UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K

(Mark One)

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

For the fiscal year ended December 31, 2019

or

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

For the transition period from to

Commission file number: 001-31826

Centene Corporation

(Exact name of registrant as specified in its charter)

Delaware	**42-1406317**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification Number)

7700 Forsyth Boulevard		
St. Louis,	**Missouri**	**63105**
(Address of principal executive offices)		(Zip Code)

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

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

Title of Each Class	Trading Symbol(s)	Name of Each Exchange on Which Registered
Common Stock, $0.001 Par Value	**CNC**	**New York Stock Exchange**

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

None

(Title of Class)

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

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 ☐ No ☒

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 ☒ No ☐

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 ☒ No ☐

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

Large accelerated filer	☒	Accelerated filer ☐
Non-accelerated filer	☐	Smaller reporting company ☐
		Emerging growth company ☐

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. ☐

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

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, 2019, was $21.7 billion.

As of February 14, 2020, the registrant had 586,768,957 shares of common stock issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Proxy Statement for the registrant's 2020 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). Centene (the Company, our or we) intends 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 recently completed acquisition (the WellCare Acquisition) of WellCare Health Plans, Inc. (WellCare), other recent and future acquisitions, investments and the adequacy of our available cash resources. These statements may be found in the various sections of this filing, such as Part I, Item IA "Risk Factors," and Part I, Item 3. "Legal Proceedings," and Part II, Item 7. "Management's Discussion and Analysis of Financial Condition and Results of Operations."

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:

- uncertainty as to our expected financial performance following completion of the WellCare Acquisition;
- the possibility that the expected synergies and value creation from the WellCare Acquisition will not be realized, or will not be realized within the expected time period;
- the risk that unexpected costs will be incurred in connection with the integration of the WellCare Acquisition or that the integration of WellCare will be more difficult or time consuming than expected;
- unexpected costs, charges or expenses resulting from the WellCare Acquisition;
- the inability to retain key personnel;
- disruption from the completion of the WellCare Acquisition, including potential adverse reactions or changes to business relationships with customers, employees, suppliers or regulators, making it more difficult to maintain business and operational relationships;
- the risk that, following the WellCare Acquisition, we may not be able to effectively manage our expanded operations;
- 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 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 the Health Insurance Marketplaces and other commercial and Medicare products;
- 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 WellCare 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;
- disruption caused by significant completed and pending acquisitions, including, among others, the WellCare 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;
- changes in expected closing dates, estimated purchase price and accretion for acquisitions;
- the risk that acquired businesses, including WellCare, will not be integrated successfully;
- the risk that we may not be able to effectively manage our operations as they have expanded as a result of the WellCare Acquisition;
- restrictions and limitations in connection with our indebtedness;
- our ability to maintain or achieve improvement in the Centers for Medicare and Medicaid Services (CMS) Star ratings and maintain or achieve improvement in other quality scores in each case that can impact revenue and future growth;
- availability of debt and equity financing, on terms that are favorable to us;
- inflation; and
- foreign currency fluctuations.

This list of important factors is not intended to be exhaustive. We discuss certain of these matters more fully, as well as certain other factors that may affect our business operations, financial condition and results of operations, in our filings with the Securities and Exchange Commission (SEC), including quarterly reports on Form 10-Q and current reports on Form 8-K. Item 1A. "Risk Factors" of Part I 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).

	Year Ended December 31,		
	2019	2018	2017
GAAP net earnings attributable to Centene	$ 1,321	$ 900	$ 828
Amortization of acquired intangible assets	258	211	156
Acquisition related expenses	104	425	20
Other adjustments (1)	301	30	(7)
Income tax effects of adjustments (2)	(127)	(155)	(108)
Adjusted net earnings	$ 1,857	$ 1,411	$ 889
GAAP diluted earnings per share (EPS) attributable to Centene	$ 3.14	$ 2.26	$ 2.34
Amortization of acquired intangible assets (3)	0.47	0.41	0.28
Acquisition related expenses (4)	0.19	0.81	0.04
Other adjustments (1)	0.62	0.06	(0.14)
Adjusted Diluted EPS	$ 4.42	$ 3.54	$ 2.52

(1) Other adjustments include the following items:

2019 - (a) non-cash goodwill and intangible asset impairment of $271 million or $0.57 per diluted share, net of an income tax benefit of $0.08 and (b) debt extinguishment costs of $30 million or $0.05 per diluted share, net of an income tax benefit of $0.02;

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; 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.

(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 is net of an income tax benefit of $0.14, $0.12, and $0.16 per diluted share for the years ended December 31, 2019, 2018 and 2017, respectively.

(4) Acquisition related expenses are net of an income tax benefit of $0.06, $0.25 and $0.02 per diluted share for the years ended December 31, 2019, 2018 and 2017, respectively. Acquisition related expenses for 2019 include net carrying costs on the $7.0 billion senior notes issued in preparation of the WellCare acquisition of approximately $13 million, or $0.03 per diluted share, net of an income tax benefit of approximately $0.01 per diluted share.

	Year Ended December 31,		
	2019	2018	2017
GAAP selling, general and administrative expenses	$ 6,533	$ 6,043	$ 4,446
Acquisition related expenses	85	421	20
Penn Treaty assessment expense	—	—	56
Charitable contribution	—	—	40
Adjusted selling, general and administrative expenses	$ 6,448	$ 5,622	$ 4,330

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

OVERVIEW

We are a leading multi-national healthcare enterprise that is committed to helping people live healthier lives. We take a local approach - with local brands and local teams - to provide fully integrated, high-quality, and cost-effective services to government-sponsored and commercial healthcare programs, focusing on under-insured and uninsured individuals. 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 population 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, 2019, our Managed Care and Specialty Services segments accounted for 95% and 5%, respectively, of our total external revenues. Our membership totaled 15.2 million as of December 31, 2019. For the year ended December 31, 2019, our total revenues and net earnings attributable to Centene were $74.6 billion and $1.3 billion, respectively, and our total cash flow from operations was $1.5 billion.

WellCare Acquisition

On January 23, 2020, we acquired all of the issued and outstanding shares of WellCare Health Plans, Inc. (WellCare, and such acquisition, the WellCare Acquisition). The transaction is valued at approximately $19.6 billion, including the assumption of $1.95 billion of outstanding debt. The cash portion of the acquisition was funded through the issuance of long-term debt in December 2019. The WellCare Acquisition brings a high-quality Medicare platform and further extends our robust Medicaid offerings. The WellCare Acquisition also enables us to provide access to more comprehensive and differentiated solutions across more markets with a continued focus on affordable, high-quality, culturally-sensitive healthcare services. With the WellCare Acquisition, we further broadened our product offerings by adding a Medicare prescription drug plan to our existing business lines. The business discussion reflects only Centene operations in 2019, prior to the completion of the WellCare Acquisition, unless specifically noted.

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.

Under the Affordable Care Act (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, 94% of the costs in 2018, 93% of the costs in 2019, and 90% of the costs in 2020. Assuming that the current program remains in effect unchanged, in subsequent years the federal share is scheduled to remain at 90%.

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, 24 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 $595 billion in 2018, and estimated the market will grow to $1.0 trillion by 2027. Medicaid spending is estimated to have increased by 2.2% in 2018 and is projected to increase at an average annual rate of 5.5% between 2018 and 2027.

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 improved the quality of care for Medicaid beneficiaries and lowered 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

Established in 2010 and operational in 2014, the ACA created Health Insurance Marketplaces, which 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 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 generally between 100-400% of the federal poverty level, with some exceptions, to help them purchase insurance through the Marketplaces. These subsidies are offered on a sliding scale basis.

We also offer commercial healthcare products to individuals through large and small employer groups. We offer 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. Coverage typically is subject to deductibles and copayments or coinsurance.

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. The Medicare program provides health care coverage primarily to individuals age 65 or older as well as to individuals with certain disabilities.

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 10.9 million dual-eligible enrollees in 2018. 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 Aged, Blind and Disabled (ABD), Long Term Services and Supports (LTSS), Medicare-Medicaid Plans (MMP) and Medicare Advantage Dual Special Needs Plan (DSNP) 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 $747 billion in 2018, and estimated the market will grow to approximately $1.4 trillion by 2027. Medicare spending is estimated to have increased 5.9% in fiscal 2018 and is projected to increase at an average annual rate of 7.4% between 2018 and 2027.

International

We currently have a growing international presence in Spain, the United Kingdom (UK) and Slovakia. In June 2019, we purchased an additional 40% ownership in Ribera Salud for $54 million, bringing our total ownership to 90%. Ribera Salud manages health administration concessions in various regions in Spain. In the UK, our subsidiary, Operose Health (Group) Limited (Operose Health), is one of the largest provider networks and 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. We also have additional noncontrolling investments in the UK. Our equity method investee in Slovakia provides radiology services in the region.

OUR COMPETITIVE STRENGTHS

Our approach is based on the following key competitive strengths:

- *Expertise in Government Sponsored Programs.* For more than 35 years, we have developed a specialized services expertise that has helped us establish and maintain relationships with members, providers and our government customers. We have implemented programs developed to achieve savings for our government customers 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 population health 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 My Health Pays 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 platforms we have developed for our existing states for configuration into new states or health plan acquisitions. We believe our predictive modeling technology enables our population health 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 approximately $75 billion in revenue and $1.5 billion in operating cash flow in 2019. 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 a 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. In 2020, we expanded our Health Insurance Marketplace footprints in several existing markets, and we completed the WellCare Acquisition, further expanding our scale and presence. In addition, a nationally recognized statistical rating organization recently raised our long-term issuer credit rating to an investment grade rating.

- *Diversified Business Lines.* We continue to broaden our service offerings to address areas that we believe have been traditionally under-served by Medicaid and Medicare managed care organizations. In addition to our Medicaid, Medicare, and Medicaid-related managed care services, our service offerings include behavioral health management, care management software, correctional healthcare services, dental benefits management, commercial programs, primary care services, life and health management, vision benefits management, pharmacy benefits management, specialty pharmacy, telehealth services and government-sponsored care under its federal contracts with the Department of Defense (DoD). 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 2019, we served managed care members in 30 states through approximately 350 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 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; and
- 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.

- *Readmission Reduction* aims to reduce preventable readmissions by ensuring optimal transitional care from acute and non-acute settings. The program focuses on post-hospitalization outreach (PHO), calls to members to verify they understand their discharge instructions, follow up with a Primary Care Physician (PCP), receive medication reconciliation, and, for the highest-risk members, are linked with a Community Health Worker.

- *Chronic Conditions* aims to improve the health and quality of life for members with diabetes, asthma, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), coronary artery disease (CAD), and/or hypertension. The program focuses on reducing emergent utilization and inpatient admissions by increasing treatment adherence, removing barriers to care, and enhancing self-management skills.

- *Fall Prevention* seeks to decrease the number and severity of older adult falls. The program also aims to support members in maintaining their safety, stability, and independence as long as possible. The program leverages an evidence-based falls prevention toolkit to identify members at risk of falling and provide education and interventions to reduce fall risk.

- *Compassionate Connections (Palliative Care)* works to identify members with at least one serious illness and provide necessary services to both members and those individuals close to them. Potential services may include detailed advanced care planning, a multi-team home visit and home health services, and additional social support. Providing palliative care services works to help alleviate members' suffering, and in turn, provide a better quality of life.

- *ER Diversion* strives to identify members' reasons for visiting the ER and educate them on optimal locations for care in the future. The program also identifies opportunities for members to better manage their chronic conditions with the help of Primary Care Physicians (PCP) and Care Managers.

- *Fluvention* works to decrease the spread of the flu by increasing the number of its managed care members that receive an annual flu vaccination. The campaign is designed to promote vaccinations as the key to flu prevention. Centene works to address these issues by utilizing enterprise-wide member and provider marketing and education, as well as increasing access to facilities that provide flu vaccinations.

- *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.

- *OpiEnd Youth Challenge* is a targeted curriculum for adolescents ages 9 through 14 to raise awareness about opioid misuse and prevention. As part of the challenge, teachers and students discuss significant attributes of addiction and opioid misuse, and students then show their understanding by developing and submitting campaign messaging that depicts ways to prevent misuse.

- *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.

- *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.

- *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.

- *My Health Pays* 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.

- *Preventive Care Programs* are designed to educate our members on the benefits of Early and Periodic Screening, Diagnosis and Treatment (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 of care delivery, cost management 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 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 can be paid under either a capitated or fee-for-service model. The arrangement, however, contains provisions for additional payments to the providers or reimbursement from the providers based upon their performance in 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 in a pay-for-performance arrangement before we transition to a risk-sharing arrangement, which is based on the total cost of care. 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 actionable financial and utilization information, physician and patient educational programs and disease and population health management programs. Our programs are also designed to help 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 service 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 panels. We 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 improved patient outcomes. Data and reporting are delivered via a secure, user-friendly web-based provider portal. This is all provided through our suite of proprietary technology, 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 population 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 population 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 population 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 population health programs focus on improving quality of care in areas that have the greatest impact on our members. We employ strategies, including 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 population health 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 23 of 25 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 and Health Net Oregon 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 contracts received 3.0 Stars. In addition, for the 2019 Star rating, we carry a 4.0 Star parent organization rating. Approximately 86% of our Medicare members are in a 4 star or above plan for the 2020 bonus year.

For the 2020 Star rating (calculated in 2019 for the quality bonus payment in 2021), our Texas D-SNP and Wisconsin D-SNP contracts received a 4.5 out of 5.0 Stars, and our California contracts received 4.0 Stars. The Oregon, New York, and Arkansas contracts measured at 3.5 Stars, and our Arizona, Florida, Texas HMO, South Carolina, and Georgia contracts received 3.0 Stars. In addition, for the 2020 Star rating, we carry a 3.5 Star parent organization rating. Approximately 46% of our Medicare members are in a 4 star or above plan for the 2021 bonus year.

We remain committed to our quality initiatives and expect to return to a 4.0 Star parent rating in the future. The parent organization Star rating is used for new Medicare contracts, while existing contracts follow their individual Star ratings to determine bonus payments.

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.

Envolve

Our Envolve brand brings together our extensive portfolio of specialty healthcare solutions. Envolve leverages our collective expertise to provide integrated and comprehensive healthcare for members and other organizations.

- *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. 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.

- *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.

- *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.

- *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.

Health Care Enterprises

Our Health Care Enterprises companies aim to improve health outcomes by developing more efficient care models to reduce healthcare costs.

- *Clinical Healthcare.* Community Medical Group (CMG) provides clinical healthcare, encompassing primary care, access to certain specialty services, and a suite of social and other support services. CMG operates in Florida through an at-risk primary care provider model, focusing on clinical and social care to at-risk beneficiaries.

- *Data Analytics.* 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.

- *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.

- *Third Party Administration*. HealthSmart provides customizable and scalable health plan solutions for self-funded employers, universities and colleges, and Native American Tribal Enterprises. Service offerings include plan administration, care management and wellness programs, network, casualty claim, and pharmacy benefit solutions.

Other Specialty Companies

Our other specialty companies provide a variety of products and services to complement and expand our business lines.

- *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.

- *Federal Services*. Health Net Federal Services (HNFS) has a Managed Support Contract in the West Region for the Department of Defense (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 Military Family and Life Counseling (MFLC) contract that was awarded by the DoD to implement, administer and monitor the non-medical counseling MFLC program.

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.

ENVIRONMENTAL, SOCIAL, GOVERANANCE AND CORPORATE RESPONSIBILITY

Our purpose is transforming the health of the community, one person at a time. The ultimate foundation of everything we do is centered on our purpose and the pillars that set us apart as a company: our focus on individuals, commitment to whole health, and active local involvement. With more than three decades of experience operating government-sponsored programs, we understand the importance of how environmental, including climate considerations, and social factors impact the long-term health and well-being of people. Our mission to attain better health outcomes at lower costs is supported by our culture of sound corporate governance to ensure quality, accessible, and affordable healthcare is available for all. Environmental consciousness, social responsibility, and sound governance have been guiding principles of our business since our humble beginnings launched by a former hospital bookkeeper, Elizabeth 'Betty' Brinn, in Milwaukee, Wisconsin. Betty's experience growing up in an orphanage enabled her to see an opportunity to make a difference in healthcare by focusing on the unique needs of the individual - including focusing on ensuring a healthy living environment and meeting social needs, such as employment opportunities, access to transportation, food and education. Corporate social responsibility is at the core of who we are and what we do. Our commitment to environmental, social, and governance matters and corporate responsibility are a living expression of our purpose as we strive to transform the health of our communities, one person at a time. In 2019, we communicated our commitment to corporate social responsibility efforts in five key areas: sustainability, governance, employee partnership, philanthropy, and community outreach and support, with special focus on the social determinants of health, which our founder, Betty Brinn, recognized as crucial to health and well-being in 1984. These five areas reflect Centene's long-term vision and full commitment to the communities we serve and those we will serve in the future. We understand the growing need to proactively address environmental challenges and climate-related factors to support the health of people today and for generations to come. We recognize the importance in providing clear and transparent information on our activities, initiatives, and plans related to environmental, social, and governance (ESG) topics.

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 includes, but is 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, Medicare and correctional 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, population health management, correctional healthcare 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 population health 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, population health 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 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. In December 2018, a 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 (i.e., that it was not "severable" from the ACA). That decision was appealed to the Fifth Circuit, which ruled in December 2019 that the individual mandate was unconstitutional after Congress eliminated the individual mandate penalty, and remanded the case to the district court for additional analysis on the question of severability. The ACA remains in effect until judicial review of the decision 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 DoD 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; and
- 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.

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), the General Data Protection Regulation (GDPR) in the European Union (EU), and 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. 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, 2019, we had approximately 56,600 employees. We believe our relationships with our employees are positive.

Information about our Executive Officers

The following table sets forth information regarding our executive officers, including their ages, at February 16, 2020:

Name	Age	Position
Michael F. Neidorff	77	Chairman, President and Chief Executive Officer
Kenneth A. Burdick	61	Executive Vice President, Markets & Products
Mark J. Brooks	50	Executive Vice President and Chief Information Officer
Brandy L. Burkhalter	47	Executive Vice President, Chief Operating Officer
Jesse N. Hunter	44	Executive Vice President and Chief Strategy Officer
Christopher R. Isaak	53	Senior Vice President, Corporate Controller and Chief Accounting Officer
Christopher A. Koster	55	Senior Vice President, Corporate Services
Jeffrey A. Schwaneke	44	Executive Vice President, Chief Financial Officer and Treasurer
David P. Thomas	54	Executive Vice President, Markets
Keith H. Williamson	67	Executive Vice President, General Counsel and Secretary

Michael F. Neidorff. Mr. Neidorff has served as our Chairman, President and Chief Executive Officer since April 2019. From November 2017 to April 2019, he served as our Chairman and Chief Executive Officer. 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.

Kenneth A. Burdick. Mr. Burdick joined Centene upon the closing of the WellCare Acquisition on January 23, 2020. From January 2015 through the closing of the WellCare Acquisition, he served as Chief Executive Officer of WellCare. From June 2014 to January 2015, he served as President and Chief Operating Officer of WellCare.

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 L. Burkhalter. Ms. Burkhalter has served as our Executive Vice President, Chief Operating Officer 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.

Christopher A. Koster. Mr. Koster has served as Senior Vice President, Corporate Services since 2017. Prior to joining Centene, Mr. Koster served as Missouri Attorney General for eight years.

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.

David P. Thomas. Mr. Thomas has served as our Executive Vice President of Markets since October 2019. From January 2019 through October 2019, he served as President and Chief Executive Officer of Fidelis Care. From May 2018 to December 2018, he served as President of Fidelis Care. He also previously served as Chief Operating Officer for Fidelis Care from January 2012 through April 2018.

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. Unless the context otherwise requires, the terms the "Company," "we," "us," "our" or similar terms and "Centene" refer to us, after giving effect to the WellCare Acquisition.

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

The majority of our revenues come from government subsidized healthcare programs including Medicaid, Medicare, TRICARE, 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 approximately 60%. We are therefore exposed to risks associated with federal 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 them, 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, 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 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 one or more contracts for the convenience of the government, may materially and adversely affect our results of operations, financial position and cash flows. In addition, if another federal government shutdown were to occur for a prolonged period of time, federal government payment obligations, including its obligations under Medicaid, Medicare, TRICARE, 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 2020 rating year is 3.5, which may negatively affect quality bonus payments for Medicare Advantage plans in 2021. The lowered Star rating for the 2020 rating year may have reduced the attractiveness of the affected plans and our other offerings to members, reduce revenue from the affected plans 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.

Although we do not anticipate that a single-payer national health insurance system will be enacted by the current Congress, several legislative initiatives have been proposed by members of Congress and presidential candidates that would establish some form of a single public or quasi-public agency that organizes healthcare financing, but under which healthcare delivery would remain private. If enacted, such a system could adversely affect our business.

