in addition to all other rights and remedies available to it, the Company may apply to any court of competent jurisdiction for specific performance and/or injunctive or other relief, without a bond, in order to enforce or prevent any violations of the provisions of this Section 10.

(ii) The Participant shall immediately repay to the Company a cash sum in the principal amount equal to all gross proceeds (before-tax) realized by Participant upon the sale or other disposition of the Shares occurring at any time during the period commencing on the date that is three years before the date of termination of the Participant's employment with the Company and all Subsidiaries of the Company and ending on the date of the Participant's breach or threatened breach of this Section 10 (the "Refund Period"), together with interest accrued thereon, from the date of such breach or threatened breach, at the prime rate (compounded calendar monthly) as published from time to time in The Wall Street Journal, electronic edition ("Interest"); and

(iii) The Participant shall repay to the Company a cash sum equal to the fair market value of all of the Shares transferred by the Participant as a gift or gifts at any time during the Refund Period, together with Interest, and for which purpose, "fair market value" shall be the Fair Market Value of one share of Common Stock on the date such gift occurs.

(iv) The Participant acknowledges and agrees that nothing contained herein shall be construed to be an excessive remedy to prohibit the Company from pursuing any other remedies available to it for such actual or threatened breach, including the recovery of money damages, proximately caused by the Participant's breach of this Section 10.

(f) Survival. The provisions of this Section 10 shall survive and continue in full force in accordance with their terms notwithstanding any forfeiture, termination or expiration of this Agreement in accordance with its terms or any termination of the Participant's employment for any reason (whether voluntary or involuntary).

11. Miscellaneous.

(a) Severability. The invalidity or unenforceability of any provision of this Agreement shall not affect the validity or enforceability of any other provision of this Agreement, and each other provision of this Agreement shall be severable and enforceable to the extent permitted by law.

(b) Waiver. Any provision for the benefit of the Company contained in this Agreement may be waived, either generally or in any particular instance, by the Board of Directors of the Company.

(c) Binding Effect. This Agreement shall be binding upon and inure to the benefit of the Company and the Participant and their respective heirs, executors, administrators, legal representatives, successors and assigns, subject to the restrictions on transfer set forth in Section 5 of this Agreement.

(d) Notice. All notices required or permitted hereunder shall be in writing and deemed effectively given upon personal delivery or five days after delivery to a United States Post Office, by registered or certified mail, postage prepaid, addressed to the other party hereto at the address shown beneath his or her respective signature to this Agreement, or at such other address or addresses as either party shall designate to the other in accordance with this paragraph (d).

(e) Entire Agreement. This Agreement and the Plan constitute the entire agreement between the parties, and supersede all prior agreements and understandings, relating to the RSUs.

(f) Participant's Acknowledgments. The Participant acknowledges that he or she: (i) has read this Agreement; (ii) has been represented in the preparation, negotiation, and execution of this Agreement by legal counsel of the Participant's own choice or has voluntarily declined to seek such counsel; (iii) understands the terms and consequences of this Agreement; (iv) is fully aware of the legal and binding effect of this Agreement; and (v) understands that the law firm of Bryan Cave LLP, is acting as counsel to the Company in connection with the transactions contemplated by the agreement, and is not acting as counsel for the Participant.

(g) Unfunded Rights. The right of the Participant to receive Common Stock pursuant to this Agreement is an unfunded and unsecured obligation of the Company. The Participant shall have no rights under this Agreement other than those of an unsecured general creditor of the Company.

(h) Relationship to Employment Contract

(i) The Plan and the grant of RSUs do not form part of any contract of employment between the Company or any group company and the Participant;

(ii) The grant of RSUs is a discretionary award made by the Company, the Participant has no right to be granted RSUs and the grant of RSUs in one year is no indication that the Participant will be granted any subsequent RSUs;

(iii) The grant of RSUs does not entitle the Participant to the exercise of any discretion in their favor;

(iv) The benefit to a Participant of participation in the Plan (including, in particular but not by way of limitation, any RSUs held by them) shall not form any part of the Eligible Employee's remuneration or count as the Participant's remuneration for any purpose and shall not be pensionable; and

(v) If the Participant ceases to be an employee or office holder of the Company or a group company for any reason, the Participant shall not be entitled to compensation for the loss or diminution in value of any right or benefit or prospective right or benefit under the Plan (including, in particular but not by way of limitation, any RSUs held by the Participant which lapse by reason of the Participant ceasing to be an employee or office holder) whether by way of damages for unfair dismissal, wrongful dismissal, breach of contract or otherwise.

