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, 2021

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, a 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 has filed a report on and attestation to its management's assessment of the effectiveness of its internal control over financial reporting under Section 404(b) of the Sarbanes-Oxley Act (15 U.S.C. 7262(b)) by the registered public accounting firm that prepared or issued its audit report. ☒

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, 2021, was $42.5 billion.

As of February 18, 2022, the registrant had 582,865,870 shares of common stock issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Proxy Statement for the registrant's 2022 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 Corporation and its subsidiaries (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, value creation strategy, competition, expected activities in completed and future acquisitions, including statements about the impact of our recently completed acquisition of Magellan Health (the Magellan Acquisition), other recent and future acquisitions and dispositions, 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 1. "Business," Part I, Item IA "Risk Factors," 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:

- our ability to accurately predict and effectively manage health benefits and other operating expenses and reserves, including fluctuations in medical utilization rates due to the impact of COVID-19;
- the risk that the election of new directors, changes in senior management and inability to retain key personnel may create uncertainty or negatively impact our ability to execute quickly and effectively;
- uncertainty as to the expected financial performance of the combined company following the recent completion of the Magellan Acquisition;
- the possibility that the expected synergies and value creation from the Magellan Acquisition or the WellCare Acquisition (or other acquired businesses) will not be realized, or will not be realized within the respective expected time periods;
- the risk that unexpected costs will be incurred in connection with the integration of the Magellan Acquisition or that the integration of Magellan Health will be more difficult or time consuming than expected, or similar risks from other acquisitions we may announce or complete from time to time;
- disruption from the integration of the Magellan Acquisition or from the integration of the WellCare Acquisition, or similar risks from other acquisitions we may announce or complete from time to time, 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;
- a downgrade of the credit rating of our indebtedness;
- 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 ACA) and any regulations enacted thereunder that may result from changing political conditions, the new administration or judicial actions;

- 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;
- tax matters;
- disasters or major epidemics;
- changes in expected contract start dates;
- provider, state, federal, foreign 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 legal or regulatory proceedings or matters, including, but not limited to, our ability to resolve claims and/or allegations made by states with regard to past practices, including at Envolve Pharmacy Solutions, Inc. (Envolve), as our pharmacy benefits manager (PBM) subsidiary, within the reserve estimate we have recorded and on other acceptable terms, or at all, or whether additional claims, reviews or investigations relating to our PBM business will be brought by states, the federal government or shareholder litigants, or government investigations;
- timing and extent of benefits from strategic value creation initiatives, including the possibility that these initiatives will not be successful, or will not be realized within the expected time periods;
- challenges to our contract awards;
- cyber-attacks or other privacy or data security incidents;
- 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;
- changes in expected closing dates, estimated purchase price and accretion for acquisitions;
- the risk that acquired businesses will not be integrated successfully;
- 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 our 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.

SUMMARY OF RISK FACTORS

Our business is subject to numerous risks and uncertainties that you should be aware of in evaluating our business, including risks that may prevent us from achieving our business objectives or may adversely affect our business, financial condition, results of operations, cash flows and prospects. These risks include, but are not limited to, the following, all of which are more fully described in Part 1, Item 1A "Risk Factors". This summary should be read in conjunction with the Risk Factors section and should not be relied upon as an exhaustive summary of the material risks facing our business.