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 depends to a significant degree 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 (such as the coronavirus), 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 removal of the penalty associated with the ACA's individual mandate in 2019.

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, changes to, or judicial challenges to the ACA, could materially and adversely affect our results of operations, financial position and cash flows.

The enactment of the ACA in March 2010 transformed the U.S. healthcare delivery system through a series of complex initiatives; however, the implementation of the ACA continues to face judicial challenges as well as challenges from the current administration to repeal or change certain of its significant provisions. 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 continue to propose changes impacting implementation of the ACA, which could materially and adversely affect our financial position or operations.

Among the most significant of the ACA's provisions was the establishment of the Health Insurance Marketplace for individuals and small employers to purchase health insurance coverage that included a minimum level of benefits and restrictions on coverage limitations and premium rates, as well as the expansion of Medicaid coverage 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 HHS additionally indicated that it would consider a limited number of premium assistance demonstration proposals from states that want to privatize Medicaid expansion. 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 on January 1, 2014. Several states have obtained Section 1115 waivers to implement the ACA's Medicaid expansion in ways that extend beyond the flexibility provided by the federal law, with additional states pursuing Section 1115 waivers regarding eligibility criteria, benefits and cost-sharing, and provider payments across their Medicaid programs. Litigation challenging Section 1115 waiver activity for both new and previously approved waivers is expected to continue both through administrative actions and the courts.

There have been significant efforts by the current administration to repeal, or limit implementation of, certain provisions of the ACA through changes in regulations. Such initiatives include repeal of the individual mandate effective in 2019, as well as easing the regulatory restrictions placed on short-term health plans and association health plans (AHPs), which plans often provide fewer benefits than the traditional ACA insurance benefits.

Additionally, the U.S. Department of Labor issued a final rule on June 19, 2018 which expanded flexibility regarding the regulation and formation of AHPs provided by small employer groups and associations. On June 13, 2019, the HHS, the U.S. Department of Labor and the U.S. Treasury issued a final rule allowing employers of all sizes that do not offer a group coverage plan to fund a new kind of health reimbursement arrangement (HRA), known as an individual coverage HRA (ICHRA). Beginning January 1, 2020, employees are able to use employer-funded ICHRAs to buy individual-market insurance, including insurance purchased on the public exchanges formed under the ACA.

In addition to efforts by the current administration to expand the flexibility of other insurance plan options that are not required to meet ACA requirements, there have also been efforts to address the ACA's non-deductible tax imposed on health insurers based on prior year net premiums written (the "health insurer fee" or "HIF"). The ACA imposed HIF was $8.0 billion in 2014, and $11.3 billion in each of 2015 and 2016, with increasing annual amounts thereafter. The HIF payable in 2017 was suspended by the Consolidated Appropriations Act for fiscal year 2016; however, a $14.3 billion payment occurred in 2018. Collection of the HIF for 2019 was also suspended, but resumed in 2020 with an anticipated $15.5 billion payment. Congress passed a spending bill in December 2019, which would repeal the health insurance tax indefinitely, effective in 2021. There is continuing litigation pending against the federal government regarding the requirement to reimburse Medicaid managed care organizations for the health insurer fee. If we are not reimbursed by the states for the cost of the HIF (including the associated tax impact), or if we are unable to otherwise adjust our business model to address the current assessment, our results of operations, financial position and cash flows may be materially adversely affected.

The constitutionality of the ACA itself continues to face judicial challenge. In December 2018, a 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 (i.e., that it was not "severable" from the ACA). That decision was appealed to the Fifth Circuit, which ruled in December 2019 that the individual mandate was unconstitutional after Congress set the individual mandate penalty to $0, and remanded the case to the district court for additional analysis on the question of severability. The ACA remains in effect until judicial review of the decision 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.

These changes and other potential changes involving the functioning of the Health Insurance Marketplace 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.

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 Tax Cuts and Jobs Act (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, are subject to a high degree of estimation and variability, and are affected by our members' acuity relative to the membership acuity of other insurers. 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.

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 or federal level in the United States or internationally 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 premiums 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 and rebate 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. 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. 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. 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.

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. CMS subsequently issued a Notice of Proposed Rulemaking on November 8, 2018, advancing CMS' efforts to streamline the Medicaid and CHIP managed care regulatory framework and to pursue a broader strategy to relieve regulatory burdens, support state flexibility and local leadership, and promote transparency, flexibility, and innovation in the delivery of care. Public comments were submitted in January 2019; however, a final rule has yet to be issued. 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, either of which could materially and adversely affect our results of operations, financial position and cash flows.

In addition, as a result of the expansion of our businesses and operations conducted in foreign countries, we face political, economic, legal, compliance, regulatory, operational and other risks and exposures that are unique and vary by jurisdiction. These foreign regulatory requirements with respect to, among other items, environmental, tax, licensing, intellectual property, privacy, data protection, investment, capital, management control, labor relations, and fraud and corruption regulations are different than those faced by our domestic businesses. In addition, we are subject to U.S. laws that regulate the conduct and activities of U.S.-based businesses operating abroad, such as the Foreign Corrupt Practices Act (FCPA). Any 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 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 pharmacy benefit management (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 and regulators 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 structuring of rebates and 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 government entities 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 required 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 either new programs to determine eligibility or new processes to assign or enroll eligible members into health plans, or when it 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 we 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 further 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 diversify our business. 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 one or any 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. In addition to state corporate law limitations, these subsidiaries are subject to more stringent state insurance and HMO laws and 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 significant portion of our premium revenues from operations in a limited number of states, and our financial position, results of operations or cash flows could 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 a significant portion 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. In addition, we may from time to time obtain significant portions of our systems-related or other services or facilities from independent third parties, which may make our operations vulnerable if such third parties fail to perform adequately.

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 EU's 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, waste and abuse laws applicable to healthcare companies. HIPAA established new enforcement mechanisms to combat fraud, waste 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. The HHS Office for Civil Rights received $28.7 million from enforcement actions in 2018, surpassing the previous record of $23.5 million from 2016 by 22 percent. It is possible that Congress may enact additional legislation in the future to increase the amount or application of 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.

If we fail to comply with the extensive federal and state fraud, waste 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, waste 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, waste 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 and other federal healthcare programs and federally funded state health programs. Fraud, waste 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, 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 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 (private parties acting on the government's behalf). Federal and state governments have made investigating and prosecuting healthcare fraud, waste and abuse a priority. In the event we fail to comply with the extensive federal and state fraud, waste 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 prevention and detection 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 or if any financing related to the acquisitions is on unfavorable terms. 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 existing business with acquired businesses, and realize the anticipated benefits of such acquisitions.

The success of acquisitions we make will depend, in part, on our ability to successfully combine the existing business of Centene with such acquired businesses 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 acquired businesses 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 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 ability to successfully manage the expanded business following any given acquisition 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 acquisitions 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, 2019, we had consolidated indebtedness of approximately $13,726 million, excluding the notes issued in the exchange offer described below, and we may further increase our indebtedness in the future. In connection with the WellCare Acquisition, we completed an exchange offer for 5.25% Senior Notes due 2025 and 5.375% Senior Notes due 2026 (collectively, the WellCare Notes) issued by WellCare and issued $1,146 million aggregate principal amount of 5.25% Senior Notes due 2025 and $747 million aggregate principal amount of 5.375% Senior Notes due 2026. Additionally, our wholly-owned subsidiary, Wellington Merger Sub II, Inc. assumed the remaining WellCare Notes. 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 term loan facility (collectively, the Company Credit Agreement) 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 certain investments or other restricted payments, sell or otherwise dispose of substantially all of our assets and engage in other activities. Our Company Credit Facility also requires us to comply with a maximum debt-to-EBITDA 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 Company 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, 2019, we held $2.1 billion notional amount of interest rate swaps that use the London interbank offered rate (LIBOR) as a reference rate and borrowings under our Company Credit Facility 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.

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.

The WellCare Acquisition may not be accretive and may cause dilution to our earnings per share, which may negatively affect the market price of our common stock.

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

We may be unable to successfully integrate our business with WellCare and realize the anticipated benefits of the WellCare Acquisition.

The success of the WellCare Acquisition will depend, in part, on our ability to successfully combine the businesses of Centene and WellCare and realize the anticipated benefits, including synergies, cost savings, innovation and operational efficiencies, from the combination. If we are unable to achieve these objectives within the anticipated time frame, or at all, the anticipated benefits may not be realized fully or at all, or may take longer to realize than expected and the value of its common stock may be harmed.

The WellCare Acquisition involves the integration of WellCare's business with our existing business, which is a complex, costly and time-consuming process. We have not previously completed an acquisition comparable in size or scope to the WellCare Acquisition. The integration of the two companies may result in material challenges, including, without limitation:

- the diversion of management's attention from ongoing business concerns and performance shortfalls at one or both of the companies as a result of the devotion of management's attention to the WellCare Acquisition;
- managing a larger company;
- maintaining employee morale and attracting and motivating and retaining management personnel and other key 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 WellCare Acquisition; and
- achieving actual cost savings of the WellCare Acquisition at the anticipated levels.

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 following the completion of the WellCare Acquisition.

Our ability to successfully manage this expanded business following the completion of the WellCare Acquisition will depend, in part, upon management's ability to design and implement strategic initiatives that address not only the integration of two independent stand-alone companies, but also the increased scale and scope of our business with its associated increased costs and complexity. There can be no assurances that we will be successful or that we will realize the expected operating efficiencies, cost savings and other benefits currently anticipated from the WellCare Acquisition.

We are expected to incur substantial expenses related to integration of our business with WellCare.

We expect to incur substantial expenses in connection with the integration of our business with WellCare. 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 and WellCare's businesses will continue to maintain a presence in St. Louis, Missouri and Tampa, Florida, respectively. The substantial majority of these costs will be non-recurring expenses related to the WellCare Acquisition (including financing of the WellCare Acquisition), facilities and systems consolidation costs. We may incur additional costs to maintain employee morale and to attract, motivate or retain management personnel and other key employees. We have incurred and will continue to incur Acquisition fees and costs related to formulating integration plans for the combined business, and the execution of these plans may lead to additional unanticipated costs. Additionally, as a result of the WellCare Acquisition, rating agencies may take negative actions with regard to the company's credit ratings, which may increase the our financing costs, including in connection with the financing of the WellCare Acquisition.

The financing arrangements that the we entered into in connection with the WellCare Acquisition may, under certain circumstances, contain restrictions and limitations that could significantly impact the our ability to operate its business.

We incurred significant new indebtedness in connection with the WellCare Acquisition. The agreements governing the indebtedness that we incurred in connection with the WellCare Acquisition contain covenants that, among other things, may, under certain circumstances, place limitations on the dollar amounts paid or other actions relating to:

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

In addition, we are required to maintain a minimum amount of excess availability as set forth in these agreements.

Our ability to maintain minimum excess availability in future periods will depend on our ongoing financial and operating performance, which in turn will be subject to economic conditions and to financial, market and competitive factors, many of which are beyond our control. The ability to comply with this covenant in future periods will also depend on our ability to successfully implement its overall business strategy and realize the anticipated benefits of the WellCare Acquisition, including synergies, cost savings, innovation and operational efficiencies.

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

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 18. *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.

	2020 Stock Price (through February 14, 2020)		2019 Stock Price		2018 Stock Price	
	High	Low	High	Low	High	Low
First Quarter	$ 68.64	$ 60.50	$ 69.25	$ 49.56	$ 56.21	$ 48.81
Second Quarter			58.25	45.44	63.15	52.14
Third Quarter			54.89	42.77	74.12	60.51
Fourth Quarter			63.79	41.62	74.49	54.25

As of February 14, 2020, there were 1,134 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 initial program authorized the repurchase of up to 6.7 million shares of our common stock from time to time on the open market or through privately negotiated transactions. In October 2019, our Board of Directors approved a $500 million increase to our Company's stock repurchase program, based on the stock price at the close of the WellCare Acquisition. Based on the closing stock price of $66.76 on January 22, 2020, we have approximately 14.2 million available shares remaining under the program for repurchases as of December 31, 2019. 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, 2019, we did not repurchase any shares through this publicly announced program.

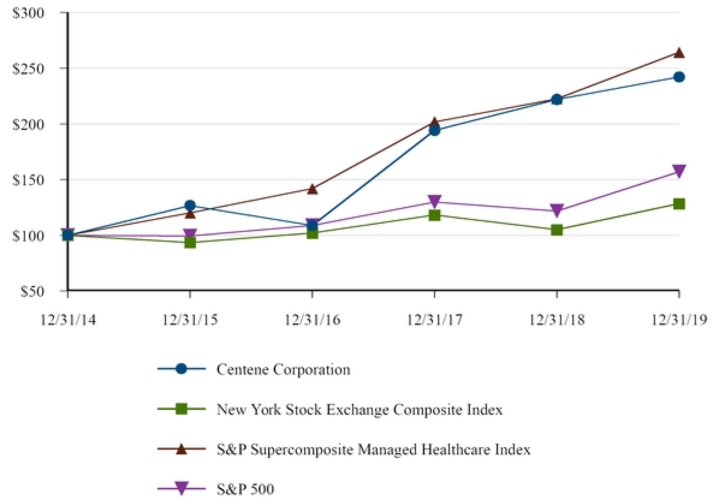
Issuer Purchases of Equity Securities
Fourth Quarter 2019
(shares in thousands)

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, 2019	2	$ 43.91	—	14,160
November 1 – November 30, 2019	3	54.50	—	14,160
December 1 – December 31, 2019	581	59.01	—	14,160
Total	586	$ 58.92	—	14,160

(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 14,160 thousand shares.

Stock Performance Graph

The graph below compares the cumulative total stockholder return on our common stock for the period from December 31, 2014 to December 31, 2019 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, 2014 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,					
	2014	2015	2016	2017	2018	2019
Centene Corporation	$ 100.00	$ 126.72	$ 108.82	$ 194.22	$ 221.99	$ 242.09
New York Stock Exchange Composite Index	100.00	93.58	102.01	118.17	104.94	128.36
S&P Supercomposite Managed Healthcare Index	100.00	120.04	141.90	201.86	222.62	264.13
S&P 500	100.00	99.27	108.74	129.86	121.76	156.92
Centene Corporation closing stock price	$ 25.97	$ 32.91	$ 28.26	$ 50.44	$ 57.65	$ 62.87
Centene Corporation annual stockholder return	76.2%	26.7%	(14.1)%	78.5%	14.3%	9.1%

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,				
	2019	2018	2017	2016	2015
	(In millions, except share data in dollars and membership data)				
Consolidating Operating Results					
Total Revenues	$ 74,639	$ 60,116	$ 48,382	$ 40,607	$ 22,760
Net earnings attributable to Centene Corporation	$ 1,321	$ 900	$ 828	$ 562	$ 355
Basic net earnings per share attributable to Centene Corporation	$ 3.19	$ 2.31	$ 2.40	$ 1.76	$ 1.49
Diluted net earnings per share attributable to Centene Corporation	$ 3.14	$ 2.26	$ 2.34	$ 1.71	$ 1.44
Health benefits ratio (1)	87.3%	85.9%	87.3%	86.5%	88.9%
Selling, general and administrative expense ratio (2)	9.3%	10.7%	9.7%	9.8%	8.5%
Membership	15,241,800	14,171,200	12,207,100	11,441,800	5,107,900
Consolidated Balance Sheet Data					
Cash and cash equivalents, Investments and Restricted deposits	$ 21,361	$ 13,480	$ 10,050	$ 9,118	$ 3,978
Total assets	40,994	30,901	21,855	20,197	7,339
Medical claims liability	7,473	6,831	4,286	3,929	2,298
Long-term debt	13,638	6,648	4,695	4,651	1,216
Total stockholders' equity	12,659	11,013	6,864	5,909	2,168

(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. The following discussion and analysis does not include certain items related to the year ended December 31, 2017, including year-to-year comparisons between the year ended December 31, 2018 and the year ended December 31, 2017. For a comparison of our results of operations for the fiscal years ended December 31, 2018 and December 31, 2017, see Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations of our Annual Report on Form 10-K for the year ended December 31, 2018, filed with the SEC on February 19, 2019.

EXECUTIVE OVERVIEW

General

We are a leading multi-national healthcare enterprise that is committed to helping people live healthier lives. We take a local approach - with local brands and local teams - to provide fully integrated, high-quality, and cost-effective services to government-sponsored and commercial healthcare programs, focusing on under-insured and uninsured individuals.

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.

Our insurance subsidiaries are subject to the Affordable Care Act annual health insurer fee (HIF), absent a HIF moratorium. The Affordable Care Act (ACA) imposed the HIF in 2018, however the HIF was suspended in 2019. In 2018, we recognized revenue for reimbursement of the HIF, including the "gross-up" to reflect the non-deductibility of the HIF. 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. Due to the size of the HIF fee, one of the primary drivers of the year-over-year variances discussed throughout this section is related to the moratorium in 2019.

WellCare Acquisition

On January 23, 2020, we acquired all of the issued and outstanding shares of WellCare Health Plans, Inc. (WellCare) (the WellCare Acquisition). The transaction is valued at approximately $19.6 billion, including the assumption of $1.95 billion of outstanding debt. Consideration for the acquisition consisted of Centene common shares valued at $11.4 billion (based on Centene's stock price of $66.76), $6.08 billion in cash, and $95 million related to the fair value of replacement equity awards associated with pre-combination service. Each WellCare share was converted into 3.38 of a validly issued, fully paid, non-assessable shares of Centene common stock and $120.00 in cash. In total, 171 million shares of Centene common stock were issued to the WellCare stockholders. The cash portion of the acquisition consideration was funded through the issuance of long-term debt in December 2019. We issued approximately $1.0 billion 4.75% Senior Notes due 2025 (the Additional 2025 Notes), $2.5 billion 4.25% Senior Notes due 2027 (the 2027 Notes), and $3.5 billion 4.625% Senior Notes due 2029 (the 2029 Notes). The net proceeds of the 2027 Notes and the 2029 Notes and a portion of the net proceeds of the Additional 2025 Notes were used to finance the cash consideration.

The WellCare Acquisition brings a high-quality Medicare platform and further extends our robust Medicaid offerings. The combination enables us to provide access to more comprehensive and differentiated solutions across more markets with a continued focus on affordable, high-quality, culturally-sensitive healthcare services.

Immediately prior to the closing of the WellCare Acquisition, Anthem, Inc. acquired WellCare's Missouri Medicaid health plan, a WellCare Missouri Medicare Advantage health plan, and WellCare's Nebraska Medicaid health plan. CVS Health Corporation acquired portions of Centene's Illinois Medicaid and Medicare Advantage health plans as part of previously announced divestiture agreements.

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, including a working capital adjustment. Due to the size of the acquisition, one of the primary drivers of the year-over-year variances discussed throughout this section for the year ended December 31, 2019, is related to the acquisition of Fidelis Care.

International

In Spain, in June 2019, we purchased an additional 40% ownership in Ribera Salud from Banco Sabadell for $54 million, bringing our total ownership to 90%. In December 2019, our Spanish subsidiary, Ribera Salud, acquired 93% of Hospital Povisa, S.A., a private hospital in the Vigo region of Spain.

Regulatory Trends and Uncertainties

The United States government, politicians, and healthcare experts continue to discuss and debate various elements of the United States healthcare payment model. From the constitutionality of the Affordable Care Act, to Medicare for All (single payer), to pharmacy pricing structures, all areas of healthcare are being challenged to assure adequate healthcare is delivered to all segments of the population.

During this time of deliberation, we remain focused on the promise of delivering access to high quality, affordable healthcare to all of our members and believe we are well positioned to meet the needs of the changing healthcare landscape. 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 under-insured and uninsured families, commercial organizations and military families. This expertise has allowed us to deliver cost effective services to our government sponsors and our members. While healthcare experts maintain focus on personalized healthcare technology, we continue to make strategic decisions to accelerate development of new software platforms and analytical capabilities. 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*."

2019 Highlights

Our financial performance for 2019 is summarized as follows:

- Year-end managed care membership of 15.2 million, an increase of 1.1 million members, or 8% over 2018.
- Total revenues of $74.6 billion, representing 24% growth year-over-year.
- HBR of 87.3% for 2019, compared to 85.9% for 2018.
- SG&A expense ratio of 9.3% for 2019, compared to 10.7% for 2018.
- Adjusted SG&A expense ratio of 9.2% for 2019, compared to 10.0% for 2018.
- Diluted EPS of $3.14 for 2019, compared to $2.26 for 2018.
- Adjusted Diluted EPS of $4.42 for 2019, compared to $3.54 for 2018.
- Operating cash flows of $1.5 billion, or 1.1 times net earnings, for 2019.