(i) Data Transfer. By accepting the grant of RSUs the Participant agrees that the holding, processing and transfer of personal data in relation to their RSUs by or to the Company or any group company shall be carried out in accordance with the data handling policy operated by the Participant's employer.

(j) Third Party Rights. Nothing in the Plan or this Agreement confers any benefit, right or expectation on a person who is not the Participant and no such third party has any rights to enforce any terms of this Agreement.

(k) Deferral. Neither the Company nor the Participant may defer delivery of any Shares issuable under unvested RSUs except to the extent that such deferral complies with the provisions of Section 409A of the Code.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement.

CENTENE CORPORATION

Exhibit 21

List of Subsidiaries

Absolute Total Care, Inc., a South Carolina corporation
AcariaHealth Pharmacy #11, Inc., a Texas corporation
AcariaHealth Pharmacy #12, Inc., a New York corporation
AcariaHealth Pharmacy #13, Inc., a California corporation
AcariaHealth Pharmacy #14, Inc., a California corporation
AcariaHealth Pharmacy, Inc., a California corporation
AcariaHealth Solutions, Inc., a Delaware corporation
AcariaHealth, Inc., a Delaware corporation
Access Medical Acquisition, Inc., a Delaware corporation
Access Medical Group of North Miami Beach, Inc., a Florida corporation
Access Medical Group of Miami, Inc., a Florida corporation
Access Medical Group of Tampa, Inc., a Florida corporation
Access Medical Group of Tampa II, Inc., a Florida corporation
Access Medical Group of Tampa III, Inc., a Florida corporation
Agate Resources, Inc., an Oregon corporation
Ambetter of Magnolia, Inc., a Mississippi corporation
Ambetter of North Carolina, Inc., a North Carolina corporation
Ambetter of Peach State Inc., a Georgia corporation
Arkansas Health & Wellness Health Plan, Inc., an Arkansas corporation
Arkansas Total Care, Inc., an Arkansas corporation
Arkansas Total Care Holding Company, LLC, a Delaware LLC
Bankers Reserve Life Insurance Company of Wisconsin, a Wisconsin corporation
Bridgeway Health Solutions LLC, a Delaware LLC
Bridgeway Health Solutions of Arizona, Inc., an Arizona corporation
Buckeye Community Health Plan, Inc., an Ohio corporation
California Health and Wellness Plan, a California corporation
Cantina Laredo Clayton, LP, a Delaware limited partnership
Carolina Complete Health Holding Company Partnership, a Delaware partnership
Carolina Complete Health, Inc., a North Carolina corporation
Casenet S.R.O., a Czech Republic S.R.O.
Casenet, LLC, a Delaware LLC
CBHSP Arizona, Inc., an Arizona corporation
Celtic Group, Inc., a Delaware corporation
Celtic Insurance Company, an Illinois corporation
CeltiCare Health Plan Holdings LLC, a Delaware LLC
CeltiCare Health Plan of Massachusetts, Inc., a Massachusetts corporation
Cenpatico Behavioral Health of Arizona, LLC, an Arizona LLC
Cenpatico Behavioral Health, LLC, a California LLC
Cenpatico of Arizona Inc., an Arizona corporation
Centene Center, LLC, a Delaware LLC
Centene Center I, LLC, a Delaware LLC
Centene Center II, LLC, a Delaware LLC
Centene Center III, LLC, a Delaware LLC
Centene Company of New York, LLC, a New York LLC
Centene Company of Texas, LP, a Texas limited partnership
Centene Health Plan Holdings, Inc., a Delaware corporation