- Our business could be materially adversely affected by the effects of widespread public health pandemics, such as COVID-19;
- Our Medicare programs are subject to a variety of unique risks that could adversely impact our financial results;
- Failure to accurately estimate and price our medical expenses or effectively manage our medical costs or related administrative costs could have a material adverse effect on our results of operations, financial position and cash flows;
- Risk-adjustment payment systems make our revenue and results of operations more difficult to estimate and could result in retroactive adjustments that have a material adverse effect on our results of operations, financial condition and cash flows;
- Any failure to adequately price products offered or any reduction in products offered in the Health Insurance Marketplaces may have a material adverse effect on our results of operations, financial position and cash flows;
- We derive a portion of our cash flow and gross margin from our prescription drug plan (PDP) operations, for which we submit annual bids for participation. The results of our bids could have a material adverse effect on our results of operations, financial condition and cash flows;
- Our encounter data may be inaccurate or incomplete, which could have a material adverse effect on our results of operations, financial condition, cash flows and ability to bid for, and continue to participate in, certain programs;
- 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;
- Ineffectiveness of state-operated systems and subcontractors could adversely affect our business;
- Execution of our value creation strategy may create disruptions in our business;
- 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;
- 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 derive a significant portion of our premium revenues from operations in a limited number of states, and our results of operations, financial position or cash flows could be materially affected by a decrease in premium revenues or profitability in any one of those states;
- Competition may limit our ability to increase penetration of the markets that we serve;
- If we are unable to maintain relationships with our provider networks, our profitability may be harmed;
- If we are unable to integrate and manage our information systems effectively, our operations could be disrupted;
- An impairment charge with respect to our recorded goodwill and intangible assets could have a material impact on our results of operations;
- 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 a material adverse effect on our business;
- We may be unable to attract, retain or effectively manage the succession of key personnel;
- 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 have a material adverse effect on our results of operations, financial position and cash flows;
- Significant changes or judicial challenges to the ACA could materially and adversely affect 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 businesses providing pharmacy benefits 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 have been and may from time to time, become involved in costly and time-consuming litigation and other regulatory proceedings, which require significant attention from our management, and could adversely affect our business;

- 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;
- 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;
- Our investment portfolio may suffer losses which could materially and adversely affect our results of operations or liquidity;
- Adverse credit market conditions may have a material adverse effect on our liquidity or our ability to obtain credit on acceptable terms;
- 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;
- Changes in the method pursuant to which the LIBOR rates are determined and the phasing out of LIBOR 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;
- Mergers and acquisitions may not be accretive and may cause dilution to our earnings per share, which may cause the market price of our common stock to decline;
- We may be unable to successfully integrate our existing business with acquired businesses and realize the anticipated benefits of such acquisitions;
- Our business and results of operations may be materially adversely affected if we fail to manage and complete divestitures; and
- Future issuances and sales of additional shares of preferred or common stock could reduce the market price of our shares of common stock.

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,		
	2021	2020	2019
GAAP net earnings attributable to Centene	$ 1,347	$ 1,808	$ 1,321
Amortization of acquired intangible assets	770	719	258
Acquisition related expenses	185	602	104
Other adjustments [1]	1,275	29	301
Income tax effects of adjustments [2]	(537)	(262)	(127)
Adjusted net earnings	$ 3,040	$ 2,896	$ 1,857
GAAP diluted earnings per share (EPS) attributable to Centene	$ 2.28	$ 3.12	$ 3.14
Amortization of acquired intangible assets [3]	1.00	0.95	0.47
Acquisition related expenses [4]	0.24	0.86	0.19
Other adjustments [1]	1.63	0.07	0.62
Adjusted Diluted EPS	$ 5.15	$ 5.00	$ 4.42

(1) Other adjustments include the following items:

2021:

(a) legal settlement expense and related legal fees of $1,264 million, or $1.76 per diluted share, net of an income tax benefit of $0.38;

(b) debt extinguishment costs of $125 million, or $0.16 per diluted share, net of an income tax benefit of $0.05;

(c) severance costs due to a restructuring of $54 million, or $0.06 per diluted share, net of an income tax benefit of $0.03;

(d) a reduction to the previously reported gain due to the finalization of the working capital adjustment related to the divestiture of certain products of our Illinois health plan of $62 million, or $0.08 per diluted share, net of an income tax benefit of $0.02;

(e) non-cash gain related to the acquisition of the remaining 60% interest of Circle Health of $309 million, or $0.52 per diluted share, net of income tax expense of $0.00;

(f) non-cash impairment of our equity method investment in RxAdvance of $229 million, or $0.32 per diluted share, net of an income tax benefit of $0.07; and

(g) gain related to the divestiture of U.S. Medical Management (USMM) of $150 million, or $0.23 per diluted share, net of income tax expense of $0.02.