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,	
	2019	**2018**
GAAP diluted EPS attributable to Centene	$ 3.14	$ 2.26
Amortization of acquired intangible assets	0.47	0.41
Acquisition related expenses	0.19	0.81
Other adjustments (1)	0.62	0.06
Adjusted Diluted EPS	$ 4.42	$ 3.54

(1) Other adjustments include the following items:

- 2019 - non-cash goodwill and intangible asset impairment of $271 million or $0.57 per diluted share, net of an income tax benefit of $0.08 and debt extinguishment costs of $30 million or $0.05 per diluted share, net of an income tax benefit of $0.02; and
- 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.

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.

- 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 2019:

- *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 and Southern regions.

- *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 assumed full-risk on this population 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 Florida.

- *Correctional.* In July 2019, Centurion began operating under a contract to provide comprehensive healthcare services to inmates housed in Arizona's state prison system, and also began operating under a re-awarded contract to continue the provision of mental and dental health services to the Georgia Department of Correction's state prison facilities. 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 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 July 2018, Centurion began operating under a contract to provide healthcare services for correctional facilities in Pima County, Arizona. 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 addition, during 2018, Centurion's contracts for correctional facilities were reprocured in New Hampshire and Tennessee.

- *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.
- *Florida.* In December 2018, our Florida subsidiary, Sunshine Health, began providing physical and behavioral healthcare 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.
- *Health Insurance Marketplace*. In January 2019, we expanded our offerings in the 2019 Health Insurance Marketplace. We entered Pennsylvania, North Carolina, South Carolina, and Tennessee, and expanded our footprint in six existing markets: Florida, Georgia, Indiana, Kansas, Missouri, and Texas. In January 2018, we expanded our offerings in the 2018 Health Insurance Marketplace. We entered Kansas, Missouri and Nevada, and expanded our footprint in the following six existing markets: Florida, Georgia, Indiana, Ohio, Texas, and Washington.
- *Health Net Federal Services.* In January 2018, our subsidiary, Health Net Federal Services, began operating under the TRICARE West Region contract to provide administrative services to Military Health System eligible beneficiaries.
- *HealthSmart*. In May 2019, we acquired HealthSmart, a third party administrator providing customizable and scalable health plan solutions for self-funded employers, universities and colleges, and Native American Tribal Enterprises. Services include plan administration, care management and wellness programs, network, casualty claim, and pharmacy benefit solutions.
- *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.
- *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%.
- *Iowa.* In July 2019, our Iowa subsidiary, Iowa Total Care, Inc., began operating under a new statewide contract for the IA Health Link Program.
- *Kansas.* In January 2019, our Kansas subsidiary, Sunflower Health Plan, continued providing managed care services to KanCare beneficiaries statewide under a new contract.
- *Medicare.* In January 2019, we expanded our Medicare offerings, entering Illinois and New Mexico. 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.
- *New Hampshire.* In September 2019, our New Hampshire subsidiary, NH Healthy Families, began operating under a new five-year contract to continue to provide service to Medicaid enrollees statewide.
- *New Mexico.* 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.
- *Pennsylvania.* In January 2018, our Pennsylvania subsidiary, Pennsylvania Health and Wellness, began serving enrollees in the Community HealthChoices program as part of the statewide contract that was fully implemented in January 2020.
- *QualChoice.* In April 2019, we completed the acquisition of QCA Health Plan, Inc. and QualChoice Life and Health Insurance Company, Inc. The acquisition expands our footprint in Arkansas by adding additional members primarily through commercial products.
- *Spain.* In December 2019, our Spanish subsidiary, Ribera Salud, acquired 93% of Hospital Povisa, S.A., a private hospital in the Vigo region of Spain. In June 2019, Primero Salud, acquired additional ownership in Ribera Salud, increasing our ownership in the Spanish healthcare company from 50% to 90%. In December 2018, Primero Salud acquired 89% of Torrejón Salud, a public-private partnership in the Community of Madrid.

- *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. This integration continued into 2019 with the addition of the Greater Columbia, King and Pierce Regions going live January 2019, followed by the North Sound Region in July 2019.

- In addition, we realized the full year benefit in 2019 of acquisitions, investments, and business commenced during 2018.

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

- Beginning January 1, 2019, Health Net of Arizona, Inc. began discontinuing and non-renewing all of its Employer Group plans for small and large business groups in Arizona. The effective date of coverage termination for existing groups is dependent on remaining renewals; however, coverage is no longer provided to any group policyholders and/or members as of December 31, 2019.

- In 2018, we were successful in reprocuring our contracts in Mississippi, New Hampshire and Washington. However, the Medicaid programs were expanded to include additional insurers, which has reduced our market share.

- We no longer serve Medicaid and correctional members in Massachusetts.

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

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

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

- We expect to realize the full year benefit in 2020 of acquisitions, investments, and business commenced during 2019, as discussed above.

- In February 2020, we began operating in Illinois under the first phase of an expanded contract for the Medicaid Managed Care Program. The expanded contract includes children who are in need through the Department of Children and Family Services/Youth Care by the Illinois Department of Healthcare and Family Services and Foster Care.

- In January 2020, we completed the WellCare Acquisition. The WellCare Acquisition brings a high-quality Medicare platform and further extends our robust Medicaid offerings. The WellCare Acquisition is a key part of our growth as we become one of the nation's largest sponsors of government health coverage. The transaction is valued at approximately $19.6 billion, including the assumption of $1.95 billion of outstanding debt.

- In January 2020, we expanded our offerings in the Health Insurance Marketplace in ten existing markets: Arizona, Florida, Georgia, Kansas, North Carolina, Ohio, South Carolina, Tennessee, Texas and Washington.

- In January 2020, our Louisiana subsidiary, Louisiana Healthcare Connections, began operating under a one-year emergency contract extension in response to protested contract awards. Louisiana's state procurement officer overturned the Louisiana Department of Health's plan to award Medicaid contracts to four health plans, excluding our Louisiana subsidiary. According to the chief procurement officer, the state health department failed to follow state law or its own evaluation and bid guidelines in its award.

- In November 2019, our Texas subsidiary, Superior HealthPlan, was awarded by the Texas Health and Human Services Commission a contract to continue to provide healthcare services to enrollees in the state's STAR+PLUS program. The contract is expected to be effective on September 1, 2020, and will allow Superior HealthPlan to offer coverage in two new service areas, for a total of nine service areas.

- In October 2019, our North Carolina joint venture, Carolina Complete Health, was awarded an additional service area to provide Medicaid managed care services in Region 4. With the addition of this new Region, Carolina Complete Health will provide Medicaid managed care services in three contiguous regions: Region 3, 4 and 5. The new three-year contract is expected to commence in the second half of 2020.

- 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.

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

- In January 2020, in connection with the WellCare Acquisition, we completed the divestiture of certain products in our Illinois health plan, including the Medicaid and Medicare Advantage lines of business.

- Effective December 2019, we no longer serve under the state-wide correctional contract in New Mexico.

- In October 2019, CMS published updated Medicare Star quality ratings for the 2020 rating year. Approximately 46% of our Medicare members are in a 4 star or above plan for the 2021 bonus year, compared to approximately 86% for the 2020 bonus year. Our quality bonus and rebates may be negatively impacted in 2021.

- In July 2019, our Oregon subsidiary, Trillium Community Health Plan, was notified by the Oregon Health Authority (OHA) of its intent to award Trillium Community Health Plan an expanded contract to serve as a coordinated care organization for six counties in the state; however, an additional competitor was added to Lane County. As a result, our membership is expected to decrease. Pending successful completion of OHA's readiness review and additional contract negotiations, the contract is expected to begin July 2020.

MEMBERSHIP

From December 31, 2018 to December 31, 2019, we increased our managed care membership by 1.1 million, or 8%. The following table sets forth our membership by line of business:

	December 31	
	2019	**2018**
Medicaid:		
TANF, CHIP & Foster Care	7,528,700	7,356,200
ABD & LTSS	1,043,500	1,002,100
Behavioral Health	66,500	36,500
Total Medicaid	8,638,700	8,394,800
Commercial	2,331,100	1,978,000
Medicare (1)	404,500	416,900
International	599,800	151,600
Correctional	180,000	151,300
Total at-risk membership	12,154,100	11,092,600
TRICARE eligibles	2,860,700	2,858,900
Non-risk membership	227,000	219,700
Total	15,241,800	14,171,200

(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	
	2019	2018
Dual-eligible [2]	639,200	598,200
Health Insurance Marketplace	1,805,200	1,459,100
Medicaid Expansion	1,346,700	1,262,100

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

From December 31, 2018 to December 31, 2019, our membership increased as a result of:

- membership growth in our Health Insurance Marketplace business;
- international acquisitions; and
- expansions and new programs in many of our states.

RESULTS OF OPERATIONS

The following discussion and analysis is based on our Consolidated Statements of Operations, which reflect our results of operations for years ended December 31, 2019, and 2018, respectively, prepared in accordance with generally accepted accounting principles in the United States ($ in millions, except per share data in dollars):

	2019	2018	% Change 2018-2019
Premium	$ 67,439	$ 53,629	26 %
Service	2,925	2,806	4 %
Premium and service revenues	70,364	56,435	25 %
Premium tax and health insurer fee	4,275	3,681	16 %
Total revenues	74,639	60,116	24 %
Medical costs	58,862	46,057	28 %
Cost of services	2,465	2,386	3 %
Selling, general and administrative expenses	6,533	6,043	8 %
Amortization of acquired intangible assets	258	211	22 %
Premium tax expense	4,469	3,252	37 %
Health insurer fee expense	—	709	n.m.
Goodwill and intangible impairment	271	—	n.m.
Earnings from operations	1,781	1,458	22 %
Other income (expense):			
Investment and other income	443	253	75 %
Debt extinguishment costs	(30)	—	n.m.
Interest expense	(412)	(343)	(20)%
Earnings from operations, before income tax expense	1,782	1,368	30 %
Income tax expense	473	474	— %
Net earnings	1,309	894	46 %
Loss attributable to noncontrolling interests	12	6	100 %
Net earnings attributable to Centene Corporation	$ 1,321	$ 900	47 %
Diluted earnings per common share attributable to Centene Corporation:	$ 3.14	$ 2.26	39 %

n.m.: not meaningful

<u>Year Ended December 31, 2019 Compared to Year Ended December 31, 2018</u>

Total Revenues

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

	2019	2018	% Change 2018-2019
Medicaid	$ 50,404	$ 39,427	28%
Commercial	14,747	12,391	19%
Medicare (1)	5,675	5,093	11%
Other	3,813	3,205	19%
Total Revenues	$ 74,639	$ 60,116	24%

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

Total revenues increased 24% in the year ended December 31, 2019, over the corresponding period in 2018, primarily due to the acquisition of Fidelis Care, growth in the Health Insurance Marketplace business, and expansions and new programs in many of our states in 2018 and 2019, particularly Arkansas, Illinois, Iowa, New Mexico and Pennsylvania. These increases were partially offset by the health insurer fee moratorium in 2019. Total revenues also increased due to at-risk, state directed and pass through payments of approximately $825 million from the State of California and pass through payments of approximately $531 million from the State of New York. During the twelve months ended December 31, 2019, we received Medicaid premium rate adjustments which yielded a net 2% 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, 2019 was 87.3%, an increase of 140 basis points over the comparable period in 2018. The HBR increase was primarily attributable to the Health Insurance Marketplace business where margins have normalized, as expected, from the favorable performance in 2018 and the health insurer fee moratorium. Also, the 2018 HBR benefited from the recognition of the IHSS program reconciliation.

Cost of Services

Cost of services increased by $79 million in the year ended December 31, 2019, compared to the corresponding period in 2018. The cost of service increase is primarily attributable to the operations of newly acquired businesses, partially offset by the Veterans Affairs contract expiration, effective October 2018.

The cost of service ratio for the year ended December 31, 2019 was 84.3%, compared to 85.0% in 2018. The decrease in the cost of service ratio was primarily due to the Veterans Affairs contract expiration.

Selling, General and Administrative Expenses

SG&A increased by $490 million in the year ended December 31, 2019, compared to the corresponding period in 2018. The SG&A increase was primarily attributable to the acquisition of Fidelis Care, expansions, new programs, and growth in many of our states in 2019, including growth in the Health Insurance Marketplace business, partially offset by a decrease in acquisition related costs.

The SG&A expense ratio was 9.3% for the year ended December 31, 2019, compared to 10.7% for the year ended December 31, 2018. The year-over-year decrease was primarily due to $336 million of lower acquisition related expenses. The Adjusted SG&A expense ratio was 9.2% for the year ended December 31, 2019, compared to 10.0% for the year ended December 31, 2018. Both ratios decreased due to the acquisition of Fidelis Care, which operates at a lower SG&A expense ratio, the Veterans Affairs contract expiration in 2018, and lower variable compensation costs in 2019.

Health Insurer Fee Expense

As a result of the health insurer fee moratorium, which suspended the health insurance provider fee for the 2019 calendar year, we did not record HIF expense for the year ended December 31, 2019, compared to $709 million for the year ended December 31, 2018.

Goodwill and Intangible Impairment

In 2019, we recorded $271 million, or $0.57 per diluted share, of non-cash goodwill and intangible asset impairment. Substantially all of the impairment is associated with our USMM physician home health business and was identified as part of our third quarter review procedures, which included an analysis of new information related to our shared savings demonstration programs, slower than expected penetration of the physician home health business model into our Medicaid population, and the related impact to revised forecasts. The business continues to generate positive cash flows and plays an important role in care management; however, it has fallen short of our overall performance expectations.

Other Income (Expense)

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

	2019	2018
Investment and other income	$ 443	$ 253
Debt extinguishment costs	(30)	—
Interest expense	(412)	(343)
Other income (expense), net	$ 1	$ (90)

Investment and other Income. Investment and other income increased by $190 million for year ended December 31, 2019 compared to 2018. The increase in investment income in 2019 reflects higher investment balances over 2018, including the proceeds of our $7.0 billion senior note issuance related to the planned financing for the cash consideration for the WellCare Acquisition and the impact of higher investment balances as a result of the Fidelis Care acquisition. The increase also reflects higher interest rates, the Ribera Salud acquisition gain of $16 million, and improved performance associated with our deferred compensation investment portfolio, which fluctuates with its underlying investments. The earnings from our deferred compensation portfolio were substantially offset by increases in deferred compensation expense, recorded in SG&A expense.

Debt Extinguishment costs. In October 2019, we redeemed the outstanding principal balance on the $1,400 million 5.625% Senior Notes due February 15, 2021, plus applicable premium for early redemption and accrued and unpaid interest through the redemption date. We recognized a pre-tax loss on extinguishment of $30 million on the redemption of the $1,400 million 5.625% Senior Notes, including the call premium, the write-off of unamortized debt issuance costs and a loss on the termination of the $600 million interest rate swap agreement associated with the notes.

Interest expense. Interest expense increased by $69 million in the year ended December 31, 2019, compared to the corresponding period in 2018. The increase is driven by a net increase in borrowings related to the issuance of an additional $7.0 billion in senior notes in December 2019, intended primarily to finance the cash consideration of the WellCare Acquisition, and increased borrowings in May 2018 related to the financing of the Fidelis Care acquisition.

The net impact of the $7.0 billion senior notes issued in preparation of the WellCare acquisition was approximately $13 million.

Income Tax Expense

For the year ended December 31, 2019, we recorded income tax expense of $473 million on pre-tax earnings of $1.8 billion, or an effective tax rate of 26.5%, which reflects the impact of the health insurer fee moratorium, partially offset by the non-deductibility of a portion of our non-cash goodwill and intangible impairment recorded in the third quarter of 2019. 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%, which reflects the impact of the non-deductibility of the health insurer fee.

Segment Results

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

	2019	2018	% Change 2018-2019
Total Revenues			
Managed Care	$ 71,379	$ 57,099	25 %
Specialty Services	13,781	12,506	10 %
Eliminations	(10,521)	(9,489)	(11)%
Consolidated Total	$ 74,639	$ 60,116	24 %
Earnings from Operations			
Managed Care	$ 1,806	$ 1,310	38 %
Specialty Services	(25)	148	(117)%
Consolidated Total	$ 1,781	$ 1,458	22 %

Managed Care

Total revenues increased 25% in the year ended December 31, 2019, compared to the corresponding period in 2018, primarily due to the acquisition of Fidelis Care, growth in the Health Insurance Marketplace business, and expansions and new programs in many of our states in 2018 and 2019, particularly Arkansas, Illinois, Iowa, New Mexico and Pennsylvania. These increases were partially offset by the health insurer fee moratorium in 2019. Total revenues also increased due to at-risk, state directed and pass through payments of approximately $825 million from the State of California and pass through payments of approximately $531 million from the State of New York. Earnings from operations increased $496 million between years primarily as a result of the acquisition of Fidelis Care and lower acquisition related expenses, partially offset by the health insurer fee moratorium in 2019.

Specialty Services

Total revenues increased 10% in the year ended December 31, 2019, compared to the corresponding period in 2018, resulting primarily from increased services associated with membership growth in the Managed Care segment and acquisitions, partially offset by the previously mentioned Veterans Affairs contract expiration. Earnings from operations decreased $173 million between years primarily due to the previously discussed non-cash goodwill and intangible impairment and our transition to transparent pharmacy pricing, partially offset by higher costs recognized in 2018 associated with our Veterans Affairs contract expiration. The transparent pricing decrease was offset by higher earnings in our Managed Care segment and reflects our commitment to transparency and more closely aligns the costs of care within each segment.

LIQUIDITY AND CAPITAL RESOURCES

Shown below is a condensed schedule of cash flows for the years ended December 31, 2019 and 2018, used in the discussion of liquidity and capital resources ($ in millions).

	Year Ended December 31,	
	2019	2018
Net cash provided by operating activities	$ 1,483	$ 1,234
Net cash used in investing activities	(1,532)	(4,585)
Net cash provided by financing activities	6,832	4,612
Effect of exchange rate changes on cash and cash equivalents	(2)	—
Net increase in cash, cash equivalents, and restricted cash and equivalents	$ 6,781	$ 1,261

Cash Flows Provided by Operating Activities

Normal operations are funded primarily through operating cash flows and borrowings under our credit facility. Cash flows from operating activities for 2019 were $1.5 billion, or 1.1 times net earnings, compared to $1.2 billion in 2018. The cash provided by operations in 2019 was primarily due to net earnings and an increase in medical claims liabilities, primarily resulting from growth in the Health Insurance Marketplace business and the commencement or expansion of the Arkansas, Iowa, New Mexico, and Pennsylvania health plans. Operating cash flows were partially offset by an increase in premium and trade receivables due to the timing of payments from our state customers, as discussed below.

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 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 minimum MLR rebates in California, which were previously accrued.

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,	
	2019	2018
(Increase) decrease in premium and trade receivables	$ (1,076)	$ (1,173)
Increase (decrease) in unearned revenue	(9)	(52)
Net increase (decrease) in operating cash flow	$ (1,085)	$ (1,225)

Cash Flows Used in Investing Activities

Investing activities used cash of $1.5 billion for the year ended December 31, 2019 and $4.6 billion in 2018. Cash flows used in investing activities in 2019 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.

We spent $730 million and $675 million in the years ended December 31, 2019 and 2018, respectively, on capital expenditures for system enhancements and market and corporate headquarters expansions.

As of December 31, 2019, our investment portfolio consisted primarily of fixed-income securities with a weighted average duration of 3.2 years. We had unregulated cash and investments of $7.2 billion at December 31, 2019, reflecting the net proceeds from our $7.0 billion senior note issuance in advance of the closing of the WellCare Acquisition, compared to $478 million at December 31, 2018. Unregulated cash and investments include private equity investments and company owned life insurance contracts.

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), and capital expenditures.

Cash Flows Provided by Financing Activities

Our financing activities provided cash of $6.8 billion in 2019, compared to providing cash of $4.6 billion in 2018. Financing activities in 2019 and 2018 are discussed below.

2019

During 2019, our net financing activities primarily related to the proceeds from the issuance of $7.0 billion of senior notes in December 2019 in preparation of the WellCare Acquisition.

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 Facility. 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.

Liquidity Metrics

Our credit agreement, dated as of September 11, 2019, by and among Centene, Wells Fargo Bank, National Association, as administrative agent, and the lenders from time to time party thereto, provides for (i) a $2.0 billion unsecured multi-currency revolving credit facility (the Revolving Credit Facility) which includes a $300 million sub-limit for letters of credit and a $200 million sub-limit for swingline loans and (ii) a $1.450 billion unsecured delayed-draw term loan facility (the Term Loan Facility, together with the Revolving Credit Facility under the credit agreement, as amended, the Company Credit Facility). Borrowings under our Revolving Credit Facility bear interest, at our option, at LIBOR, EURIBOR, CDOR, BBR or base rates plus, in each case, an applicable margin based on the total debt to EBITDA ratio. Borrowings under the Term Loan Facility bear interest, at our option, at LIBOR or base rates plus, in each case, an applicable margin based on the total debt to EBITDA ratio. Our Revolving Credit Facility will mature on May 7, 2024. The Term Loan Facility will mature on September 11, 2022.