Centene International Ventures, LLC, a Delaware LLC
Centene Management Company, LLC, a Wisconsin LLC
Centene UK Limited, an English and Welsh private company
Centurion Correctional Healthcare of New Mexico, LLC, a New Mexico LLC
Centurion Detention Health Services, LLC, a Delaware LLC
Centurion of Arizona, LLC, an Arizona LLC
Centurion of Florida, LLC, a Florida LLC
Centurion of Minnesota, LLC, a Minnesota LLC
Centurion of Mississippi, LLC, a Mississippi LLC
Centurion of Tennessee, LLC, a Tennessee LLC
Centurion of Vermont, LLC, a Vermont LLC
Centurion, LLC, a Delaware LLC
CMC Hanley, LLC, a Missouri LLC
CMC Real Estate Company, LLC, a Delaware LLC
Comfort Hospice of Missouri, LLC, a Michigan LLC
Comfort Hospice of Texas, LLC, a Michigan LLC
ComfortBrook Hospice, LLC, an Ohio LLC
Community Medical Holdings Corporation, a Delaware corporation
Coordinated Care Corporation, an Indiana corporation
Coordinated Care of Washington, Inc., a Washington corporation
Country Style Health Care, LLC, a Texas LLC
Envolve Benefits Options, Inc., a Delaware corporation
Envolve Captive Insurance Company, Inc., a South Carolina corporation
Envolve Dental, Inc., a Delaware corporation
Envolve Dental of Florida, Inc., a Florida corporation
Envolve Dental of Texas, Inc., a Texas corporation
Envolve Dental IPA of New York, Inc., a New York corporation
Envolve Holdings, Inc., a Delaware corporation
Envolve, Inc., a Delaware corporation
Envolve - New York, Inc., a New York corporation
Envolve PeopleCare, Inc., a Delaware corporation
Envolve Pharmacy IPA, LLC, a New York LLC
Envolve Pharmacy Solutions, Inc., a Delaware corporation
Envolve Optical, Inc. a Delaware corporation
Envolve Total Vision, Inc., a Delaware corporation
Envolve Vision Benefits, Inc., a Delaware corporation
Envolve Vision, Inc., a Delaware corporation
Envolve Vision IPA of New York, Inc., a New York corporation
Envolve Vision of Florida, Inc., a Florida corporation
Envolve Vision of Texas, Inc., a Texas corporation
Family Nurse Care II, LLC, a Michigan LLC
Family Nurse Care of Ohio, LLC, a Michigan LLC
Family Nurse Care, LLC, a Michigan LLC
FH Assurance Company, a Cayman Islands corporation
Forensic Health Services, LLC, a Delaware LLC
Foundation Care, LLC, a Missouri LLC
GPT Acquisition, LLC, a Delaware LLC
Grace Hospice of Austin, LLC, a Michigan LLC
Grace Hospice of Grand Rapids, LLC, a Michigan LLC
Grace Hospice of Illinois, LLC, an Illinois LLC

Grace Hospice of Indiana, LLC, a Michigan LLC
Grace Hospice of San Antonio, LLC, a Michigan LLC
Grace Hospice of Virginia, LLC, a Michigan LLC
Grace Hospice of Wisconsin, LLC, a Michigan LLC
Granite State Health Plan, Inc., a New Hampshire corporation
Hallmark Life Insurance Company, an Arizona corporation
Health Care Enterprises, LLC, a Delaware LLC
Health Net Access, Inc., an Arizona corporation
Health Net Community Solutions, Inc., a California corporation
Health Net Community Solutions of Arizona, Inc., an Arizona corporation
Health Net Federal Services, LLC, a Delaware LLC
Health Net Health Plan of Oregon, Inc., an Oregon corporation
Health Net, Inc., a Delaware corporation
Health Net Life Insurance Company, a California corporation
Health Net Life Reinsurance Company, a Cayman Islands corporation
Health Net of Arizona Administrative Services, Inc., an Arizona corporation
Health Net of Arizona, Inc., an Arizona corporation
Health Net of California, Inc., a California corporation
Health Net of California Real Estate Holdings, Inc., a California corporation
Health Net of Pennsylvania, LLC, a Pennsylvania LLC
Health Net Pharmaceutical Services, a California corporation
Health Net Preferred Providers, LLC, a Delaware LLC
Health Net Services Inc., a Delaware corporation
Health Net Veterans, LLC, a Delaware LLC
Health Plan Real Estate Holdings, Inc., a Missouri corporation
Healthy Louisiana Holdings, LLC, a Delaware LLC
Healthy Missouri Holdings, Inc., a Missouri corporation
Healthy Washington Holdings, Inc., a Delaware corporation
Heritage Home Hospice, LLC, a Michigan LLC
Home State Health Plan, Inc., a Missouri corporation
HomeScripts.com, LLC, a Michigan LLC
Hospice DME Company, LLC, a Michigan LLC
IAH of Florida, LLC, a Florida LLC
IlliniCare Health Plan, Inc., an Illinois corporation
Illinois Health Practice Alliance, LLC, a Delaware corporation
Integrated Mental Health Management LLC, a Texas LLC
Integrated Mental Health Services, a Texas corporation
Integrated Pharmacy Systems, Inc., a Pennsylvania corporation
Interpreta Holdings, Inc., a Delaware corporation
Interpreta, Inc., a Delaware corporation
Iowa Total Care, Inc., an Iowa corporation
Kentucky Spirit Health Plan, Inc., a Kentucky corporation
LBB Industries, Inc., a Texas corporation
LifeShare Management Group, LLC, a New Hampshire LLC
LiveHealthier, Inc., a Delaware corporation
Louisiana Healthcare Connections, Inc., a Louisiana corporation
LSM Holdco, Inc., a Delaware corporation
Magnolia Health Plan, Inc., a Mississippi corporation
Managed Health Network, a California corporation
Managed Health Network, LLC, a Delaware LLC