2020:

(a) debt extinguishment costs of $61 million, or $0.07 per diluted share, net of an income tax benefit of $0.04;

(b) gain related to the divestiture of certain products of our Illinois health plan of $104 million, or $0.10 per diluted share, net of income tax expense of $0.08; and

(c) non-cash impairment of $72 million, or $0.10 per diluted share, net of an income tax benefit of $0.02.

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.

(2) The income tax effects of adjustments are based on the effective income tax rates applicable to each adjustment.

(3) Amortization of acquired intangible assets is net of an income tax benefit of $0.31, $0.29, and $0.14 per diluted share for the years ended December 31, 2021, 2020 and 2019, respectively.

(4) Acquisition related expenses are net of an income tax benefit of $0.07, $0.18 and $0.06 per diluted share for the years ended December 31, 2021, 2020 and 2019, respectively.

	Year Ended December 31,		
	2021	**2020**	**2019**
GAAP selling, general and administrative expenses	$ 10,166	$ 9,867	$ 6,533
Less:			
Acquisition related expenses	157	580	85
Restructuring costs	54	—	—
Legal fees related to legal settlement	14	—	—
Adjusted selling, general and administrative expenses	$ 9,941	$ 9,287	$ 6,448

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, 2021, our Managed Care and Specialty Services segments accounted for 95% and 5%, respectively, of our total external revenues. Our membership totaled 26.6 million as of December 31, 2021. For the year ended December 31, 2021, our total revenues and net earnings attributable to Centene were $126.0 billion and $1.3 billion, respectively, and our total cash flow from operations was $4.2 billion.

Magellan Acquisition

On January 4, 2022, we acquired all of the issued and outstanding shares of Magellan Health, Inc. (Magellan) for a total purchase price of approximately $2.6 billion. The Magellan acquisition enables Centene to provide whole-health, integrated healthcare solutions to deliver better health outcomes at lower costs for complex, high-cost populations.

INDUSTRY

We provide a full spectrum of managed healthcare products and services, primarily through Medicaid, Medicare and commercial 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 by the federal government. 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, subject to the states' elections. The federal government paid 90% of the costs for Medicaid Expansion coverage for newly eligible beneficiaries in 2021. 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, the Aged, Blind, or Disabled (ABD) program 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 more complicated 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 ADvancing States (formerly National Association of States United for Aging and Disabilities), as of August 2021, 25 states utilize some form of managed LTSS.

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.

As of the first quarter of 2020, CMS estimated the total Medicaid market to be approximately $684 billion in 2021, and estimates the market will grow to over $1.0 trillion by 2028. Medicaid spending is estimated to have increased by 5.5% in 2021 and is projected to increase at an average annual rate of 5.8% between 2021 and 2028. Due to the timing of the CMS report and highly uncertain nature of the pandemic, the aforementioned projections do not take into account the impact of COVID-19.

A portion of Medicaid 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 11.3 million dual-eligible enrollees in 2020. These dual-eligible members may receive assistance from Medicaid for benefits, such as nursing home care, HCBS, and/or assistance with Medicare premiums and cost sharing. Dual-eligibles also use more services due to their tendency to have more chronic health issues. We serve dual-eligibles through our ABD, LTSS, Medicare-Medicaid Plans (MMP), Medicare Advantage Dual Special Needs Plan (DSNP) and standard Medicare Advantage lines of business.

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.

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 healthcare 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. As our Medicare Advantage members reach their deductibles and out-of-pocket maximums, our medical costs rise, creating seasonality in the business with a higher percentage of earnings in the first half of the year.

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.

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 were 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 $923 billion in 2021, and estimates the market will grow to approximately $1.6 trillion by 2028. Medicare spending is estimated to have increased 7.5% in fiscal 2021 and is projected to increase at an average annual rate of 7.7% between 2021 and 2028.