In October 2019, we borrowed $1,450 million under the Term Loan Facility. We also redeemed the outstanding principal balance on the $1,400 million 5.625% Senior Notes due February 15, 2021, plus applicable premium for early redemption and accrued and unpaid interest through the redemption date. We recognized a loss on extinguishment of debt of $30 million on the redemption of the notes in the fourth quarter of 2019, including the call premium, the write-off of unamortized debt issuance costs, and a loss on the termination of the $600 million interest rate swap agreement associated with the note.

In October 2019, our Board of Directors approved a $500 million increase to our Company's stock repurchase program. Under the increased stock repurchase program, we will have flexibility to repurchase shares or pay down debt with the proceeds from divestitures related to the WellCare acquisition.

In December 2019, in connection with the planned financing of the WellCare Acquisition, we issued approximately $1.0 billion 4.75% Senior Notes due 2025 (the Additional 2025 Notes), $2.5 billion 4.25% Senior Notes due 2027 (the 2027 Notes), and $3.5 billion 4.625% Senior Notes due 2029 (the 2029 Notes). The net proceeds of the 2027 Notes and the 2029 Notes and a portion of the net proceeds of the Additional 2025 Notes were used to finance the cash consideration.

The credit agreement underlying our Revolving Credit Facility and Term Loan 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, 2019, we had $93 million in borrowings outstanding under our Revolving Credit Facility and $1,450 million in borrowings outstanding under our Term Loan Facility and we were in compliance with all covenants. As of December 31, 2019, there were no limitations on the availability under the Revolving Credit Facility 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 Company Credit Facility. We have guaranteed completion of the construction project associated with the loan. As of December 31, 2019, we had $140 million of borrowings outstanding under the loan.

We had outstanding letters of credit of $68 million as of December 31, 2019, which were not part of our Revolving Credit Facility. We also had letters of credit for $27 million (valued at the December 31, 2019 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 0.9% as of December 31, 2019. In addition, we had outstanding surety bonds of $611 million as of December 31, 2019.

The indentures governing our various maturities of senior notes contain restrictive covenants of Centene Corporation. As of December 31, 2019, we were in compliance with all covenants.

At December 31, 2019, we had working capital, defined as current assets less current liabilities, of $7,391 million, compared to $27 million at December 31, 2018, reflecting the net proceeds from our $7.0 billion senior note issuance in advance of the closing of the WellCare Acquisition. 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, 2019, our debt to capital ratio, defined as total debt divided by the sum of total debt and total equity, was 52.0%, compared to 37.8% at December 31, 2018. Excluding $194 million of non-recourse debt, our debt to capital ratio was 51.7% as of December 31, 2019, compared to 37.4% at December 31, 2018. At December 31, 2019, excluding non-recourse debt and the senior notes issued to fund the WellCare Acquisition in advance of closing, our debt to capital was 34.3%. 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 common stock from time to time on the open market or through privately negotiated transactions. Based on the closing stock price of $66.76 on December 31, 2019, we have 14.2 million available shares remaining under the program for repurchases as of December 31, 2019. 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 2019 or 2018.

During the year ended December 31, 2019 and 2018, we received dividends of $713 million and $475 million, respectively, from our regulated subsidiaries.

2020 Expectations

During 2020, we do not expect to make any material net capital contributions to our insurance subsidiaries and expect to spend approximately $775 million in additional capital expenditures primarily associated with system enhancements and market and corporate headquarters expansions. These amounts exclude any contributions or capital expenditures related to our newly acquired WellCare subsidiaries. Capital contributions and capital expenditures 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.

In February 2020, we issued $2,000 million 3.375% Senior Notes due 2030 (the 2030 Notes). We intend to use the net proceeds from the 2030 Notes, together with available cash on hand, to redeem our outstanding $1,000 million 4.75% Senior Notes due 2022 and outstanding $1,000 million 6.125% Senior Notes due 2024, including all premiums, accrued interest and costs and expenses related to the redemption. In connection with this refinancing, we terminated the remaining $2,100 million interest rate swap agreements.

On January 23, 2020, we acquired all of the issued and outstanding shares of WellCare Health Plans, Inc. (WellCare, and such acquisition, the WellCare Acquisition). Total consideration for the acquisition was $17.6 billion, consisting of Centene common shares valued at $11.4 billion (based on Centene's stock price of $66.76), $6.1 billion in cash, and $95 million related to the fair value adjustment to stock based compensation associated with pre-combination service. Each WellCare share was converted into 3.38 of a validly issued, fully paid, non-assessable shares of Centene common stock and $120.00 in cash. In total, 171,225 thousand shares of Centene common stock were issued to the WellCare stockholders. The cash portion of the acquisition consideration was funded through the issuance of long-term debt in December 2019. We issued approximately $1.0 billion 4.75% Senior Notes due 2025 (the Additional 2025 Notes), $2.5 billion 4.25% Senior Notes due 2027 (the 2027 Notes), and $3.5 billion 4.625% Senior Notes due 2029 (the 2029 Notes). The net proceeds of the 2027 Notes and the 2029 Notes and a portion of the net proceeds of the Additional 2025 Notes were used to finance the cash consideration.

In connection with the WellCare Acquisition, in January 2020, we completed an exchange offer for 5.25% Senior Notes due 2025 and 5.375% Senior Notes due 2026 (collectively, the WellCare Notes) issued by WellCare and issued $1,146 million aggregate principal amount of 5.25% Senior Notes due 2025 and $747 million aggregate principal amount of 5.375% Senior Notes due 2026.

Based on our operating plan, we expect that our available cash, cash equivalents and investments, cash from our operations and cash available under our Company 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, Term Loan 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	$ 7,473	$ 7,473	$ —	$ —	$ —
Debt and interest	17,833	669	3,797	2,108	11,259
Lease obligations	1,176	190	330	218	438
Purchase obligations	260	132	93	23	12
Other long-term liabilities (1)	—	—	—	—	—
Total	$ 26,742	$ 8,464	$ 4,220	$ 2,349	$ 11,709

(1) Our Consolidated Balance Sheet as of December 31, 2019, includes $1,732 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, and $136 million has been paid through 2019.

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; of which we have invested $13 million through 2019;
- 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 $24 million through 2019;
- 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 $20 million through 2019, and;
- invest $75 million of its investment portfolio in vehicles supporting California's healthcare infrastructure, of which we have invested $27 million through 2019.

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, 2019, our subsidiaries had aggregate statutory capital and surplus of $8,725 million, compared with the required minimum aggregate statutory capital and surplus requirements of $3,407 million. During the year ended December 31, 2019, we received $18 million of net dividends from our regulated subsidiaries. For our subsidiaries that file with the National Association of Insurance Commissioners (NAIC), we estimate our RBC percentage to be in excess of 350% of the Authorized Control Level.

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, 2019, 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, 2019, the amount of capital and surplus or net worth that was unavailable for the payment of dividends or return of capital to us was $3,407 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, and 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, 2019, we had $6,863 million of goodwill and $2,063 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 - 21 years
Provider contracts	4 - 15 years
Customer relationships	3 - 15 years
Trade names	7 - 20 years
Developed technologies	2 - 7 years
Other intangibles	2 - 5 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, financial performance, state funding, medical contracts and provider networks and contracts.

In January 2017, the Financial Accounting Standards Board issued an Accounting Standards Update (ASU) simplifying the test for goodwill impairment. During the third quarter of 2019, we adopted the new guidance. The amendments in the ASU eliminated step 2 from the quantitative goodwill impairment test while still allowing management to first perform the qualitative assessment to determine if a quantitative assessment is necessary. If the quantitative assessment is required, the impairment test under the new ASU is performed by comparing the fair value of the reporting unit with its carrying amount and recognizing an impairment charge for the amount by which the carrying amount exceeds the fair value. The impairment charge under the new ASU is limited to the total amount of goodwill allocated to that reporting unit. We first assess qualitative factors to determine if a quantitative impairment test is necessary. 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. During the third quarter of 2019, we recorded $271 million of non-cash goodwill ($259 million) and intangible asset ($12 million) impairment, substantially all associated with our U.S. Medical Management (USMM) physician home health business in the Specialty Services segment. The impairment was identified as part of our quarterly review procedures, which included an analysis of new information related to its shared savings demonstration programs, slower than expected penetration of the physician home health business model into its Medicaid population, and the related impact to revised forecasts. We utilized the income approach in the analysis, which derives the fair value of the intangible assets and goodwill based on the present value of discounted expected cash flows.

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. The claims amounts ultimately settled will most likely 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 that have been received or adjudicated as of the end of a reporting period relative to the estimate of the total ultimate incurred costs for that same period. 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, 2019 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)%	$ 430	(1.00)%	$ (112)
(0.75)	321	(0.75)	(84)
(0.50)	214	(0.50)	(56)
(0.25)	107	(0.25)	(28)
0.25	(106)	0.25	28
0.50	(212)	0.50	56
0.75	(317)	0.75	84
1.00	(421)	1.00	112

(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 $55 million for the year ended December 31, 2019, 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,		
	2019	2018	2017
Balance, January 1,	$ 6,831	$ 4,286	$ 3,929
Less: reinsurance recoverable	27	18	5
Balance, January 1, net	6,804	4,268	3,924
Acquisitions	59	1,204	—
Less: acquired reinsurance recoverable	—	8	—
Incurred related to:			
Current year	59,539	46,484	38,225
Prior years	(677)	(427)	(374)
Total incurred	58,862	46,057	37,851
Paid related to:			
Current year	52,453	41,161	34,196
Prior years	5,819	3,556	3,311
Total paid	58,272	44,717	37,507
Balance, December 31, net	7,453	6,804	4,268
Plus: reinsurance recoverable	20	27	18
Balance, December 31,	$ 7,473	$ 6,831	$ 4,286
Days in claims payable (1)	45	48	41

(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, 2019 will be known by the end of 2020.

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 $49 million, $25 million and $1 million of the "Incurred related to: Prior years" was recorded as a reduction to premium revenues in 2019, 2018 and 2017, 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 population health management initiatives may also contribute to changes in medical claim liability estimates. While we have evidence that population health management initiatives are effective on a case by case basis, these 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 population health management initiative are not known by us. Additionally, certain population health 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 population health 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 population health 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 update 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. For performance-based measures in our contracts, revenue is recognized as data sufficient to measure performance is available. We recognize 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, our insurance subsidiaries are subject to the Affordable Care Act annual HIF. The ACA imposed the HIF in 2014, 2015, 2016 and 2018 and is imposing the HIF in 2020. 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.

Some states require state directed payments that have minimal risk, but are administered as a premium adjustment. These payments are recorded as premium revenue and medical costs at close to a 100% HBR. We have little visibility to the timing of these payments until they are paid by the state.

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

INVESTMENTS AND DEBT

As of December 31, 2019, we had short-term investments of $863 million and long-term investments of $8,375 million, including restricted deposits of $658 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, 2019, the fair value of our fixed income investments would decrease by approximately $262 million. Declines in interest rates over time will reduce our investment income.

We have interest rate swap agreements for a notional amount of $2,100 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 $2,100 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, 2019, the fair value of our debt would decrease by approximately $69 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 health care reform 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, 2019 and 2018, 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, 2019, 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, 2019 and 2018, and the results of its operations and its cash flows for each of the years in the three-year period ended December 31, 2019, 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, 2019, 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 18, 2020 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.

Critical Audit Matters

The critical audit matters communicated below are matters arising from the current period audit of the consolidated financial statements that were communicated or required to be communicated to the audit committee and that: (1) relate to accounts or disclosures that are material to the consolidated financial statements and (2) involved our especially challenging, subjective, or complex judgments. The communication of critical audit matters does not alter in any way our opinion on the consolidated financial statements, taken as a whole, and we are not, by communicating the critical audit matters below, providing separate opinions on the critical audit matters or on the accounts or disclosures to which they relate.

Evaluation of the estimated medical claims liability

As discussed in Notes 2 and 8 to the consolidated financial statements, the Company's medical claims liability includes claims reported but not yet paid, estimates for claims incurred but not reported, and estimates for the costs necessary to process unpaid claims. The balance at December 31, 2019 was $7,473 million, or 26% of total liabilities.

We identified the evaluation of the estimated medical claims liability as a critical audit matter. The Company estimates its medical claims liability using actuarial methods. Specialized skills were required to evaluate these actuarial methods, which include analyzing historical claims data in order to estimate the medical claims liability. The medical claims liability included an estimate for medical claims developing under moderately adverse conditions, which represents the risk of adverse deviation in the Company's actuarial methods of reserving, which required auditor judgment to evaluate.

The primary procedures we performed to address this critical audit matter included the following. We tested certain internal controls over the Company's process to evaluate the estimate of the medical claims liability including the results of the Company's independent actuaries' analysis. We involved actuarial professionals with specialized skills and knowledge who evaluated the Company's methodology for consistency with the Actuarial Standards of Practice. With the assistance of the actuarial professionals, we challenged the Company's estimate of the medical claims liability, including the effects of moderately adverse conditions, by developing an independent estimate, and relative range. We assessed the potential for management bias by evaluating the Company's position and movement within the actuarial professionals' relative range.

Evaluation of the estimated Affordable Care Act risk adjustment accruals

As discussed in Notes 2 and 9 to the consolidated financial statements, the Affordable Care Act (ACA) established a permanent risk adjustment program. This program transfers funds from qualified individual and small group insurance plans with below average risk scores to those insurance plans with above average risk scores within each state. At December 31, 2019, the Company recorded an estimated asset and liability (the ACA risk adjustment accruals) of $245 million and $1,239 million, respectively.

We identified the evaluation of the estimated ACA risk adjustment accruals as a critical audit matter. Specialized skills and a higher degree of auditor judgment were required to evaluate the Company's estimates. The Company's estimates are based on its analysis of member data, claims data, and projections of claims data expected to be submitted by the Company, and other insurance plans, to the Centers for Medicare and Medicaid Services (CMS) for settlement. The final settlement of the December 31, 2019 ACA risk adjustment accruals is scheduled to be determined by CMS in June 2020, based on data submitted by insurance companies through April 2020.

The primary procedures we performed to address this critical audit matter included the following. We tested certain internal controls over the Company's process to develop the estimated ACA risk adjustment accruals. We involved actuarial professionals with specialized skills and knowledge who assisted in evaluating the Company's methodology used in estimating the ACA risk adjustment accruals for consistency with the federally developed risk adjustment methodology. Additionally, the actuarial professionals assisted in evaluating the projections of claims data utilized to estimate the ACA risk adjustment accruals, and assessed the methodologies utilized by the Company for consistency with Actuarial Standards of Practice. We assessed the Company's process to estimate the ACA risk adjustment accruals, in order to consider the potential for management bias, by performing a retrospective review of the prior period ACA risk adjustment accruals and assessing the consistency of those estimated balances with the subsequent settlement.

/s/ KPMG LLP

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

St. Louis, Missouri
February 18, 2020

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

	December 31, 2019	December 31, 2018
ASSETS		
Current assets:		
Cash and cash equivalents	$ 12,123	$ 5,342
Premium and trade receivables	6,247	5,150
Short-term investments	863	722
Other current assets	1,090	784
Total current assets	20,323	11,998
Long-term investments	7,717	6,861
Restricted deposits	658	555
Property, software and equipment, net	2,121	1,706
Goodwill	6,863	7,015
Intangible assets, net	2,063	2,239
Other long-term assets	1,249	527
Total assets	$ 40,994	$ 30,901
LIABILITIES, REDEEMABLE NONCONTROLLING INTERESTS AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims liability	$ 7,473	$ 6,831
Accounts payable and accrued expenses	4,164	4,051
Return of premium payable	824	666
Unearned revenue	383	385
Current portion of long-term debt	88	38
Total current liabilities	12,932	11,971
Long-term debt	13,638	6,648
Other long-term liabilities	1,732	1,259
Total liabilities	28,302	19,878
Commitments and contingencies		
Redeemable noncontrolling interests	33	10
Stockholders' equity:		
Preferred stock, $.001 par value; authorized 10,000 shares; no shares issued or outstanding at December 31, 2019 and December 31, 2018	—	—
Common stock, $.001 par value; authorized 800,000 shares; 421,508 issued and 415,048 outstanding at December 31, 2019, and 417,695 issued and 412,478 outstanding at December 31, 2018	—	—
Additional paid-in capital	7,647	7,449
Accumulated other comprehensive earnings (loss)	134	(56)
Retained earnings	4,984	3,663
Treasury stock, at cost (6,460 and 5,217 shares, respectively)	(214)	(139)
Total Centene stockholders' equity	12,551	10,917
Noncontrolling interest	108	96
Total stockholders' equity	12,659	11,013
Total liabilities, redeemable noncontrolling interests and stockholders' equity	$ 40,994	$ 30,901

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,		
	2019	**2018**	**2017**
Revenues:			
Premium	$ 67,439	$ 53,629	$ 43,353
Service	2,925	2,806	2,267
Premium and service revenues	70,364	56,435	45,620
Premium tax and health insurer fee	4,275	3,681	2,762
Total revenues	74,639	60,116	48,382
Expenses:			
Medical costs	58,862	46,057	37,851
Cost of services	2,465	2,386	1,847
Selling, general and administrative expenses	6,533	6,043	4,446
Amortization of acquired intangible assets	258	211	156
Premium tax expense	4,469	3,252	2,883
Health insurer fee expense	—	709	—
Impairment loss	271	—	—
Total operating expenses	72,858	58,658	47,183
Earnings from operations	1,781	1,458	1,199
Other income (expense):			
Investment and other income	443	253	190
Debt extinguishment costs	(30)	—	—
Interest expense	(412)	(343)	(255)
Earnings from operations, before income tax expense	1,782	1,368	1,134
Income tax expense	473	474	326
Net earnings	1,309	894	808
Loss attributable to noncontrolling interests	12	6	20
Net earnings attributable to Centene Corporation	$ 1,321	$ 900	$ 828
Net earnings per common share attributable to Centene Corporation:			
Basic earnings per common share	$ 3.19	$ 2.31	$ 2.40
Diluted earnings per common share	$ 3.14	$ 2.26	$ 2.34
Weighted average number of common shares outstanding:			
Basic	413,487	390,248	344,853
Diluted	420,409	398,506	353,404

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,		
	2019	2018	2017
Net earnings	$ 1,309	$ 894	$ 808
Reclassification adjustment, net of tax	(5)	2	(2)
Change in unrealized gain (loss) on investments, net of tax	203	(52)	28
Defined benefit pension plan net (loss) gain, net of tax	(6)	1	1
Foreign currency translation adjustments	(2)	(4)	6
Other comprehensive earnings (loss)	190	(53)	33
Comprehensive earnings	1,499	841	841
Comprehensive loss attributable to noncontrolling interests	12	6	20
Comprehensive earnings attributable to Centene Corporation	$ 1,511	$ 847	$ 861

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 Earnings (Loss)	Retained Earnings	$.001 Par Value Shares	Amt	Non controlling Interest	Total
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
Contribution from noncontrolling interest	—	—	13	—	—	—	—	—	13
Balance, December 31, 2017	360,758	$ —	$ 4,349	$ (3)	$ 2,748	13,884	$ (244)	$ 14	$ 6,864
Net earnings (loss)	—	—	—	—	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
Net earnings (loss)	—	—	—	—	1,321	—	—	(9)	1,312
Other comprehensive earnings, net of $59 tax	—	—	—	190	—	—	—	—	190
Common stock issued for employee benefit plans	3,813	—	21	—	—	—	—	—	21
Common stock repurchases	—	—	—	—	—	1,243	(75)	—	(75)
Stock compensation expense	—	—	177	—	—	—	—	—	177
Contribution from noncontrolling interest	—	—		—	—	—	—	21	21
Balance, December 31, 2019	421,508	$ —	$ 7,647	$ 134	$ 4,984	6,460	$ (214)	$ 108	$ 12,659

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,		
	2019	**2018**	**2017**
Cash flows from operating activities:			
Net earnings	$ 1,309	$ 894	$ 808
Adjustments to reconcile net earnings to net cash provided by operating activities			
Depreciation and amortization	643	495	361
Stock compensation expense	177	145	135
Goodwill and intangible impairment	271	—	—
Loss on debt extinguishment	30	—	—
Deferred income taxes	55	(129)	(108)
Changes in assets and liabilities			
Premium and trade receivables	(1,076)	(1,173)	(50)
Other assets	(234)	(38)	(146)
Medical claims liabilities	578	1,325	359
Unearned revenue	(9)	(52)	19
Accounts payable and accrued expenses	(421)	(533)	53
Other long-term liabilities	185	258	68
Other operating activities, net	(25)	42	(10)
Net cash provided by operating activities	1,483	1,234	1,489
Cash flows from investing activities:			
Capital expenditures	(730)	(675)	(422)
Purchases of investments	(2,575)	(3,846)	(2,656)
Sales and maturities of investments	1,809	1,991	1,862
Acquisitions, net of cash acquired	(36)	(2,055)	(50)
Other investing activities, net	—	—	12
Net cash used in investing activities	(1,532)	(4,585)	(1,254)
Cash flows from financing activities:			
Proceeds from the issuance of common stock	—	2,779	—
Proceeds from long-term debt	24,721	6,077	1,400
Payments of long-term debt	(17,803)	(4,083)	(1,353)
Common stock repurchases	(75)	(71)	(65)
Purchase of noncontrolling interest	—	(74)	(66)
Contribution from noncontrolling interest	21	—	—
Payments for debt extinguishment	(23)	—	—
Debt issuance costs	(25)	(25)	(3)
Other financing activities, net	16	9	5
Net cash provided by (used in) financing activities	6,832	4,612	(82)
Effect of exchange rate changes on cash, cash equivalents, and restricted cash	(2)	—	—
Net increase in cash, cash equivalents, and restricted cash and equivalents	6,781	1,261	153
Cash, cash equivalents, and restricted cash and cash equivalents, beginning of period	5,350	4,089	3,936
Cash, cash equivalents, and restricted cash and cash equivalents, end of period	$ 12,131	$ 5,350	$ 4,089
Supplemental disclosures of cash flow information:			
Interest paid	$ 374	$ 323	$ 237
Income taxes paid	$ 612	$ 448	$ 496
Equity issued in connection with acquisitions	$ —	$ 507	$ —

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

Centene Corporation, or the Company is a leading multi-national healthcare enterprise that is committed to helping people live healthier lives. The Company takes a local approach - with local brands and local teams - to provide fully integrated, high-quality, and cost-effective services to government-sponsored and commercial healthcare programs, focusing on under-insured and uninsured individuals. The Company operates 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 the Company's 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 its 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.