Managed Health Services Insurance Corporation, a Wisconsin corporation
MHM Services, Inc., a Delaware corporation
MHM Correctional Services, LLC, a Delaware LLC
MHM Maryland, Inc., a Maryland corporation
MHM Ohio, Inc., a Ohio corporation
MHM Services of California, LLC, a California LLC
MHM Solutions, LLC, a Delaware LLC
MHM Health Professionals, LLC, a Delaware LLC
MHN Global Services, Inc., a Delaware corporation
MHN Government Services LLC, a Delaware LLC
MHN Government Services-Guam, Inc., a Delaware corporation
MHN Government Services-International, Inc., a Delaware corporation
MHN Government Services-Puerto Rico, Inc., a Delaware corporation
MHN Services, LLC, a California LLC
MHS Consulting International, Inc., a Delaware corporation
MH Services International Holdings (UK) Limited, an English and Welsh private company
MH Services International (UK) Limited, an English and Welsh private company
MHS Travel & Charter, Inc., a Wisconsin corporation
Michigan Complete Health, a Michigan corporation
National Pharmacy Services Inc., a Delaware corporation
Nebraska Total Care, Inc., a Nebraska corporation
Network Providers, LLC, a Delaware LLC
New York Quality Healthcare Corporation, a New York corporation
North Florida Health Services, Inc., a Florida corporation
Novasys Health, Inc., a Delaware corporation
Peach State Health Plan, Inc., a Georgia corporation
Pennsylvania Health Care Plan, Inc., a Pennsylvania corporation
Phoenix Home Health Care, LLC, a Delaware LLC
Pinnacle Home Care, LLC, a Texas LLC
Pinnacle Senior Care of Indiana, LLC, a Michigan LLC
Pinnacle Senior Care of Kalamazoo, LLC, a Michigan LLC
Pinnacle Senior Care of Missouri, LLC, a Michigan LLC
Pinnacle Senior Care of Wisconsin, LLC, a Wisconsin LLC
PrimeroSalud, S.L., a Spanish Sociedad Limitada
QualMed, Inc., a Delaware corporation
QualMed Plans for Health of Pennsylvania, Inc., a Pennsylvania corporation
QualMed Plans for Health of Western Pennsylvania, Inc., a Pennsylvania corporation
R&C Healthcare, LLC, a Texas LLC
Rapid Respiratory Services, LLC, a Delaware LLC
RMED, LLC, a Florida LLC
RX Direct, Inc., a Texas corporation
Salus Administrative Services, Inc., a New York corporation
Salus IPA, LLC, a New York LLC
Seniorcorps Peninsula, LLC, a Virginia LLC
SilverSummit Healthplan, Inc., a Nevada corporation
Specialty Therapeutic Care Holdings, LLC, a Delaware LLC
Specialty Therapeutic Care, GP, LLC, a Texas LLC
Specialty Therapeutic Care, LP, a Texas limited partnership
Sunflower State Health Plan, Inc., a Kansas corporation
Sunshine Health Holding, LLC, a Florida LLC