Medicare Prescription Drug Plan

We have contracted with CMS to serve as a plan sponsor offering stand-alone Medicare Part D PDP plans to Medicare-eligible beneficiaries. We offer PDPs in 50 states and the District of Columbia. Our PDPs offer national in-network prescription drug coverage, including a preferred pharmacy network, subject to limitations in certain circumstances.

Our PDP contracts with CMS are renewable for successive one-year terms unless CMS notifies us of its decision not to renew by May 1 of the current contract year or we notify CMS of our decision not to renew by the first Monday in June of the contract year.

The Medicare Part D prescription drug benefit is supported by risk sharing with the federal government through risk corridors designed to limit the losses and gains of the participating drug plans and by reinsurance for catastrophic drug costs. The government subsidy is based on the national weighted average monthly bid for this coverage, adjusted for risk factor payments. Additional subsidies are provided for dually-eligible beneficiaries and specified low-income beneficiaries.

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 families 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. 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 individuals and 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 copays and can be subject to deductibles and coinsurance. As our commercial members reach their deductibles and out-of-pocket maximums, our medical costs rise, creating seasonality in the business with a higher percentage of earnings in the first half of the year.

International

We have an international presence in the United Kingdom (UK), Spain, and Slovakia. In July 2021, we acquired the remaining interest in Circle Health, which includes BMI Healthcare and represents one of the UK's largest independent hospital operators. Also, in the UK, we have subsidiaries operating as part of Operose Health Group, which includes AT Medics Holdings, representing one of the largest provider networks in the country and delivering medical and community based services in the primary care sector of the National Health Service (NHS), which is the publicly funded, national healthcare system for England. Our presence in Spain is mainly associated with our subsidiaries operating as part of the Ribera Salud Group, which manages health administration concessions and private hospitals in various regions in Spain. Ribera Salud Group also holds a noncontrolling investment in Slovakia, which provides radiology services in the region. As previously disclosed, we are exploring strategic alternatives for our international business as part of our portfolio review.

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 support providers with tools and information to 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, Start Smart for Your Baby, Living Well with Sickle Cell, Fluvention 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 systems are capable of expanding to support additional members in an efficient manner. We continue to design and deploy enhanced capabilities that we expect will streamline and digitize the member and provider experience, increase satisfaction and deliver administrative efficiencies.

- *Financial Strength and Scale.* We are a large healthcare enterprise with $126.0 billion in revenue and $4.2 billion in operating cash flow in 2021. Our strong historical operating performance, size, and scale allow us to continue to invest in our businesses through technology, strategic acquisitions, and key resources that support our business, allowing us to navigate the changing healthcare landscape. We are a leader in many states, including 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 targeted acquisitions.

- *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 and Medicare services, our service offerings include commercial programs, PDP, correctional healthcare services, government-sponsored care under federal contracts with the Department of Defense (DoD), and other various specialty services. Through the utilization of a multi-business line approach, through products such as Ambetter Value, we are able to improve the quality of care, improve outcomes, diversify our revenues and help control our medical costs. In 2021, we served members in all 50 states through hundreds of product solutions and are constantly evaluating new opportunities for expansion.

- *Localized Approach with Centralized Support Infrastructure.* We take a localized approach to managing our subsidiaries, including provider and certain 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 systems. 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 government-sponsored programs 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 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, such as NCQA and Medicare Star ratings, and various 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 value-based approach where network providers are actively incentivized by provisions for additional payments to the providers or reimbursement from the providers based upon their performance in cost and quality measures. Value-based collaboration with providers leads to improved quality outcomes and reduced administrative burden.

- *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. Covered healthcare benefits vary from customer to customer and program to program.

- primary and specialty physician care;
- inpatient and outpatient hospital care;
- emergency and urgent care;
- prenatal and postpartum 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.

- *Chronic Conditions* aims to improve the health and quality of life for members with diabetes, asthma, chronic obstructive pulmonary disease (COPD), congestive heart failure, coronary artery disease, 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.

- *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.