Certain amounts in the consolidated financial statements and notes have been reclassified to conform to the 2019 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 earnings (loss), 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 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. As of December 31, 2019 and 2018, restricted deposits included $8 million of cash and cash equivalents.

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 the Company's 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 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 - 21 years
Provider contracts	4 - 15 years
Customer relationships	3 - 15 years
Trade names	7 - 20 years
Developed technologies	2 - 7 years
Other intangibles	2 - 5 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 fair value.

The Company first assesses qualitative factors to determine whether it is necessary to perform the 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 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 Company then compares the fair value of the reporting unit calculated using the income approach or market approach with its carrying amount and recognizes an impairment charge for the amount by which the carrying amount exceeds fair value. The impairment charge is limited to the total amount of goodwill allocated to the reporting unit. Changes in economic and operating conditions impacting assumptions used in the Company's 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 the Centers for Medicare and Medicaid Services (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 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 its 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 the Company has 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.

Some states require state directed payments that have minimal risk, but are administered as a premium adjustment. These payments are recorded as premium revenue and medical costs at close to a 100% HBR. The Company little visibility to the timing of these payments until they are paid by the state.

Affordable Care Act

The Affordable Care Act (ACA) established risk spreading premium stabilization programs as well as minimum medical loss ratio (MLR) and cost sharing reductions.

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.

Minimum Medical Loss Ratio

Additionally, the ACA established a minimum MLR for the Health Insurance Marketplace. The risk adjustment program described above is taken into consideration to determine if the Company's estimated annual medical costs are less than the minimum MLR 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):

	2019	2018	2017
Allowances, beginning of year	$ 123	$ 24	$ 29
Amounts charged to expense	76	134	35
Write-offs of uncollectible receivables	(42)	(35)	(40)
Allowances, end of year	$ 157	$ 123	$ 24

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 11%, 13% and 18% for the years ended December 31, 2019, 2018 and 2017, respectively; the State of New York, where the percentage of the Company's total revenue was 15% for the year ended December 31, 2019, and the State of Texas, where the percentage of the Company's total revenue was 10% and 12% for the years ended December 31, 2018 and 2017, 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, mortgage and construction loans, and 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. 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 earnings (loss).

Recently Adopted Accounting Guidance

In February 2016, the Financial Accounting Standards Board (FASB) issued an Accounting Standards Update (ASU) that 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. The Company adopted the new guidance in the first quarter of 2019 using the modified retrospective transition approach. 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. The impact of the new guidance is further discussed in Note 11. *Leases*.

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 Company adopted the new guidance in the third quarter of 2019. The Company has an immaterial amount of goodwill at reporting units with negative carrying value. 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 that 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 August 2017, the FASB issued an ASU that 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.

Recent Accounting Guidance Not Yet Adopted

In December 2019, the FASB issued an ASU which simplifies the accounting for income taxes by removing certain exceptions to the general principles in ASC Topic 740. The ASU also clarifies and amends certain areas of ASC Topic 740 to improve consistent application of and simplify the generally accepted accounting principles within Topic 740. The guidance is effective for annual and interim periods beginning after December 15, 2020. The Company is currently evaluating the potential impact of the ASU on the Company's consolidated financial position, results of operations and cash flows.

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 Company adopted the new guidance in the first quarter of 2020. The new guidance did not have a material impact on the Company's consolidated financial position, results of operations or cash flows.

In June 2016, the FASB issued an ASU, and related amendments, which changes how entities measure credit losses for most financial assets and certain other investments that are not measured at fair value through net income. The ASU is intended to improve financial reporting by requiring timelier recording of credit losses on loans and other financial instruments held by financial institutions and other organizations. The amended guidance requires the measurement of all expected credit losses for financial assets (or groups of financial assets) and available for sale debt securities held at the reporting date over the remaining life based on historical experience, current conditions, and reasonable and supportable forecasts. The guidance is effective for annual and interim periods beginning after December 15, 2019. The Company adopted the new guidance in the first quarter of 2020. The vast majority of the Company's receivables and other financial instruments are with government entities and therefore the adoption did not have a material impact on its receivables and other financial instruments. The Company evaluated its investment portfolio under the new available-for-sale debt securities impairment model guidance for identification of securities with an impairment due to credit loss. The vast majority of the Company's investment portfolio is low risk, investment grade securities. The impact of the adoption related to the Company's investment portfolio resulted in an immaterial cumulative-effect adjustment to retained earnings. The new guidance did not have a material impact on the Company's consolidated financial position, 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. Acquisitions

WellCare Acquisition

On January 23, 2020, the Company acquired all of the issued and outstanding shares of WellCare Health Plans, Inc. (WellCare, and such acquisition, the WellCare Acquisition). The transaction is valued at approximately $19.6 billion, including the assumption of $1.95 billion of outstanding debt.

Total consideration for the acquisition was $17,605 million, consisting of Centene common shares valued at $11,431 million (based on Centene's stock price of $66.76), $6,079 million in cash, and $95 million related to the fair value of replacement equity awards associated with pre-combination service. Each WellCare share was converted into 3.38 of validly issued, fully paid, non-assessable shares of Centene common stock and $120.00 in cash. In total, 171 million shares of Centene common stock were issued to the WellCare stockholders. The cash portion of the acquisition consideration was funded through the issuance of long-term debt as further discussed in Note 10. *Debt*.

The acquisition of WellCare will be 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. The valuation of assets acquired and liabilities assumed has not yet been finalized. 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. Due to the timing of the acquisition, the Company has performed limited valuation procedures, and the valuation of all assets and liabilities assumed is not yet complete.

Divestitures

Immediately prior to the closing of the WellCare Acquisition, Anthem, Inc. acquired WellCare's Missouri Medicaid health plan, a WellCare Missouri Medicare Advantage health plan, and WellCare's Nebraska Medicaid health plan. CVS Health Corporation acquired portions of Centene's Illinois Medicaid and Medicare Advantage health plans as part of previously announced divestiture agreements.

Unaudited Pro Forma Financial Information

The following table presents supplemental pro forma information for the year ended December 31, 2019 and 2018, respectively ($ in millions, except per share data):

	Year Ended December 31, 2019	Year Ended December 31, 2018
Total revenues	$ 102,379	$ 88,842
Net earnings attributable to common stockholders	1,462	$ 1,211
Diluted earnings per share	$ 2.47	$ 2.06

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, 2018 and is not a projection of future results.

The unaudited pro forma financial information reflects the historical results of Centene and WellCare adjusted as if the acquisition had occurred on January 1, 2018, primarily for the following:

- Interest expense associated with debt incurred to finance the transaction.
- Elimination of historical WellCare intangible asset amortization expense and addition of amortization expense based on the current estimated values of identifiable intangible assets of approximately $7 billion.
- Issuance of 171 million shares of Centene common stock in connection with the per share common stock consideration.
- Elimination of acquisition related costs.
- Adjustments to income tax expense related to pro forma adjustments and increased income tax expense related to IRS Regulation 162(m)(6).

In addition, the acquisition of Fidelis Care by Centene and the acquisition of Meridian by WellCare both occurred in 2018. The pro forma information gives effect to both acquisitions and the related financing as if they occurred on January 1, 2018.

The unaudited pro forma financial information does not reflect the previously discussed divestitures as the impact would be impracticable to quantify.

Fidelis Care Acquisition

On July 1, 2018, the Company acquired substantially all of the assets of Fidelis Care for approximately $3,621 million of cash consideration, including a working capital adjustment. The acquisition consideration was funded through the issuance of $53.2 million shares of Centene common stock and the issuance of long-term 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 that requires assets acquired and liabilities assumed to be recognized at fair value as of the acquisition date. The valuation of all assets acquired and liabilities assumed was finalized in the second quarter of 2019.

The Company's 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		442
Other current assets		32
Restricted deposits		495
Property, software and equipment		48
Intangible assets [(a)]		956
Other long-term assets		2
Total assets acquired		3,976
Medical claims liability		1,218
Accounts payable and accrued expenses		238
Return of premium payable		123
Unearned revenue		115
Other long-term liabilities		324
Total liabilities assumed		2,018
Total identifiable net assets		1,958
Goodwill [(b)]		1,663
Total assets acquired and liabilities assumed	$	3,621

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 $956 million with a weighted average life of 13 years. The identifiable intangible assets include customer relationships, provider contracts, trade names and developed technologies.

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	$	711	11
Trade name		196	20
Provider contracts		33	15
Developed technologies		16	2
Total intangible assets acquired	$	956	13

(b) The acquisition resulted in $1.7 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 following table presents supplemental pro forma information for the year ended December 31, 2018 and 2017, respectively ($ in millions, except per share data):

	Year Ended December 31, 2018	Year Ended December 31, 2017
Total revenues	$ 65,792	$ 58,275
Net earnings attributable to common stockholders	$ 1,342	$ 936
Diluted earnings per share	$ 3.22	$ 2.27

The pro forma results do not reflect any anticipated synergies, efficiencies, or other cost savings of the acquisition prior to July 1, 2018, or the impact of the WellCare acquisition and related financing. 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 and expense 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 the Company's 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. As of December 31, 2019, the Company has paid $136 million.

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, 2019				December 31, 2018			
	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	$ 211	$ 1	$ —	$ 212	$ 362	$ 1	$ (2)	$ 361
Corporate securities	3,629	108	(4)	3,733	3,190	8	(52)	3,146
Restricted certificates of deposit	482	—	—	482	433	—	—	433
Restricted cash equivalents	8	—	—	8	8	—	—	8
Municipal securities	2,320	69	(1)	2,388	2,196	9	(18)	2,187
Asset-backed securities	741	5	(2)	744	686	1	(4)	683
Residential mortgage-backed securities	464	8	(1)	471	452	1	(9)	444
Commercial mortgage- backed securities	380	9	(1)	388	366	1	(6)	361
Private equity investments	664	—	—	664	387	—	—	387
Life insurance contracts	148	—	—	148	128	—	—	128
Total	$ 9,047	$ 200	$ (9)	$ 9,238	$ 8,208	$ 21	$ (91)	$ 8,138

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, 2019, 97% of the Company's investments in rated securities carry an investment grade rating by nationally recognized statistical rating organizations. At December 31, 2019, 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 4 years at December 31, 2019.

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, 2019				December 31, 2018			
	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	$ —	$ 11	$ —	$ 31	$ —	$ 59	$ (2)	$ 202
Corporate securities	(2)	192	(2)	48	(27)	1,389	(25)	871
Municipal securities	(1)	185	—	11	(4)	591	(14)	806
Asset-backed securities	(1)	153	(1)	151	(2)	318	(2)	168
Residential mortgage- backed securities	—	44	(1)	81	(1)	61	(8)	233
Commercial mortgage- backed securities	(1)	118	—	21	(2)	137	(4)	140
Total	$ (5)	$ 703	$ (4)	$ 343	$ (36)	$ 2,555	$ (55)	$ 2,420

As of December 31, 2019, the gross unrealized losses were generated from 682 positions out of a total of 4,529 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, 2019				December 31, 2018			
	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	$ 750	$ 752	$ 550	$ 550	$ 647	$ 646	$ 205	$ 205
One year through five years	3,034	3,106	106	108	3,026	2,998	351	350
Five years through ten years	2,974	3,069	—	—	2,387	2,362	—	—
Greater than ten years	48	50	—	—	88	89	—	—
Asset-backed securities	1,585	1,603	—	—	1,504	1,488	—	—
Total	$ 8,391	$ 8,580	$ 656	$ 658	$ 7,652	$ 7,583	$ 556	$ 555

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 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, 2019, 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	$ 12,123	$ —	$ —	$ 12,123
Investments available for sale:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ 73	$ —	$ —	$ 73
Corporate securities	—	3,713	—	3,713
Municipal securities	—	2,379	—	2,379
Asset-backed securities	—	744	—	744
Residential mortgage-backed securities	—	471	—	471
Commercial mortgage-backed securities	—	388	—	388
Total investments	$ 73	$ 7,695	$ —	$ 7,768
Restricted deposits available for sale:				
Cash and cash equivalents	$ 8	$ —	$ —	$ 8
Certificates of deposit	—	482	—	482
Corporate securities	—	20	—	20
Municipal securities	—	9	—	9
U.S. Treasury securities and obligations of U.S. government corporations and agencies	139	—	—	139
Total restricted deposits	$ 147	$ 511	$ —	$ 658
Other long-term assets:				
Interest rate swap agreements	$ —	$ 10	$ —	$ 10
Total other long-term assets	$ —	$ 10	$ —	$ 10
Total assets at fair value	$ 12,343	$ 8,216	$ —	$ 20,559
Liabilities				
Other long-term liabilities:				
Interest rate swap agreements	$ —	$ 11	$ —	$ 11
Total liabilities at fair value	$ —	$ 11	$ —	$ 11

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 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 $812 million and $515 million as of December 31, 2019, and December 31, 2018, respectively.

6. Property, Software and Equipment

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

	2019	2018
Computer software	$ 1,018	$ 757
Building	778	614
Furniture and office equipment	457	335
Leasehold improvements	390	291
Computer hardware	378	308
Land	202	201
Property, software and equipment, at cost	3,223	2,506
Less: accumulated depreciation	(1,102)	(800)
Property, software and equipment, net	$ 2,121	$ 1,706

Depreciation expense for the years ended December 31, 2019, 2018 and 2017 was $342 million, $237 million and $161 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, 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
Acquisitions and purchase accounting adjustments	61	47	108
Impairment	(16)	(243)	(259)
Translation impact	(1)	—	(1)
Balance as of December 31, 2019	$ 5,730	$ 1,133	$ 6,863

During the third quarter of 2019, the Company recorded $271 million of non-cash goodwill ($259 million) and intangible asset ($12 million) impairment, substantially all associated with the Company's U.S. Medical Management (USMM) physician home health business in the Specialty Services segment. The impairment was identified as part of the Company's quarterly review procedures, which included an analysis of new information related to its shared savings demonstration programs, slower than expected penetration of the physician home health business model into its Medicaid population, and the related impact to revised forecasts. The Company conducted an impairment analysis of the identifiable intangible assets and goodwill of the reporting unit using the income approach, in which fair value is derived based on the present value of discounted expected cash flows.

The majority of the increase in the managed care segment goodwill in 2018 was related to the acquisition and fair value allocations related to the Fidelis Care acquisition discussed in Note 3. *Acquisitions*. The majority of the increase in the specialty services segment goodwill related to other acquisitions discussed in Note 12. *Stockholders' Equity*.

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

			Weighted Average Life in Years	
	2019	2018	2019	2018
Purchased contract rights	$ 1,214	$ 1,173	12.8	12.6
Provider contracts	299	311	12.4	12.3
Customer relationships	812	769	10.8	10.9
Trade names	361	361	15.2	15.2
Developed technologies	179	180	5.2	5.2
Other intangibles	5	5	2.7	2.7
Intangible assets	2,870	2,799	12.0	11.9
Less accumulated amortization:				
Purchased contract rights	(375)	(283)		
Provider contracts	(115)	(90)		
Customer relationships	(122)	(57)		
Trade names	(80)	(55)		
Developed technologies	(111)	(72)		
Other intangibles	(4)	(3)		
Total accumulated amortization	(807)	(560)		
Intangible assets, net	$ 2,063	$ 2,239		

Amortization expense was $258 million, $211 million and $156 million for the years ended December 31, 2019, 2018 and 2017, respectively. Estimated total amortization expense related to the December 31, 2019 intangible assets for each of the five succeeding fiscal years is as follows ($ in millions):

Year	Expense
2020	$ 252
2021	228
2022	222
2023	220
2024	213

8. Medical Claims Liability

The Specialty Services segment 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,		
	2019	2018	2017
Balance, January 1	$ 6,831	$ 4,286	$ 3,929
Less: reinsurance recoverable	27	18	5
Balance, January 1, net	6,804	4,268	3,924
Acquisitions and purchase accounting adjustments	59	1,204	—
Less: acquired reinsurance recoverable	—	8	—
Incurred related to:			
Current year	59,539	46,484	38,225
Prior years	(677)	(427)	(374)
Total incurred	58,862	46,057	37,851
Paid related to:			
Current year	52,453	41,161	34,196
Prior years	5,819	3,556	3,311
Total paid	58,272	44,717	37,507
Balance at December 31, net	7,453	6,804	4,268
Plus: reinsurance recoverable	20	27	18
Balance, December 31	$ 7,473	$ 6,831	$ 4,286

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 $49 million, $25 million, and $1 million of the "Incurred related to: Prior years" was recorded as a reduction to premium revenues in 2019, 2018, and 2017, 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 population health management initiatives may also contribute to changes in medical claim liability estimates. While the Company has evidence that population health management initiatives are effective on a case by case basis, population health 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 population health management initiative are not known by the Company. Additionally, certain population health 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 population health 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, 2019 is included in the table below and is inclusive of claims incurred and paid related to the Fidelis Care businesses prior and subsequent to the acquisition date. 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, 2019 is as follows ($ in millions):

Cumulative Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance			
	For the Years Ended December 31,		
Claim Year	2017 (unaudited)	2018 (unaudited)	2019
2017	$ 47,574	$ 46,994	$ 46,950
2018		51,572	50,944
2019			59,627
		Total incurred claims	$ 157,521

Cumulative Paid Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance			
	For the Years Ended December 31,		
Claim Year	2017 (unaudited)	2018 (unaudited)	2019
2017	$ 42,205	$ 46,767	$ 46,904
2018		45,039	50,682
2019			52,482
		Total payment of incurred claims	$ 150,068
		Medical claims liability, net of reinsurance	$ 7,453

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, 2019 are included in the following table and are inclusive of the acquired Fidelis Care business. 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. The Company estimates its 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, 2019		
	Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance	Total IBNR Plus Expected Development on Reported Claims	Cumulative Paid Claims
2017	$ 46,950	$ —	260.2
2018	50,944	88	281.7
2019	59,627	5,347	290.2

9. Affordable Care Act

The Affordable Care Act established risk spreading premium stabilization programs as well as minimum annual MLR and cost sharing reductions.

On June 28, 2019, the Centers for Medicare and Medicaid Services announced the final risk adjustment transfers for the 2018 benefit year. As a result of the announcement, the Company reduced its risk adjustment net payables by $238 million from December 31, 2018. After consideration of minimum MLR, Risk Adjustment Data Validation audit results, and other related impacts, the net pre-tax benefit recognized was approximately $131 million recorded in the second quarter of 2019.