Sunshine State Health Plan, Inc., a Florida corporation
Superior HealthPlan, Inc., a Texas corporation
The Practice (Group) Limited, an English and Welsh private company
The Practice Health Division Limited , an English and Welsh private company
The Practice Properties Limited, an English and Welsh private company
The Practice Services Limited, an English and Welsh private company
Torrejon Salud, S.A., a Spanish S.A.
Traditional Home Health Services, LLC, a Texas LLC
Trillium Community Health Plan, Inc., an Oregon corporation
U.S. Medical Management Holdings, Inc., a Delaware corporation
U.S. Medical Management, LLC, a Delaware LLC
USMM Accountable Care Network, LLC, a Delaware LLC
USMM Accountable Care Partners, LLC, a Delaware LLC
USMM Accountable Care Solutions, LLC, a Delaware LLC

Exhibit 23

Consent of Independent Registered Public Accounting Firm

The Board of Directors
Centene Corporation:

We consent to the incorporation by reference in the registration statements on Form S-8 (Nos. 333-217634, 333-210376, 333-197737, 333-180976, 333-108467, and 333-90976) and in the registration statements on Form S-3 (Nos. 333-217636 and 333-209252) of Centene Corporation of our reports, dated February 19, 2019, with respect to the consolidated balance sheets of Centene Corporation and subsidiaries as of December 31, 2018 and 2017, and the related consolidated statements of operations, comprehensive earnings, stockholders' equity, and cash flows for each of the years in the three-year period ended December 31, 2018, and the related notes (collectively, the consolidated financial statements), and the effectiveness of internal control over financial reporting as of December 31, 2018, which reports appear in the December 31, 2018 annual report on Form 10-K of Centene Corporation.

Our report dated February 19, 2019, on the effectiveness of internal control over financial reporting as of December 31, 2018, contains an explanatory paragraph that states the Company acquired Fidelis Care on July 1, 2018. Fidelis Care had total assets representing 19% of consolidated assets and total revenues representing 9% of consolidated revenues, as of and for the year ended December 31, 2018. Management excluded from its assessment of the effectiveness of the Company's internal control over financial reporting as of December 31, 2018, Fidelis Care's internal control over financial reporting. Our audit of internal control over financial reporting of the Company also excluded an evaluation of the internal control over financial reporting of Fidelis Care.

/s/ KPMG LLP

St. Louis, Missouri
February 19, 2019

EXHIBIT 31.1

CERTIFICATION

I, Michael F. Neidorff, certify that:

1. I have reviewed this Annual Report on Form 10-K of Centene Corporation;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

    a. Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

    b. Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

    c. Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

    d. Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

    a. All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

    b. Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: February 19, 2019

/s/ MICHAEL F. NEIDORFF

Chairman and Chief Executive Officer
(principal executive officer)

EXHIBIT 31.2

CERTIFICATION

I, Jeffrey A. Schwaneke, certify that:

1. I have reviewed this Annual Report on Form 10-K of Centene Corporation;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a. Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b. Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   c. Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d. Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting;

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   a. All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b. Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: February 19, 2019

/s/ JEFFREY A. SCHWANEKE

Executive Vice President and Chief Financial Officer
(principal financial officer)

EXHIBIT 32.1

CERTIFICATION PURSUANT TO 18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Annual Report on Form 10-K of Centene Corporation (the Company) for the period ended December 31, 2018, as filed with the Securities and Exchange Commission on the date hereof (the Report), the undersigned, Michael F. Neidorff, Chairman and Chief Executive Officer of the Company, hereby certifies, pursuant to 18 U.S.C. Section 1350, that:

(1) the Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: February 19, 2019

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

EXHIBIT 32.2

CERTIFICATION PURSUANT TO 18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Annual Report on Form 10-K of Centene Corporation (the Company) for the period ended December 31, 2018, as filed with the Securities and Exchange Commission on the date hereof (the Report), the undersigned, Jeffrey A. Schwaneke, Executive Vice President and Chief Financial Officer of the Company, hereby certifies, pursuant to 18 U.S.C. Section 1350, that:

(1) the Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: February 19, 2019	/s/ JEFFREY A. SCHWANEKE
	Executive Vice President and Chief Financial Officer *(principal financial officer)*