- *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.

- *Emergency Department Diversion* strives to identify members' reasons for visiting the emergency department and connect them with the right care, at the right time, in the right place in the future. The program also identifies opportunities for members to better manage their chronic conditions with the help of PCPs and Care Managers.

- *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.

- *Fluvention* works to decrease the spread of the flu by increasing the number of members that receive a timely annual flu vaccination. This multi-layered 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.

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

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

- *Hepatitis C Care Management 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.

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

- *Member Access Campaign* is a nationwide effort focused on COVID-19 testing and vaccinations through events hosted by Centene health plans or their partners.

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

- *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.

- *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, COPD, diabetes, heart disease and HIV.

- *Neighborhood, Environment and Social Traits (NEST)* is a predictive model created by Centene, supported by artificial intelligence, using more than 200 geo-demographic characteristics as inputs that enables us to more proactively address risks and barriers to health that impact our members and the community as a whole, such as access to the COVID-19 vaccine and other necessary care.

- *OpiEnd* is a clinical program with a 98% accuracy rate 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.

- *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.

- *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.

- *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 local 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.

- *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, 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, linking with a Community Health Worker.

- *Start Smart for Your Baby*, or Start Smart, is our award winning prenatal and infant health program designed to increase the percentage of pregnant people 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. This program has led to a 70% increase in the prediction of low birth weight babies resulting in reduced pregnancy complications, preterm deliveries and infant disease.

- *Strong Beginnings* addresses the rising U.S. rates of neonatal abstinence syndrome and neonatal opioid withdrawal syndrome. The program aims to support pregnant people at risk for substance use disorder through case management and care coordination, and to support their providers through incentives and plan of safe care guidance.

- *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.

- *The Neonatal Admissions Program* is an extension of the Start Smart for Your Baby program with a focus on newborns who have a hospital stay longer than standard after delivery, including those with admissions to the Newborn Intensive Care Unit (NICU). The program strives for timely identification of neonatal admissions to coordinate care and provide member education, resources and member-specific care plans to keep both birth parent and baby safe and healthy in the home environment upon discharge from the hospital.

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 primarily 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, has 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 provider support and service levels are important as our key customers are increasingly using performance-based measures to select and pay health plans. We have 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.

- *Our 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 clinical outcomes and improved member satisfaction.

- *The 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 provided through our suite of technology platforms.

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 multiple strategies, including care coordination and complex case management, which are tailored to meet the individual needs of our members as well as address the unique health needs within the communities where we serve. We promote local physician participation in quality improvement through physician committees chaired by local physician leaders. This structure ensures clinical oversight and is critical to the success of any clinical quality improvement program.

We have implemented specialized information systems to support our 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 those 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 health 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 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. 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. Accreditation is only one measure of our ability to provide access to quality care for our members. In 2021, we achieved accreditation in 31 of 33 eligible states for at least one product (Medicare, Medicaid, or Commercial, including Health Insurance Marketplace).

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 2021 Star rating (calculated in 2020 for the quality bonus payment in 2022), two contracts received 4.5 out of 5.0 Stars, three contracts received 4.0 Stars, 17 contracts received 3.5 Stars, and 13 contracts received 3.0 Stars. In addition, for the 2021 Star rating, we carry a 3.5 Star parent organization rating. Approximately 30% of our Medicare members are in a 4.0 star or above plan for the 2022 bonus year.

- For the 2022 Star rating (calculated in 2021 for the quality bonus payment in 2023), one contract received 5.0 out of 5.0 Stars, three contracts received 4.5 Stars, 11 contracts received 4.0 Stars, 23 contracts received 3.5 Stars, and eight contracts received 3.0 Stars. In addition, for the 2022 Star rating, we carry a 4.0 Star parent organization rating. Over 50% of our Medicare members are in a 4.0 star or above plan for the 2023 bonus year. The year-over-year increase in our Star quality ratings is primarily due to certain disaster relief provisions, which we do not expect to be applicable in future years. As a result, we expect to experience a meaningful decrease to our Star ratings for the 2023 Star rating year, which impacts the 2024 bonus year. We expect this to be followed by a subsequent increase to our Star ratings for the 2024 Star rating year, which impacts the 2025 bonus year.