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

	December 31, 2019	December 31, 2018
Risk adjustment receivable	$ 245	$ 91
Risk adjustment payable	(1,239)	(1,019)
Minimum medical loss ratio	(367)	(265)
Cost sharing reduction receivable	73	57
Cost sharing reduction payable	(1)	(107)

10. Debt

Debt consists of the following ($ in millions):

	December 31, 2019	December 31, 2018
$1,400 million 5.625% Senior notes, due February 15, 2021	$ —	$ 1,400
$1,000 million 4.75% Senior notes, due May 15, 2022	1,004	1,005
$1,000 million 6.125% Senior notes, due February 15, 2024	1,000	1,000
$2,200 million 4.75% Senior notes, due January 15, 2025	2,228	1,200
$1,800 million 5.375% Senior notes, due June 1, 2026	1,800	1,800
$2,500 million 4.25% Senior notes due December 15, 2027	2,479	—
$3,500 million 4.625% Senior notes due December 15, 2029	3,500	—
Fair value of interest rate swap agreements	(1)	(95)
Total senior notes	12,010	6,310
Term Loan Credit Facility	1,450	—
Revolving Credit Facility	93	284
Mortgage notes payable	54	57
Construction loan payable	140	63
Capital leases and other	122	47
Debt issuance costs	(143)	(75)
Total debt	13,726	6,686
Less current portion	(88)	(38)
Long-term debt	$ 13,638	$ 6,648

Senior Notes

In February 2020, the Company issued $2,000 million 3.375% Senior Notes due 2030 (the 2030 Notes). The Company intends to use the net proceeds from the 2030 Notes, together with available cash on hand, to redeem all of its outstanding $1,000 million 4.75% Senior Notes due 2022 and all of its outstanding $1,000 million 6.125% Senior Notes due 2024, including all premiums, accrued interest and costs and expenses related to the redemption.

In connection with the WellCare Acquisition, in January 2020, the Company completed an exchange offer for 5.25% Senior Notes due 2025 and 5.375% Senior Notes due 2026 (collectively, the WellCare Notes) issued by WellCare and issued $1,146 million aggregate principal amount of 5.25% Senior Notes due 2025 and $747 million aggregate principal amount of 5.375% Senior Notes due 2026. Additionally, our wholly owned subsidiary, WellCare Health Plans, Inc., assumed the remaining WellCare Notes.

In December 2019, the Company issued approximately $1,000 million 4.75% Senior Notes due 2025 (the Additional 2025 Notes), $2,500 million 4.25% Senior Notes due 2027 (the 2027 Notes), and $3,500 million 4.625% Senior Notes due 2029 (the 2029 Notes). The Company used the net proceeds of the 2027 Notes and the 2029 Notes and a portion of the net proceeds of the Additional 2025 Notes to fund the cash consideration of the WellCare acquisition, which closed on January 23, 2020.

In October 2019, the Company redeemed the outstanding principal balance on the $1,400 million 5.625% Senior Notes due February 15, 2021, plus applicable premium for early redemption and accrued and unpaid interest through the redemption date. The Company recognized a pre-tax loss on extinguishment of $30 million on the redemption of the $1,400 million 5.625% Senior Notes in the fourth quarter of 2019, including the call premium, the write-off of unamortized debt issuance costs and a loss on the termination of the $600 million interest rate swap agreement associated with the 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, 2019, 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, 2019 and 2018 ($ in millions):

Expiration Date	**December 31, 2019**	**December 31, 2018**
February 15, 2021	$ —	$ 600
May 15, 2022	500	500
February 15, 2024	1,000	1,000
January 15, 2025	600	600
Total	$ 2,100	$ 2,700

The fair value of the swap agreements shown above are recorded in other long-term assets and 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 3.44% adjusted monthly or quarterly, based on the terms of the individual swap agreements. At December 31, 2019, the weighted average rate was 5.30%.

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.

In connection with the redemption of the $1,400 million 5.625% Senior Notes in October 2019, the Company terminated the $600 million interest rate swap agreement associated with those notes. In connection with the February 2020 senior note issuance and anticipated redemptions, the Company terminated the remaining $2,100 million interest rate swap agreements.

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 Facility and Term Loan Credit Facility

On May 7, 2019, the Company amended and restated its existing credit agreement by and among Centene, Wells Fargo Bank, National Association, as administrative agent, and the lenders from time to time party thereto (as amended, restated, amended and restated or otherwise modified , the Company Credit Agreement), to, among other things, increase the revolving commitments available under its unsecured multi-currency revolving credit facility from $1.5 billion to $2.0 billion. (the Revolving Credit Facility), which includes a $300 million sub-limit for letters of credit and a $200 million sub-limit for swingline loans. On September 11, 2019, the Company further amended and restated the Company Credit Agreement, to provide for a new $1.45 billion unsecured delayed-draw term loan facility (the Term Loan Facility, the credit agreement, as amended, the Company Credit Facility). On November 14, 2019, the Company amended the Company Credit Agreement to exclude the indebtedness issued for the purpose of financing the WellCare Acquisition in the calculation of certain financial covenants until the earlier of the consummation of the WellCare Acquisition and September 20, 2020. Borrowings under the Company's Revolving Credit Facility bear interest, at the Company's option, at LIBOR, EURIBOR, CDOR, BBR or base rates plus, in each case, an applicable margin based on total debt to EBITDA ratio. Borrowings under the Term Loan Facility bear interest, at the Company's option, at LIBOR or base rates plus, in each case, an applicable margin based on the total debt to EBITDA ratio. The Company has an uncommitted option to increase its Company Credit Facility by an additional $500 million plus certain additional amounts based on its total debt to EBITDA ratio.

The Company Credit Agreement contains financial covenants including maintenance of a minimum fixed charge coverage ratio and a restriction on the Company's maximum total debt to EBITDA ratio exceeding 3.5 to 1.0. It also contains certain non-financial covenants including: limitations on incurrence of additional indebtedness; restrictions on incurrence of liens; restrictions on dividends and other restricted payments; restrictions on investments, mergers, consolidations and asset sales; and limitations on transactions with affiliates. As of December 31, 2019, the Company was in compliance with all financial and non-financial covenants under the Company Credit Facility.

As of December 31, 2019, the Company had $93 million of borrowings outstanding under the Revolving Credit Facility, with a weighted average interest rate of 1%. In October 2019, the Company borrowed $1.45 billion under the Term Loan Facility. The proceeds of the Term Loan Facility were used to fund the redemption of certain senior notes discussed below and pay fees and expenses in connection therewith, with any remaining proceeds to be used for general corporate purposes.

The Revolving Credit Facility will mature on May 7, 2024. The Term Loan Facility will mature on September 11, 2022.

Mortgage Notes Payable

The Company has a non-recourse mortgage note of $54 million at December 31, 2019 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 $130 million at December 31, 2019.

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 Credit Facility. The Company has guaranteed completion of the construction project associated with the loan. As of December 31, 2019, the Company had $140 million in borrowings outstanding under the loan.

Letters of Credit & Surety Bonds

The Company had outstanding letters of credit of $68 million as of December 31, 2019, which were not part of the Revolving Credit Facility. The Company also had letters of credit for $27 million (valued at December 31, 2019 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 0.9% as of December 31, 2019. The Company had outstanding surety bonds of $611 million as of December 31, 2019.

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

2020	$	88
2021		201
2022		2,469
2023		6
2024		1,094
Thereafter		10,001
Total	$	13,859

The fair value of outstanding debt was approximately $14,160 million and $6,619 million at December 31, 2019 and 2018, respectively.

11. Leases

In February 2016, the FASB issued ASU No. 2016-02, Leases, which introduced a lessee model that requires the majority of leases to be recognized on the balance sheet. On January 1, 2019, the Company adopted the ASU using the modified retrospective transition approach and elected the transition option to recognize the adjustment in the period of adoption rather than in the earliest period presented. Adoption of the new guidance resulted in the initial recognition of right-of-use (ROU) assets of $661 million, ROU lease liabilities of $774 million and the elimination of $113 million of straight-line lease liabilities.

The Company records ROU assets and liabilities for non-cancelable operating leases primarily for real estate and equipment. Leases with an initial term of 12 months or less are not recorded on the balance sheet. Expense related to leases is recorded on a straight-line basis over the lease term, including rent holidays. During the year ended December 31, 2019, the Company recognized operating lease expense of $203 million.

The following table sets forth the ROU assets and liabilities as of December 31, 2019 ($ in millions):

	December 31, 2019	
Assets		
ROU assets (recorded within other long-term assets)	$	661
Liabilities		
Short-term (recorded within accounts payable and accrued expenses)	$	161
Long-term (recorded within other long-term liabilities)		622
Total operating lease liabilities	$	783

During the year ended December 31, 2019, the Company reduced its operating lease liabilities by $227 million for cash paid. In addition, during the year ended December 31, 2019, new operating leases commenced resulting in the recognition of ROU assets and liabilities of $162 million, respectively. As of December 31, 2019, the Company had additional operating leases that have not yet commenced of $101 million, which included two significant leases executed during the third quarter. These operating leases will commence in 2020 with lease terms of 5 to 10 years.

As of December 31, 2019, the weighted average remaining lease term of the Company's operating leases was 6.6 years. The ROU liabilities as of December 31, 2019 reflect a weighted average discount rate of 4.2%. Lease payments over the next five years and thereafter are as follows ($ in millions):

	December 31, 2019
2020	$ 190
2021	182
2022	148
2023	119
2024	99
Thereafter	438
Total lease payments	1,176
Less: imputed interest	(393)
Total ROU liabilities	$ 783

The following discussion relates to the Company's lease accounting policy under ASC Topic 840 for the year ended December 31, 2018. Annual noncancellable minimum lease payments over the next five years and thereafter were as follows ($ in millions):

	December 31, 2018
2019	$ 174
2020	176
2021	145
2022	101
2023	71
Thereafter	200
Total lease payments	$ 867

12. Stockholders' Equity

The Company has 10 million authorized shares of preferred stock at $.001 par value. At December 31, 2019, there were no preferred shares outstanding.

The Company's Board of Directors has authorized a stock repurchase program of the Company's common stock from time to time on the open market or through privately negotiated transactions. The initial program, which was extended in 2009, authorized the repurchase of up to 16.0 million shares, of which 6.7 million shares are remaining. In October 2019, the Company's Board of Directors approved a $500 million increase to the program based on the closing stock price on the date of the WellCare Acquisition. Based on the stock price of $66.76, an additional 7.5 million shares were approved. As of December 31, 2019, 14.2 million remaining shares are available under the program for repurchase. No duration has been placed on the repurchase program. The Company reserves the right to discontinue the repurchase program at any time. During the year ended December 31, 2019 and 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 $75 million in 2019 and 1 million shares at an aggregate cost of $71 million in 2018. These shares are included in the Company's treasury stock.

In January 2020, the Company acquired WellCare and issued 171 million shares of Centene stock, with an approximate value of $11,431 million.

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.

13. 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, 2019 and 2018, Centene's subsidiaries had aggregate statutory capital and surplus of $8,725 million and $7,259 million, respectively, compared with the required minimum aggregate statutory capital and surplus of $3,407 million and $3,279 million, respectively. As of December 31, 2019, 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 $3,407 million in the aggregate.

14. Income Taxes

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

	2019	2018	2017
Current provision			
Federal	$ 381	$ 498	$ 421
State and local	41	107	14
Total current provision	422	605	435
Deferred provision	51	(131)	(109)
Total income tax expense	$ 473	$ 474	$ 326

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):

	2019	2018	2017
Earnings from operations, before income tax expense	$ 1,782	$ 1,368	$ 1,134
Loss (earnings) attributable to flow through noncontrolling interest	11	4	15
Earnings from operations, less noncontrolling interest, before income tax expense	1,793	1,372	1,149
Tax provision at the U.S. federal statutory rate	377	288	402
State income taxes, net of federal income tax benefit	49	52	11
Nondeductible compensation	42	33	58
ACA Health Insurer Fee	—	149	—
Income Tax Reform	—	—	(125)
Valuation Allowance	—	(28)	14
Nondeductible goodwill impairment	30	—	—
Other, net	(25)	(20)	(34)
Income tax expense	$ 473	$ 474	$ 326

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):

	2019	2018
Deferred tax assets:		
Medical claims liability	$ 66	$ 78
Nondeductible liabilities	97	128
Net operating loss and tax credit carryforwards	83	77
Compensation accruals	113	109
Premium and trade receivables	78	76
Operating lease liability	186	—
Other	46	61
Deferred tax assets	669	529
Valuation allowance	(66)	(53)
Net deferred tax assets	$ 603	$ 476
Deferred tax liabilities:		
Intangible assets	$ 346	$ 343
Prepaid assets	26	31
Fixed assets	187	132
Investments in joint ventures	2	27
Deferred revenue	13	19
Right of use asset	171	—
Other	47	6
Deferred tax liabilities	792	558
Net deferred tax assets (liabilities)	$ (189)	$ (82)

The Company adopted an ASU that introduces a lessee model that requires the majority of leases to be recognized on the balance sheet, which resulted in a right of use asset and operating lease liability for GAAP purposes. With limited exceptions these items have no tax basis, therefore both deferred tax assets and deferred tax liabilities have been grossed up in 2019 to reflect the underlying GAAP change.

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 $13 million increase in valuation allowance relates to tax losses in international jurisdictions.

Federal net operating loss carryforwards of $13 million expire beginning in 2021 through 2038; state net operating loss and tax credit carryforwards of $48 million expire beginning in 2020 through 2039. 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,	
	2019	2018
Gross unrecognized tax benefits, beginning of period	$ 277	$ 257
Gross increases:		
Current year tax positions	39	7
Prior year tax positions	14	14
Gross decreases:		
Prior year tax positions	(8)	—
Settlements	(16)	
Statute of limitation lapses	(1)	(1)
Gross unrecognized tax benefits, end of period	$ 305	$ 277

Uncertain tax positions increased $28 million due to various federal positions. As of December 31, 2019, $258 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 $71 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. The Company recognized net interest expense related to uncertain positions of $2 million and $5 million for the years ended December 31, 2019 and 2018, respectively. The Company had $16 million and $14 million of accrued interest and penalties for uncertain tax positions as of December 31, 2019 and 2018, respectively.

The Company files tax returns for federal as well as numerous state and international tax jurisdictions. As of December 31, 2019, Health Net is under federal examination for tax years 2014 through its final return in 2016. Additionally, Centene's tax returns are under federal examination for tax years 2014 through 2017.

15. 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 2019. The plans have 8 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 $177 million, $145 million and $135 million for the years ended December 31, 2019, 2018 and 2017, respectively. The total income tax benefit recognized in the Statements of Operations for stock-based compensation arrangements was $22 million, $34 million and $50 million for the years ended December 31, 2019, 2018 and 2017, respectively.

A summary of the Company's non-vested restricted stock and restricted stock unit shares as of December 31, 2019, and changes during the year ended December 31, 2019, is presented below (shares in thousands):

	Shares	Weighted Average Grant Date Fair Value
Non-vested balance as of December 31, 2018	7,365	$ 47.72
Granted	3,520	58.19
Vested	(3,373)	40.58
Forfeited	(525)	51.11
Non-vested balance as of December 31, 2019	6,987	$ 56.19

The total fair value of restricted stock and restricted stock units vested during the years ended December 31, 2019, 2018 and 2017, was $202 million, $209 million and $174 million, respectively.

As of December 31, 2019, there was $266 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 2.4 years.

The Company maintains an employee stock purchase plan and issued 416 thousand shares, 256 thousand shares, and 258 thousand shares in 2019, 2018 and 2017, respectively.

16. 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 $64 million, $53 million and $42 million during the years ended December 31, 2019, 2018 and 2017, respectively.

17. Commitments

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. *Acquisitions* 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; of which the Company has invested $13 million through 2019;
- 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 $24 million through 2019;
- 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 $20 million through 2019, and;
- invest $75 million of its investment portfolio in vehicles supporting California's healthcare infrastructure, of which the Company has invested $27 million through 2019.

18. Contingencies

Overview

The Company is 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 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.

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 March 2018, the Court overruled the Company's demurrer seeking to dismiss the complaint and denied the Company's motion to strike allegations seeking retroactive relief. 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. In March 2019, the California Court of Appeals denied the writ of mandate. The defendants in those Related Actions sought review by the California Supreme Court, which declined to review the matter. The case is back before the trial court which has scheduled a hearing in March 2020 to consider a motion for summary judgment by Health Net California. In the meantime, discovery and depositions are proceeding. The court has tentatively set the case for trial in August 2020. 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 the Company's 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 complaint in September 2017. In August 2019, the Court granted the Company's motion to dismiss in part and denied it in part, dismissing allegations regarding certain statements and thereby narrowing the time period to which the allegations will be subject. The case is now in the discovery phase.

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 the Company's 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 Carpenters 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. The three derivative suits have been consolidated. Lead plaintiffs and counsel have been appointed. Defendants filed a motion to dismiss on October 31, 2019. The motion has not yet been set for hearing.

The parties are in advanced negotiations to seek to settle the action for an immaterial amount to be paid by Company's insurance carrier. A settlement would be subject to negotiation and execution of a settlement agreement, as well as preliminary and final court approvals.

Veterans Administration Matter

In October 2017, a Civil Investigative Demand (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 healthcare 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 met 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. Plaintiffs filed a motion for class certification on January 8, 2020. 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 the Company's financial position and results of operations.

19. 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):

	2019	2018	2017
Earnings attributable to Centene Corporation	$ 1,321	$ 900	$ 828
Shares used in computing per share amounts:			
Weighted average number of common shares outstanding	413,487	390,248	344,853
Common stock equivalents (as determined by applying the treasury stock method)	6,922	8,258	8,551
Weighted average number of common shares and potential dilutive common shares outstanding	420,409	398,506	353,404
Net earnings per common share attributable to Centene Corporation:			
Basic earnings per common share	$ 3.19	$ 2.31	$ 2.40
Diluted earnings per common share	$ 3.14	$ 2.26	$ 2.34

The calculation of diluted earnings per common share for 2019, 2018 and 2017 excludes the impact of 1,048 thousand shares, 58 thousand shares and 106 thousand shares, respectively, related to anti-dilutive stock options, restricted stock and restricted stock units.

20. 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.

Segment information as of and for the year ended December 31, 2019, follows ($ in millions):

	Managed Care	Specialty Services	Eliminations	Consolidated Total
Total revenues from external customers	$ 71,209	$ 3,430	$ —	$ 74,639
Total revenues internal customers	170	10,351	(10,521)	—
Total revenues	$ 71,379	$ 13,781	(10,521)	$ 74,639
Earnings from operations	$ 1,806	$ (25)	—	$ 1,781
Total assets	$ 37,689	$ 3,305	—	$ 40,994

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

21. Quarterly Selected Financial Information

Quarterly selected financial information for 2019 and 2018 is as follows:

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

	For the Quarter Ended			
	March 31, 2019	June 30, 2019	September 30, 2019	December 31, 2019
Total revenues	$ 18,444	$ 18,356	$ 18,976	$ 18,863
Net earnings attributable to Centene Corporation	$ 522	$ 495	$ 95	$ 209
Net earnings per common share attributable to Centene Corporation:				
Basic earnings per common share	$ 1.26	$ 1.20	$ 0.23	$ 0.50
Diluted earnings per common share	$ 1.24	$ 1.18	$ 0.23	$ 0.49

	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

22. 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, 2019	December 31, 2018
ASSETS		
Current assets:		
Cash and cash equivalents	$ 6,257	$ 6
Short-term investments	3	2
Other current assets	50	61
Total current assets	6,310	69
Long-term investments	130	14
Investment in subsidiaries	19,561	17,409
Other long-term assets	337	278
Total assets	$ 26,338	$ 17,770
LIABILITIES, REDEEMABLE NONCONTROLLING INTERESTS AND STOCKHOLDERS' EQUITY		
Current liabilities	$ 198	$ 109
Long-term debt	13,411	6,521
Other long-term liabilities	37	117
Total liabilities	13,646	6,747
Redeemable noncontrolling interest	33	10
Stockholders' equity:		
Preferred stock, $.001 par value; authorized 10,000 shares; no shares issued or outstanding at December 31, 2019 and December 31, 2018	—	—
Common stock, $.001 par value; authorized 800,000 shares; 421,508 issued and 415,048 outstanding at December 31, 2019, and 417,695 issued and 412,478 outstanding at December 31, 2018	—	—
Additional paid-in capital	7,647	7,449
Accumulated other comprehensive loss	134	(56)
Retained earnings	4,984	3,663
Treasury stock, at cost (6,460 and 5,217 shares, respectively)	(214)	(139)
Total Centene stockholders' equity	12,551	10,917
Noncontrolling interest	108	96
Total stockholders' equity	12,659	11,013
Total liabilities, redeemable noncontrolling interests and stockholders' equity	$ 26,338	$ 17,770

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,		
	2019	**2018**	**2017**
Expenses:			
Selling, general and administrative expenses	$ 11	$ 28	$ 7
Contingent consideration	(24)	(4)	(1)
Other income (expense):			
Investment and other income	11	3	2
Debt extinguishment costs	(30)	—	—
Interest expense	(394)	(334)	(247)
Loss before income taxes	(400)	(355)	(251)
Income tax benefit	(172)	(64)	(114)
Net (loss) before equity in subsidiaries	(228)	(291)	(137)
Equity in earnings from subsidiaries	1,537	1,185	945
Net earnings	1,309	894	808
Loss attributable to noncontrolling interests	12	6	20
Net earnings attributable to Centene	$ 1,321	$ 900	$ 828
Net earnings per share:			
Basic earnings per common share	$ 3.19	$ 2.31	$ 2.40
Diluted earnings per common share	$ 3.14	$ 2.26	$ 2.34

See notes to condensed financial information of registrant.