The parent organization Star rating is used for new Medicare contracts, while existing contracts follow their individual Star ratings to determine bonus payments. We remain committed to our quality initiatives and continue to invest in the programs which we expect to translate into value over the next few years.

SPECIALTY SERVICES

Our specialty services are a key component of our healthcare strategy and complement our core Managed Care business. Our specialty services diversify our revenue stream, enhance the quality of health outcomes for our members and others, and allow 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.

- *Pharmacy Solutions.* Envolve Pharmacy Solutions utilizes innovative, flexible solutions and customized care management. We offer traditional pharmacy clinical and administrative services as well as comprehensive specialized pharmacy benefit services through our specialty pharmacy businesses, AcariaHealth and PANTHERx. Our traditional pharmacy benefits management program offers progressive services that are specifically designed to improve quality of care while containing costs. Services that we provide include drug utilization review, formulary and rebate management, patient and physician interventions and prior authorization services and analytics. We have announced our intention to transition Envolve Pharmacy Solutions from a pharmacy benefit manager to an enterprise center of excellence for our health plans, continuing standardization across clinical protocols and benefits administration. AcariaHealth, a specialty pharmacy, 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. PANTHERx serves patients living with rare and orphan diseases through a comprehensive approach to delivering medications and clinical support.

- *Nurse Advice Line & After-Hours Support*. Envolve's Nurse Advice Line brings together our nurse advice, telehealth, and health and wellness 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.

- *Vision and Dental Services.* Envolve 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 innovative technologies and utilizing 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*. Apixio, one of our healthcare analytics companies, offers, among other solutions, artificial intelligence (AI) technology which performs retrospective chart reviews for more accurate risk score submission to CMS. Apixio provides services to third party customers as well as our health plans. 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. These businesses continue to digitize the administration of healthcare and accelerate innovation and modernization across the enterprise.

- *Behavioral, Pharmacy and Specialty Health.* Magellan Health, which we acquired on January 4, 2022, provides carve-out management services for behavioral health, pharmacy, employee assistance plans and other areas of specialty healthcare including diagnostic imaging, musculoskeletal management, cardiac and physical medicine. These services are provided through Magellan's comprehensive network of medical and behavioral health professionals, clinics, hospitals, skilled nursing facilities, home care agencies and ancillary service providers.

Other Specialty Companies

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

- *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 has a Managed Support Contract in the West Region for the DoD TRICARE program. We provide administrative services to Military Health System eligible beneficiaries, which includes eligible active duty service members and their families, retired service members and their families, survivors of retired service members and qualified former spouses.

- *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.

We currently have NCQA accreditation and/or 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 Compliance Program description, our Business Ethics and Code of Conduct Policy, 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, HEALTH, GOVERNANCE AND CORPORATE RESPONSIBILITY

Centene's steadfast commitment to the environment, the health and social well-being of our communities, and our culture of sound and ethical corporate governance extends far beyond individual programs or initiatives. Through the delivery of high-quality healthcare to at-risk populations, our responsibilities to members, stakeholders, and our planet serve as a living expression of our purpose – transforming the health of communities, one person at a time. Continued focus on environmental, social, and governance (ESG) matters remain foundational to supporting our strategy and long-term value creation. These themes were vital in the development of Centene's Environmental, Social, Health, and Governance (ESHG) Strategic Framework (the Framework) which was established in 2020 and incorporates our commitment to healthy individuals and healthy communities. Implementation of the Framework is overseen by a board-level Environmental and Social Responsibility Committee and ESHG initiatives throughout the organization are driven by a cross-functional work group comprised of executive representatives. We issued an ESHG Report to the Community to communicate the value of our ESHG efforts in 2020; and in 2021, we issued a Task Force on Climate-related Financial Disclosures (TCFD) report outlining our governance structure, strategy, risks, opportunities, and metrics and target-setting related to managing climate change. In December 2021, we issued our first Sustainability Accounting Standards Board (SASB) Index report aligned with the SASB Managed Care standard, providing meaningful sustainability information to our stakeholders. Centene’s Framework enables us to align our business strategy and long-term planning with our commitments to protect our planet, serve our communities, cultivate healthier lives, and live our values. Interested parties can find our ESG / ESHG-related reports within the Investors section of our website, the URL of which is https://investors.centene.com/esg. *Please note: Nothing on our website, including our ESG / ESHG reports or sections thereof, shall be deemed incorporated by reference into this Annual Report.*

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:

- *National and Regional Commercial Managed Care Organizations* that focus on providing healthcare services to Medicaid, Medicare and correctional members in addition to members in marketplace and private commercial plans. 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). 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.

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. We believe that we compete effectively against other healthcare industry participants.

REGULATION

Our operations are comprehensively regulated at the 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 health maintenance organizations (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. The ultimate content, timing or effect of any potential future legislation enacted under the new administration remains uncertain.

Our regulated subsidiaries are licensed to operate as 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, prescription drug 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.

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.

Federal law has also implemented other health programs that are partially funded by the federal government, such as the Medicaid and Medicare programs. 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.

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 in years when imposed (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. 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 U.S. Supreme Court heard oral arguments in November 2020 and issued its decision in June 2021, ruling that the plaintiffs lacked standing to challenge the individual mandate provision, thus leaving the ACA in effect. For a further discussion of the ACA, see "Risk Factors - Significant changes or judicial challenges to the ACA could materially and adversely affect our results of operations, financial position and cash flows".

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 provide Medicare Advantage, PDPs, DSNPs, and 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 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 27 states under federally-facilitated marketplace contracts with CMS and state-based exchanges. Both contract types are renewable on an annual basis.

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, 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 General 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 in October 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. Additional fraud, waste and abuse prohibitions include a wide range of operating activities, such as kickbacks or other inducements for referral of members or for the coverage of products (such as prescription drugs) by a plan, billing for unnecessary medical services by a provider, improper marketing and violation of patient privacy rights. The laws and regulations relating to fraud, waste and abuse and the requirements applicable to health plans, PDPs 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.

HUMAN CAPITAL RESOURCES

As the pace of change, complexity and uncertainty in the broader environment accelerates, we continue our strong investment in creating a purpose-driven culture and attracting, developing and retaining top talent with diverse voices and experiences. We seek out individuals with ambition for extraordinary impact and believe every employee is a leader and is critical to helping us transform the health of communities for those we serve. Our entrepreneurial spirited workforce is driven by a steadfast commitment to a diverse, equitable, inclusive and safe workplace, and is enabled through robust talent development programs, supported by competitive compensation, benefits and health and well-being programs, and is optimized by full alignment with our purpose, values and strategy through meaningful connections between our employees and their communities.

As of December 31, 2021, we had approximately 72,500 full-time equivalent (FTE) employees. During fiscal 2021, the number of employees increased primarily due to the international expansion offset by the divestiture of USMM. During fiscal 2021, our voluntary turnover rate was less than 17%.

Diversity, Equity and Inclusion

We believe that a diverse workforce and equitable and inclusive environment enables competitive advantage and fuels improved service, innovation and performance with all stakeholders. We thoughtfully engage diverse talent across Centene, preparing women and underrepresented employees for leadership roles, and hiring diverse candidates who have a passion for serving our members and ambition for extraordinary impact.