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

	Year Ended December 31,		
	2019	**2018**	**2017**
Cash flows from operating activities:			
Dividends from subsidiaries, return on investment	$ 429	$ 464	$ 292
Other operating activities, net	(231)	(317)	(132)
Net cash provided by operating activities	198	147	160
Cash flows from investing activities:			
Capital contributions to subsidiaries	(731)	(681)	(339)
Purchases of investments	(124)	(23)	(38)
Sales and maturities of investments	—	7	4
Dividends from subsidiaries, return of investment	291	11	28
Investments in acquisitions	(302)	(4,226)	(59)
Intercompany activities	140	215	322
Other investing activities, net	—	—	(1)
Net cash used in investing activities	(726)	(4,697)	(83)
Cash flows from financing activities:			
Proceeds from the issuance of common stock	—	2,778	—
Proceeds from long-term debt	24,647	6,014	1,400
Payments of long-term debt	(17,778)	(4,080)	(1,350)
Common stock repurchases	(75)	(71)	(65)
Contribution from noncontrolling interest	21	—	—
Payments for debt extinguishment	(23)	—	—
Debt issuance costs	(25)	(25)	—
Purchase of noncontrolling interest	—	(76)	(66)
Other financing activities, net	12	10	5
Net cash provided by (used in) financing activities	6,779	4,550	(76)
Net increase in cash and cash equivalents	6,251	—	1
Cash and cash equivalents, beginning of period	6	6	5
Cash and cash equivalents, end of period	$ 6,257	$ 6	$ 6

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 the Company's restricted subsidiaries. The management and service fees received by its 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, population health 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 the Company's centralized cash management function, cash flows generated by its unrestricted subsidiaries are utilized by the parent company to the extent required, primarily to repay borrowings on the parent company's credit facilities, make acquisitions, fund capital contributions to subsidiaries and fund its operations.

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, 2019. 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, 2019, 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, 2019. Our management's assessment of the effectiveness of our internal control over financial reporting as of December 31, 2019, has been audited by KPMG LLP, an independent registered public accounting firm, as stated in their report which is included herein.

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, 2019, 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, 2019, 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, 2019, 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, 2019 and 2018, 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, 2019, and the related notes (collectively, the consolidated financial statements), and our report dated February 18, 2020 expressed an unqualified opinion on those consolidated financial statements.

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 18, 2020

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 2020 annual meeting of stockholders under "Proposal One: Election of Directors." This portion of the Proxy Statement is incorporated herein by reference.

(b) Information about our Executive Officers

Pursuant to General Instruction G(3) to Form 10-K and the Instruction to Item 401of 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 "Information about our Executive Officers."

Information concerning our executive officers' compliance with Section 16(a) of the Exchange Act will appear in our Proxy Statement for our 2020 annual meeting of stockholders under "Delinquent Section 16(a) Reports." Information concerning our audit committee financial expert and identification of our audit committee will appear in our Proxy Statement for our 2020 annual meeting of stockholders under "Board of Directors Committees." Information concerning our code of ethics will appear in our Proxy Statement for our 2020 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 2020 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 2020 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 2020 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 2020 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 2020 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 2020 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, 2019 and 2018
    Consolidated Statements of Operations for the years ended December 31, 2019, 2018 and 2017
    Consolidated Statements of Comprehensive Earnings for the years ended December 31, 2019, 2018 and 2017
    Consolidated Statements of Stockholders' Equity for the years ended December 31, 2019, 2018 and 2017
    Consolidated Statements of Cash Flows for the years ended December 31, 2019, 2018 and 2017
    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

			INCORPORATED BY REFERENCE [1]		
EXHIBIT NUMBER	DESCRIPTION	FILED WITH THIS FORM 10-K	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
2.2	Agreement and Plan of Merger, dated as of March 26, 2019, by and among Centene Corporation, Wellington Merger Sub I, Inc., Wellington Merger Sub II, Inc., and WellCare Health Plans, Inc., incorporated by reference to Exhibit 2.1 to Centene Corporation's Current Report on Form 8-K dated March 27, 2019.		8-K	March 27, 2019	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 and restated effective as of October 22, 2019.		8-K	October 22, 2019	3.1
4.1	Description of Securities of the Company	X			
4.2	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
4.3	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 5.625% Senior Notes due 2021 (including Form of Global Note as Exhibit A thereto)		8-K	February 11, 2016	4.1
4.4	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
4.5	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

4.6	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
4.7	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
4.8	Indenture, dated as of December 6, 2019, by and between Centene Corporation, as issuer, and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to the Company’s 4.75% Senior Notes due 2025 (including the Form of Global Note attached thereto).	8-K	December 6, 2019	4.1
4.9	Indenture, dated as of December 6, 2019, by and between Centene Corporation, as issuer, and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to the Company’s 4.25% Senior Notes due 2027 (including the Form of Global Note attached thereto).	8-K	December 6, 2019	4.2
4.10	Indenture, dated as of December 6, 2019, by and between Centene Corporation, as issuer, and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to the Company’s 4.625% Senior Notes due 2029 (including the Form of Global Note attached thereto).	8-K	December 6, 2019	4.3
4.11	Registration Rights Agreement, dated December 6, 2019, by and among Centene Corporation, and Barclays Capital Inc., J.P. Morgan Securities LLC, SunTrust Robinson Humphrey, Inc., Wells Fargo Securities, LLC, and BofA Securities, Inc., as representatives of the initial purchasers, relating to the Company’s 4.75% Senior Notes due 2025.	8-K	December 6, 2019	4.4
4.12	Registration Rights Agreement, dated December 6, 2019, by and among Centene Corporation, and Barclays Capital Inc., J.P. Morgan Securities LLC, SunTrust Robinson Humphrey, Inc., Wells Fargo Securities, LLC, and BofA Securities, Inc., as representatives of the initial purchasers, relating to the Company’s 4.25% Senior Notes due 2027.	8-K	December 6, 2019	4.5
4.13	Registration Rights Agreement, dated December 6, 2019, by and among Centene Corporation, and Barclays Capital Inc., J.P. Morgan Securities LLC, SunTrust Robinson Humphrey, Inc., Wells Fargo Securities, LLC, and BofA Securities, Inc., as representatives of the initial purchasers, relating to the Company’s 4.625% Senior Notes due 2029.	8-K	December 6, 2019	4.6
4.14	Indenture, dated as of January 23, 2020, by and between Centene Corporation, as issuer, and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to the Company’s 5.25% Senior Notes due 2025 (including the Form of Global Note attached thereto).	8-K	January 23, 2020	4.1
4.15	Indenture, dated as of January 23, 2020, by and between Centene 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 the Form of Global Note attached thereto).	8-K	January 23, 2020	4.2
4.16	Indenture, dated as of February 13, 2020, by and between Centene Corporation, as issuer, and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to the Company's 3.375% Senior Notes due 2030 (including the Form of Global Note attached thereto).	8-K	February 13, 2020	4.1

4.17		Registration Rights Agreement, dated February 13, 2020, between Centene Corporation and Barclays Capital Inc., relating to the Company's 3.375% Senior Notes due 2030.	8-K	February 13, 2020	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	10-Q	July 23, 2019	10.1
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	10-K	February 19, 2019	10.6
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		10-K	February 19, 2019	10.19
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		Amendment and Restatement Agreement, dated as of May 7, 2019, to the Credit Agreement, dated as of March 24, 2016, as amended and restated as of December 14, 2017, among Centene Corporation, as borrower, the various financial institutions party thereto, as lenders, the other financial institutions party thereto and Wells Fargo Bank, National Association, as administrative agent.		10-Q	July 23, 2019	10.2
10.25b		Credit Agreement originally dated as of March 24, 2016, as amended and restated as of December 14, 2017, as further amended and restated as of May 7, 2019, and as further amended and restated as of September 11, 2019 among Centene Corporation, as the Company, the various financial institutions party hereto, as lenders, and Wells Fargo Bank, National Association, as administrative agent.		10-Q	October 22, 2019	10.1
10.25c		Amendment No. 1, dated as of November 14, 2019, to the Credit Agreement dated as of March 24, 2016, as amended and restated as of December 14, 2017, as further amended and restated as of May 7, 2019, and as further amended and restated as of September 11, 2019, among Centene Corporation, a Delaware corporation, the lenders party thereto and Wells Fargo Bank, National Association, as administrative agent.	X			
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	The following materials from the Centene Corporation Annual Report on Form 10-K for the fiscal year ended December 31, 2019, formatted in iXBRL (Inline Extensible Business Reporting Language): (i) the Consolidated Balance Sheets, (ii) the Consolidated Statements of Operations, (iii) the Consolidated Statements of Comprehensive Earnings, (iv) the Consolidated Statements of Stockholders' Equity, (v) the Consolidated Statements of Cash Flows and (vi) related notes.	X
104	Cover Page Interactive Data File (embedded within the Inline XBRL 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 18, 2020.

CENTENE CORPORATION

By: /s/ Michael F. Neidorff

Michael F. Neidorff
Chairman, President 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 18, 2020.

Signature	Title
/s/ Michael F. Neidorff **Michael F. Neidorff**	Chairman, President and Chief Executive Officer (principal executive officer)
/s/ Jeffrey A. Schwaneke **Jeffrey A. Schwaneke**	Executive Vice President, Chief Financial Officer and Treasurer (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/ Lori J. Robinson **Lori J. Robinson**	Director
/s/ David L. Steward **David L. Steward**	Director
/s/ Tommy G. Thompson **Tommy G. Thompson**	Director

Exhibit 4.1

DESCRIPTION OF CENTENE COMMON STOCK

Authorized Capital Stock of Centene

The Centene certificate of incorporation, as amended, provides that the total number of shares of capital stock which may be issued by Centene is 810,000,000, consisting of 800,000,000 shares of common stock, par value $0.001 per share, and 10,000,000 shares of preferred stock, par value $0.001 per share.

Voting Rights

The holders of Centene common stock are entitled to one vote on each matter submitted for their vote at any meeting of Centene stockholders for each share of Centene common stock held as of the record date for the meeting, including the election of directors. Holders of Centene common stock do not have cumulative voting rights.

Generally, the affirmative vote of the holders of a majority of the total number of votes cast of Centene capital stock represented at a meeting and entitled to vote on a matter is required in order to approve such matter. Certain extraordinary transactions and other actions require supermajority votes, including, but not limited to, the supermajority voting provisions described below in "—Anti-takeover Provisions—Other Supermajority Voting Requirements."

Liquidation Rights

In the event that Centene is liquidated, dissolved or wound up, the holders of Centene common stock will be entitled to share ratably in all assets remaining after the payment of liabilities, subject to any rights of holders of Centene preferred stock prior to distribution.

Dividends

Subject to any preference rights of holders of Centene preferred stock, the holders of Centene common stock are entitled to receive dividends and other distributions in cash, stock or property, if any, declared from time to time by the Centene Board out of legally available funds.

Fully Paid and Non-Assessable

All outstanding shares of Centene common stock are fully paid and non-assessable.

No Preemptive Rights or Conversion Rights

The Centene common stock has no preemptive or conversion rights or other subscription rights.

No Redemption Rights or Sinking Fund

No redemption or sinking fund provisions apply to the Centene common stock.

NYSE Listing

Centene common stock is listed on the NYSE under the symbol "CNC."

Transfer Agent and Registrar

The transfer agent and registrar for the Centene common stock is Broadridge Corporate Issuer Solutions, Inc.

Anti-takeover Provisions

Some of the provisions in the Centene certificate of incorporation, as amended, the Centene amended and restated by-laws and the DGCL could have the following effects, among others:

- delaying, deferring or preventing a change in control of Centene;
- delaying, deferring or preventing the removal of Centene's existing management or directors;

- deterring potential acquirers from making an offer to the Centene stockholders; and

- limiting the Centene stockholders' opportunity to realize premiums over prevailing market prices of Centene common stock in connection with offers by potential acquirers.

The following is a summary of some of the provisions in the Centene certificate of incorporation, as amended, and the Centene amended and restated by-laws that could have the effects described above. Centene believes that the benefits of increased protection of its potential ability to negotiate with the proponent of an unfriendly or unsolicited proposal to acquire or restructure Centene outweigh the disadvantages of discouraging takeover or acquisition proposals because negotiation of these proposals could result in an improvement of their terms.

Delaware Business Combination Statute

Centene must comply with Section 203 of the DGCL, an anti-takeover law. In general, Section 203 prohibits a publicly held Delaware corporation from engaging in a “business combination” with an “interested stockholder” for a period of three years following the date the person became an interested stockholder, unless the business combination or the transaction in which the person became an interested stockholder is approved in a prescribed manner or certain other exceptions are met. Generally, a “business combination” includes a merger, asset or stock sale, or other transaction resulting in a financial benefit to an interested stockholder. An “interested stockholder” includes a person who, together with affiliates and associates, owns, or did own within three years prior to the determination of interested stockholder status, 15% or more of the corporation’s voting stock. The existence of this provision generally will have an anti-takeover effect for transactions not approved in advance by the Centene Board, including discouraging attempts that might result in a premium over the market price for the shares of common stock held by stockholders.

Other Supermajority Voting Requirements

In addition to the supermajority requirement for certain business combinations discussed above, Centene’s certificate of incorporation also contains other supermajority requirements, including:

- a requirement that the vote of 75% of the outstanding shares of Centene common stock (and any other voting shares that may be outstanding) entitled to vote generally in the election of directors is required to remove a director, with or without cause;

- a requirement that the vote of 75% of the outstanding shares of Centene common stock (and any other voting shares that may be outstanding) entitled to vote generally in the election of directors is required for the stockholders to adopt, amend, alter or repeal Centene’s amended and restated by-laws; and

- a requirement that any amendment or repeal of specified provisions of Centene’s certificate of incorporation (including provisions relating to directors and amendment of Centene’s amended and restated by-laws) must be approved by at least 75% of the outstanding shares of Centene common stock (and any other voting shares that may be outstanding) entitled to vote generally in the election of directors.

Actions at Meetings of Stockholders; Special Meetings

Centene’s certificate of incorporation, as amended, and amended and restated by-laws require that any action required or permitted to be taken by Centene’s stockholders must be effected at a duly called annual or special meeting of the stockholders and may not be effected by a consent in writing. In addition, special meetings of

Centene’s stockholders may be called only by the Centene Board, the chairman of the Centene Board or Centene’s chief executive officer. These provisions may have the effect of deterring hostile takeovers or delaying or preventing changes in control or management of Centene.

Classified Board of Directors

Centene’s certificate of incorporation, as amended, and amended and restated by-laws provide that the Centene Board is divided into three classes of directors serving staggered three-year terms. Each class, to the extent possible, will be equal in number. Each class holds office until the third annual stockholders’ meeting for election of directors following the most recent election of such class.

Directors, and Not Stockholders, Fix the Size of the Centene Board

Centene's certificate of incorporation, as amended, and amended and restated by-laws provide that the number of directors will be fixed from time to time exclusively pursuant to a resolution adopted by a majority of the Centene Board, but in no event will it consist of less than five nor more than 11 directors.

Board Vacancies to Be Filled by Remaining Directors and Not Stockholders

Under Centene's certificate of incorporation, as amended, and amended and restated by-laws, any vacancy on the Centene Board created by any reason prior to the expiration of the term in which the vacancy occurs will be filled by a majority of the remaining directors, even if less than a quorum. A director elected to fill a vacancy will be elected for the unexpired term of his or her predecessor.

Advance Notice for Stockholder Proposals

Centene's amended and restated by-laws contain provisions requiring that advance notice be delivered to Centene of any business to be brought by a stockholder before an annual meeting and providing for procedures to be followed by Centene stockholders in nominating persons for election to the Centene Board. Ordinarily, the stockholder must give notice not less than 120 days nor more than 150 days prior to the anniversary date of the immediately preceding annual meeting; provided, however, that in the event that the date of the meeting is not within 30 days before or 70 days after such date, notice by the stockholder must be received no earlier than 120 days prior to such meeting and no later than the later of 70 days prior to the meeting or the 10th day following the day on which public disclosure of the date of the annual meeting was first made by Centene. The notice must include a description of the proposal, the reasons for the proposal, and other specified matters. The Centene Board may reject any proposals that have not followed these procedures.

Limitation on Liability of Directors; Indemnification

Centene's certificate of incorporation, as amended, provides that no director shall be personally liable to Centene or any of its stockholders for monetary damages for breach of fiduciary duty as a director, except to the extent such exemption from liability or limitation thereof is not permitted under the DGCL as the same exists or may hereafter be amended. If the DGCL is amended hereafter to authorize the further elimination or limitation of the liability of directors, then the liability of directors shall be eliminated or limited to the fullest extent authorized by the DGCL, as so amended. Centene's certificate of incorporation, as amended, further provides that any repeal or modification of this limitation of liability by the Centene stockholders shall not adversely affect any right or protection of a director of Centene existing at the time of such repeal or modification with respect to acts or omissions occurring prior to such repeal or modification.

Centene's certificate of incorporation, as amended, requires that Centene indemnify its directors and officers to the fullest extent authorized or permitted by law, as now or hereafter in effect, and that such right to indemnification shall continue as to a person who has ceased to be a director or officer and shall inure to the benefit of his or her heirs, executors and personal and legal representatives. Except for proceedings to enforce rights to indemnification, however, Centene shall not be obligated to indemnify in connection with a proceeding (or part thereof) if such director, officer or successor in interest initiated such proceeding (or part thereof) unless such proceeding was authorized or consented to by the Centene Board. The right to indemnification includes the right to be paid the expenses incurred in defending or otherwise participating in any proceeding in advance of its final disposition. Any repeal or modification by the stockholders of indemnification or advancement rights shall not adversely affect any rights to indemnification and to the advancement of expenses of a director or officer of Centene existing at the time of such repeal or modification with respect to any acts or omissions occurring prior to such repeal or modification.

The Centene Board may in its discretion provide rights to indemnification and to the advancement of expenses to employees and agents of Centene similar to those described above.

The inclusion of these provisions in the Centene certificate of incorporation, as amended, and amended and restated by-laws may have the effect of reducing the likelihood of derivative litigation against Centene's directors and may discourage or deter Centene or its stockholders from bringing a lawsuit against Centene's directors for breach of their duty of care, even though such an action, if successful, might otherwise have benefited Centene and its stockholders.

General Provisions Related to Centene Preferred Stock

The following is a description of general terms and provisions of the Centene preferred stock. All of the terms of the Centene preferred stock are, or will be contained in Centene's certificate of incorporation, as amended, or in one or more certificates of designation relating to each series of the preferred stock, which will be filed with the SEC at or prior to the issuance of the series of preferred stock, and will be available as described under the heading "Where You Can Find More Information."

The Centene Board is authorized, without further stockholder approval but subject to applicable rules of the NYSE and any limitations prescribed by law, to issue up to ten million shares of preferred stock from time to time. The Centene Board has the discretion to provide for the issuance of all or any shares of preferred stock in one or more classes or series, and to fix for each such class or series such voting powers, full or limited, or no voting powers, and such designations, preferences and relative, participating, optional or other special rights and such qualifications, limitations or restrictions thereof, as shall be stated and expressed in the resolution or resolutions adopted by the board of directors providing for the issuance of such class or series, including, without limitation, the authority to provide that any such class or series may be:

- subject to redemption at such time or times and at such price or prices;
- entitled to receive dividends (which may be cumulative or non-cumulative) at such rates, on such conditions, and at such times, and payable in preference to, or in such relation to, the dividends payable on any other class or classes or any other series;
- entitled to such rights upon the dissolution of Centene or upon any distribution of Centene's assets; or
- convertible into, or exchangeable for, shares of any other class or classes of stock or of any other series of the same or any other class or classes of stock of Centene at such price or prices or at such rates of exchange and with such adjustments as the board may determine.

The purpose of authorizing the Centene Board to issue preferred stock and determine its rights and preferences is to eliminate delays associated with a stockholder vote on specific issuances. The issuance of preferred stock may provide desirable flexibility in connection with possible acquisitions and other corporate purposes, but could have the effect of making it more difficult for a third party to acquire, or could discourage a third party from acquiring, a majority of Centene's outstanding voting stock.

Certain Effects of Authorized but Unissued Stock

Centene may issue additional shares of common stock or preferred stock without stockholder approval, subject to applicable rules of the NYSE and Delaware law, for a variety of corporate purposes, including future public or private offerings to raise additional capital, corporate acquisitions, and employee benefit plans and equity grants. The existence of unissued and unreserved common and preferred stock may enable Centene to issue shares to persons who are friendly to current management, which could discourage an attempt to obtain control of Centene by means of a proxy contest, tender offer, merger or otherwise. Centene will not solicit approval of its stockholders for issuance of common and preferred stock unless the Centene Board believes that approval is advisable or is required by applicable rules of the NYSE or Delaware law.

AMENDMENT NO 1., dated as of November 14, 2019 (this "Agreement"), to the Credit Agreement dated as of March 24, 2016, as amended and restated as of December 14, 2017, as further amended and restated as of May 7, 2019, and as further amended and restated as of September 11, 2019 (the "Existing Credit Agreement"), among CENTENE CORPORATION, a Delaware corporation (the "Company"), the LENDERS party thereto and WELLS FARGO BANK, NATIONAL ASSOCIATION, as Administrative Agent (in such capacity, the "Administrative Agent").

Capitalized terms used but not otherwise defined herein (including in the preamble and recitals hereto) have the meanings assigned to them in the Existing Credit Agreement.

WHEREAS, the Lenders, the Issuing Lenders and the Swing Line Lender party to the Existing Credit Agreement have agreed to extend credit to the Company under the Existing Credit Agreement on the terms and subject to the conditions set forth therein;

WHEREAS, the Company has requested that, on the Amendment Effective Date (as defined below), certain modifications be made to the Existing Credit Agreement; and

WHEREAS, the Administrative Agent and each of the Lenders party hereto, which Lenders constitute the Required Lenders under the Existing Credit Agreement, are willing to agree to the foregoing, in each case, on the terms and subject to the conditions set forth herein.

NOW THEREFORE, in consideration of the mutual agreements herein contained and other good and valuable consideration, the sufficiency and receipt of which are hereby acknowledged, and intending to be legally bound, the parties hereto hereby agree as follows:

SECTION 1. Amendment of the Existing Credit Agreement. Effective as of the Amendment Effective Date (as defined below), the Existing Credit Agreement is hereby amended by replacing the following definitions in Section 1.1 thereof in their entirety with the following:

"Fixed Charge Coverage Ratio" means, for any Computation Period, the ratio of (a) the total for such period of EBITDA minus the sum of income taxes paid in cash by the Loan Parties, all non-financed Capital Expenditures and cash dividends paid by the Company to (b) the sum for such period of (i) cash Interest Expense plus (ii) required payments of principal of Funded Debt (excluding (x) any balloon payments at maturity and (y) any payments in connection with any special mandatory redemption of the New Senior Notes as a result of the Wellington Acquisition not being consummated) (but, for all purposes of this definition, treating Unrestricted Subsidiaries as if they were not consolidated with the Company and otherwise eliminating all accounts of Unrestricted Subsidiaries); provided however, that until the earlier of (x) the consummation of the Wellington Acquisition pursuant to the Wellington Acquisition Agreement and (y) September 26, 2020, for purposes of this definition, Interest Expense shall not include any Interest Expense in respect of New Senior Notes that are subject to special mandatory redemption provisions related to the consummation of the Wellington Acquisition.

"Total Debt to EBITDA Ratio" means, as of the last day of any Fiscal Quarter, the ratio of (a) (i) Total Debt as of such day less (ii) the lesser of (x) unrestricted cash and cash equivalents of the Company and its Subsidiaries as of such day in excess of $50,000,000 and (y) $750,000,000 to (b) EBITDA for the Computation Period ending on such day; provided however, that until the earlier of (x) the consummation of the Wellington Acquisition pursuant to the Wellington Acquisition Agreement and (y) September 26, 2020, for purposes of this definition (A) Total Debt shall not include any New Senior Notes that are subject to special mandatory redemption provisions related to the consummation of the Wellington Acquisition and (B) the proceeds of any such New Senior Notes shall not be included in unrestricted cash and cash equivalents of the Company and its Subsidiaries.

SECTION 2. Reserved.

SECTION 3. Representations and Warranties. The Company represents and warrants to the Administrative Agent and to each of the Lenders, as of the Amendment Effective Date, that:

(a) this Agreement has been duly authorized by all necessary action of the Company, and this Agreement has been duly executed and delivered by the Company and constitutes a legal, valid and binding obligation of the Company, enforceable against it in accordance with its terms, subject to bankruptcy, insolvency and similar Laws affecting the enforceability of creditors' rights generally and to general principles of equity;

(b) after giving effect to this Agreement, the representations and warranties of each Loan Party set forth in the Loan Documents are true and correct (i) in the case of the representations and warranties qualified as to materiality, in all respects and (ii) otherwise, in all material respects, in each case on and as of the Amendment Effective Date, except in the case of any such representation and warranty that expressly relates to a prior date, in which case such representation and warranty is so true and correct on and as of such prior date; and

(c) on and as of the Amendment Effective Date, after giving effect to this Agreement, no Event of Default or Unmatured Event of Default has occurred and is continuing under the Existing Credit Agreement.

SECTION 4. Effectiveness. The amendment of the Existing Credit Agreement as set forth in Section 1 hereof shall become effective on the first date on which the following conditions shall have been satisfied or waived (the "Amendment Effective Date"):

(a) The Administrative Agent shall have executed a counterpart hereto and shall have received from (i) the Company and (ii) Lenders party to the Existing Credit Agreement that together constitute the Required Lenders under the Existing Credit Agreement either (A) a counterpart of this Agreement signed on behalf of such party or (B) evidence satisfactory to the Administrative Agent (which may include a facsimile transmission or other electronic transmission of a signed counterpart of this Agreement) that such party has signed a counterpart of this Agreement.

(b) The Administrative Agent shall have received a certificate, dated the Amendment Effective Date and signed by a Senior Officer on behalf of the Company, certifying that the representations and warranties set forth in Section 3 hereof are true and correct as of the Amendment Effective Date.

The Administrative Agent shall notify the Company and the Lenders of the Amendment Effective Date, and such notice shall be conclusive and binding.

SECTION 5. Effect of Amendment; No Novation.

(a) Except as expressly set forth herein, this Agreement shall not by implication or otherwise limit, impair, constitute a waiver of, or otherwise affect the rights and remedies of the Administrative Agent, the Issuing Lenders, the Swing Line Lender or the Lenders under the Existing Credit Agreement or any other Loan Document, and shall not alter, modify, amend or in any way affect any of the terms, conditions, obligations, covenants or agreements contained in the Existing Credit Agreement or any other Loan Document, all of which shall continue in full force and effect in accordance with the provisions thereof.

(b) Nothing herein shall be deemed to entitle any Loan Party to a consent to, or a waiver, amendment, modification or other change of, any of the terms, conditions, obligations, covenants or agreements contained in the Existing Credit Agreement or any other Loan Document in similar or different circumstances.

(c) On and after the Amendment Effective Date, each reference in the Existing Credit Agreement to "this Agreement", "hereunder", "hereof", "herein", or words of like import shall refer to the Existing Credit Agreement as amended hereby, and the term "Credit Agreement", as used in any Loan Document, shall mean the Existing Credit Agreement as amended hereby. This Agreement shall constitute a "Loan Document" for all purposes of the Existing Credit Agreement and the other Loan Documents.

(d) This Agreement shall not extinguish the obligations for the payment of money outstanding under the Existing Credit Agreement. Nothing herein contained shall be construed as a substitution or novation of the Obligations outstanding under the Existing Credit Agreement. Nothing expressed or implied in this Agreement, the Existing Credit Agreement or any other document contemplated hereby or thereby shall be construed as a release or other discharge of the Company under the Existing Credit Agreement or any Loan Party under any Loan Document from any of its obligations and liabilities thereunder.

SECTION 6. Governing Law. THIS AGREEMENT AND THE RIGHTS AND OBLIGATIONS OF THE PARTIES HEREUNDER SHALL BE GOVERNED BY, AND SHALL BE CONSTRUED AND ENFORCED IN ACCORDANCE WITH, THE LAWS OF THE STATE OF NEW YORK WITHOUT REGARD TO CONFLICT OF LAW PRINCIPLES THAT WOULD RESULT IN THE APPLICATION OF ANY LAW OTHER THAN THE LAW OF THE STATE OF NEW YORK.

SECTION 7. Counterparts. This Agreement may be executed in counterparts (and by different parties hereto on different counterparts), each of which shall constitute an original, but all of which when taken together shall constitute a single contract. Delivery of an executed counterpart of a signature page of this Agreement by facsimile or other electronic imaging shall be effective as delivery of a manually executed counterpart of this Agreement. Electronic records of executed Loan Documents maintained by the Lenders shall be deemed to be originals.

SECTION 8. Severability. Any provision of this Agreement held to be invalid, illegal or unenforceable in any jurisdiction shall, as to such jurisdiction, be ineffective to the extent of such invalidity, illegality or unenforceability without affecting the validity, legality and enforceability of the remaining provisions hereof; and the invalidity of a particular provision in a particular jurisdiction shall not invalidate such provision in any other jurisdiction.

SECTION 9. Headings. Section headings used herein are for convenience of reference only, are not part of this Agreement and are not to be taken into consideration in interpreting, this Agreement.

[Signature pages follow.]

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be duly executed by their respective authorized officers as of the date set forth above.

CENTENE CORPORATION

by /s/ Jeffrey A. Schwaneke
Name: Jeffrey A. Schwaneke
Title: Executive Vice President and Chief Financial Officer

WELLS FARGO BANK, NATIONAL ASSOCIATION

by /s/ Darin Mullis
Name: Darin Mullis
Title: Managing Director

Barclays Bank PLC

by /s/ Edward Pan
Name: Edward Pan
Title: Associate

Current Revolving Commitment: $225,000,000
Current Revolving Outstandings: $13,500,000
Current 2019 Incremental Term Loan: $25,000,000

BMO Harris Bank NA

by /s/ Joseph Podrabsky
Name: Joseph Podrabsky
Title: Vice President

Current Revolving Commitment: $60,000,000
Current Revolving Outstandings: $3,319,452.09
Current 2019 Incremental Term Loan: $115,000,000

Bank of America, N.A.

by /s/ Yinghua Zhang
Name: Yinghua Zhang
Title: Director

Current Revolving Commitment: $205,000,000
Current Revolving Outstandings:
- Revolving Loans - €8,518,088
- Participation in Letters of Credit: $2,824,588

Current 2019 Incremental Term Loan: $185,000,000

CIBC Bank USA

by /s/ Kloie McCann
Name: Kloie McCann
Title: Associate Managing Director

Current Revolving Commitment: $50,000,000
Current Revolving Outstandings: $2,975,838.14
Current 2019 Incremental Term Loan: $90,000,000

Fifth Third Bank

by /s/ Nathaniel E. Sher
Name: Nathaniel E. Sher
Title: Senior Vice President

Current Revolving Commitment: $175,000,000
Current Revolving Outstandings: $10,410,084.79
Current 2019 Incremental Term Loan: $60,000,000

JPMorgan Chase Bank, N.A

by /s/ Danielle D. Babine
Name: Danielle D. Babine
Title: Vice President

Current Revolving Commitment: $225,000,000
Current Revolving Outstandings: $13,411,695
Current 2019 Incremental Term Loan: $185,000,000

MUFG Bank, LTD

by /s/ Teuta Ghilaga
Name: Teuta Ghilaga
Title: Director

Current Revolving Commitment: $125,000,000
Current Revolving Outstandings: $7,400,000
Current 2019 Incremental Term Loan: $185,000,000

PNC Bank, National Association, as a Lender

by /s/ Samreen Fatima
Name: Samreen Fatima
Title: Assistant Vice President

Current Revolving Commitment: $75,000,000
Current Revolving Outstandings: $4,502,031
Current 2019 Incremental Term Loan: $90,000,000

Regions Bank

by /s/ Brian Walsh
Name: Brian Walsh
Title: Director

Current Revolving Commitment: $175,000,000
Current Revolving Outstandings: $8,128,555
Current 2019 Incremental Term Loan: $45,000,000

Stifil Bank & Trust

by /s/ John H. Phillips
Name: John H. Phillips
Title: Executive Vice President

Current Revolving Commitment: $60,000,000
Current Revolving Outstandings: $2,823,366.45
Current 2019 Incremental Term Loan: $0

SunTrust Bank

by /s/ Katherine Bass
Name: Katherine Bass
Title: Director

Current Revolving Commitment: $225,000,000
Current Revolving Outstandings: $13,476,348.69
Current 2019 Incremental Term Loan: $100,000,000

U.S Bank National Association

by /s/ David C. Mruk
Name: David C. Mruk
Title: Senior Vice President

Current Revolving Commitment: $175,000,000
Current Revolving Outstandings: $10,496,603
Current 2019 Incremental Term Loan: $45,000,000

WELLS FARGO BANK, NATIONAL ASSOCIATION, as Administrative Agent,

by /s/ Darin Mullis
Name: Darin Mullis
Title: Managing Director

Current Revolving Commitment: $225,000,000
Current Revolving Outstandings: $10,396,809.55
Current 2019 Incremental Term Loan: $275,000,000

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 Florida City, Inc., a Florida corporation
Access Medical Group of Hialeah, Inc., a Florida corporation
Access Medical Group of Lakeland, LLC, a Florida LLC
Access Medical Group of Miami, Inc., a Florida corporation
Access Medical Group of North Miami Beach, Inc., a Florida corporation
Access Medical Group of Opa-Locka, Inc., a Florida corporation
Access Medical Group of Perrine, 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
Access Medical Group of Westchester, 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
Arch Personalized Medicine Initiative, LLC, a Missouri LLC
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
B2B Gestion Integra S.L.U., a Spanish S.L.U.
B2B Lab S.L., a Spanish S.L.
B2B Salud S.L.U., a Spanish S.L.U.
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
Buckeye Health Plan Community Solutions, Inc., an Ohio corporation
Calibrate Acquisition Company, a Delaware 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
CCTX Holdings, LLC, a Texas LLC
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 Europe Finance Company Limited, a limited liability Malta company
Centene Health Plan Holdings, Inc., a Delaware corporation
Centene International Ventures, LLC, a Delaware LLC
Centene Management Company, LLC, a Wisconsin LLC
Centene Venture Company Alabama Health Plan, Inc., an Alabama corporation
Centene Venture Company Florida, Inc., a Florida corporation
Centene Venture Company Illinois, Inc., an Illinois corporation
Centene Venture Company Indiana, Inc., an Indiana corporation
Centene Venture Company Kansas, Inc., a Kansas corporation
Centene Venture Company Michigan, Inc., a Michigan corporation
Centene Venture Company Tennessee, Inc., a Tennessee corporation
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 Delaware, LLC, a Delaware LLC
Centurion of Florida, LLC, a Florida LLC
Centurion of Kansas, LLC, a Kansas LLC
Centurion of Minnesota, LLC, a Minnesota LLC
Centurion of Mississippi, LLC, a Mississippi LLC
Centurion of New Hampshire, LLC, a Delaware LLC
Centurion of Pennsylvania, LLC, a Pennsylvania LLC
Centurion of Tennessee, LLC, a Tennessee LLC
Centurion of Vermont, LLC, a Vermont LLC
Centurion of West Virginia, LLC, a West Virginia LLC
Centurion of Wyoming, LLC, a Wyoming 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
CT Poprad, a Slovakia S.R.O.
District Community Care, Inc., a Washington D.C. corporation
DR Magnet, a Slovakia S.R.O.

Elche-Crevillente Salud, a Spanish S.A.
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, LLC, a Delaware LLC
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
HealthSmart Benefit Solutions, Inc., an Illinois corporation
HealthSmart Benefits Management, LLC, a Texas LLC
HealthSmart Care Management Solutions, LP, a Texas partnership
HealthSmart Information Systems, Inc., a Texas corporation
HealthSmart Preferred Care II, LP, a Texas partnership
HealthSmart Preferred Network II Inc., a Delaware corporation
HealthSmart Primary Care Clinics, LP, a Texas partnership
HealthSmart Rx Solutions, Inc., an Ohio 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
Hospital Povisa, S.A., a Spanish S.A.
Hudson Acquisition, LLC, a Texas LLC
IAH of Florida, LLC, a Florida LLC
IlliniCare Health Plan, Inc., an Illinois corporation
Illinois Health Practice Alliance, LLC, a Delaware corporation
Infraestructuras y Servicios de Alzira S. L., a Spanish S.L.
Integrated Care Network of Florida, LLC, a Delaware LLC
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
Mauli Ola Health and Wellness, Inc., a Hawaii corporation
Medicina Nove Zamky, a Slovakia S.R.O.
MH Services International (UK) Limited, an English and Welsh private company
MH Services International Holdings (UK) Limited, an English and Welsh private company
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
MHS Travel & Charter, Inc., a Wisconsin corporation
Michigan Complete Health, a Michigan corporation
MR Poprad, a Slovakia S.R.O.
MR Zilina, a Slovakia S.R.O.
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
Next Door Neighbors, Inc., a Delaware corporation
Next Door Neighbors, LLC., a Delaware LLC
nirvanaHealth, LLC, a Delaware LLC
North Florida Health Services, Inc., a Florida corporation
Novasys Health, Inc., a Delaware corporation
OB Care, a Czech Republic S.R.O.
OB Klinika, a Czech Republic A.S.
Operose Health (Group) Ltd., an English and Welsh private company
Operose Health (Group) UK Ltd., an English and Welsh private company
Operose Health Ltd., an English and Welsh private company
Parker LP, LLC, a Nevada LLC
Peach State Health Plan, Inc., a Georgia corporation
Pennsylvania Health and Wellness, Inc., a Pennsylvania 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 Illinois, LLC, an Illinois 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 S.L.
Pro Diagnostic Group, A.S., a Slovakia A.S.
Pro Magnet, a Slovakia S.R.O.
Pro Magnet CZ, a Czech Republic S.R.O.
Pro RTG, a Slovakia S.R.O.
Progress Medical A.S., a Czech Republic A.S.
QCA Healthplan, Inc., an Arkansas corporation
Qualchoice Life and Health Insurance Company, and Arkansas company
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

Ribera Salud II, a Spanish UTE

Ribera Slaud Infraestructuras S.L.U., a Spanish S.L.U.

Ribera Salud Proyectos S.L., a Spanish S.L.

Ribera Salud Tecnologias S.L.U., a Spanish S.L.U.

Ribera Salud, S.A., a Spanish S.A.

Ribera-Quilpro UTE, a Spanish UTE

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

Social Health Bridge Trust, a Delaware trust

Social Health Bridge, LLC, a Delaware LLC

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 Community Solutions, Inc., a Florida corporation

Sunshine Health Holding, LLC, a Florida LLC

Sunshine State Health Plan, Inc., a Florida corporation

Superior HealthPlan, Inc., a Texas corporation

Superior HealthPlan Community Solutions, Inc., a Texas corporation

The Practice Properties Limited, an English and Welsh private company

Torrejon Salud, S.A., a Spanish S.A.

Torrevieja Salud S.L.U., a Spanish S.L.U.

Torrevieja Salud UTE, a Spanish UTE

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

Wellington Merger Sub I, LLC, a Delaware LLC

Wellington Merger Sub II, LLC, a Delaware LLC

Western Sky Community Care, Inc., a New Mexico corporation

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. 333-236036, 333-217634, 333-210376, 333-197737, 333-180976, 333-108467, and 333-90976) and in the registration statement on Form S-3 (No. 333-217636) of Centene Corporation of our reports dated February 18, 2020, with respect to the consolidated balance sheets of Centene Corporation and subsidiaries as of December 31, 2019 and 2018, 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, 2019 and the related notes (collectively, the consolidated financial statements), and the effectiveness of internal control over financial reporting as of December 31, 2019, which reports appear in the December 31, 2019 annual report on Form 10-K of Centene Corporation.

/s/ KPMG LLP

St. Louis, Missouri
February 18, 2020

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 18, 2020

/s/ MICHAEL F. NEIDORFF

Chairman, President 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 18, 2020

/s/ JEFFREY A. SCHWANEKE

Executive Vice President, Chief Financial Officer and Treasurer *(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, 2019, 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 18, 2020

/s/ MICHAEL F. NEIDORFF

Chairman, President 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, 2019, 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 18, 2020

/s/ JEFFREY A. SCHWANEKE

Executive Vice President, Chief Financial Officer and Treasurer (principal financial officer)