We have a wide range of programs focused on early identification and accelerated development of diverse talent, including our Employee Inclusion Groups (EIGs), which help us further enhance our inclusive workforce culture. These voluntary, employee led groups support the attraction, development and retention of talent at all levels. EIGs provide professional and leadership opportunities, contribute to community engagement initiatives and support business innovation and corporate best practices. Our EIGs are key drivers of Centene's culture. Because of their significant value to us, we support EIGs through leadership involvement, work time and space, resources and executive mentors. Today, there are over 10,000 members across all five EIGs providing professional and leadership development opportunities for women, military veterans, individuals with disabilities, LGBTQ+ and multicultural employees. Each EIG offers mentorship programs aligned with our leadership model and bring in unique lived experiences in an effort to ensure we are meeting employees at their level to deliver the best outcomes for their development. EIGs also partake in networking events, training programs, fireside chats and panels addressing current issues and other development opportunities for their members. In 2021, our EIGs produced more than 250 development programs ranging from panel discussions to personal development workshops.

Our team of talent advisors are responsible for leading the end-to-end search process, and leveraging our resources, tools and technologies to help our hiring leaders carefully consider the capabilities required to continue to propel our organization forward. Centene's talent advisors, in partnership with hiring leaders, work to nurture a pipeline that connects us to a diverse workforce. All of our talent advisors receive training to become Certified Diversity Recruiters and this past year, several participated in the Association of Talent Acquisition Professionals Diversity, Equity and Inclusion (DEI) Excellence Program. The program empowers talent advisors to further their capabilities and bring DEI talent acquisition best practices into their respective organizations.

In 2022, we released our 2021 Diversity, Equity & Inclusion Annual Report, which may be reviewed for more detailed information regarding our Human Capital programs and initiatives. Interested parties can find our 2021 Diversity, Equity & Inclusion Annual Report within the Investors section of our website, the URL of which is https://www.centene.com/who-we-are/corporate-facts-reports.html. *Please note: Nothing on our website, including our Diversity, Equity and Inclusion Report or sections thereof, shall be deemed incorporated by reference into this Annual Report.*

Workforce Well-Being and Support

Centene keeps the health and well-being of our employees as one of the main driving factors of business decisions. We provide our employees and their families with access to a variety of health and wellness programs, including benefits that provide protection and security when events arise that may require time away from work or that impact our employees' financial well-being; that support their physical and mental health; and that offer choice where possible so they can customize their benefits to meet their needs and the needs of their families.

For nearly two years, our workforce has demonstrated resilience, courage, and leadership as we've navigated the pandemic and provided uninterrupted service to our members, with more than 90% of our workforce working from home. In 2021, based on feedback from our employees, we enhanced our benefits to provide employees with permanent remote working options and enhanced hybrid working arrangements. We also continued to offer the enhanced employee benefits implemented in 2020, such as: our Medical Reserve Leave policy; providing clinical staff paid leave and benefits for up to three months of volunteer service; additional paid leave for employees caring for a family or household member affected by COVID-19; covering screening, testing, treatment, and vaccination for COVID-19; and employees were offered up to a $1,000 discount to their health insurance premiums if they completed healthy behaviors, including receiving a COVID-19 vaccination. Importantly, we continued to support employees with virtual programming focused on a variety of well-being topics and further developed our employee resource site to provide increased access to well-being resources. As part of our employee resources, we established a highly trained, dedicated COVID-19 concierge team to support employee’s well-being and provide easy access to professionals to respond to COVID-related questions.

Compensation and Benefits

Our compensation and benefits programs are market competitive and designed to attract and retain talent. Our overall compensation philosophy is to pay for performance by linking the achievement of both Company and individual goals to total

compensation. In addition to base pay, these programs (which vary by country/region) include annual bonuses, stock awards, an employee stock purchase plan and a 401(k) plan.

Our benefits cover various aspects of an employee's life to help them live healthy. These include medical, dental and vision insurance, short- and long-term disability, supplemental accidental death and dismemberment and life insurance, wellness program, flexible spending accounts, parental leave and caregiver leave.

We also offer benefits to help employees achieve optimum work-life balance. These include vacation, paid personal and sick time, paid company holidays, paid community volunteer time, an employee assistance program, tuition reimbursement/educational assistance, adoption reimbursement, on-site fitness centers or a discount at local fitness centers.

Talent Development

Through our robust talent infrastructure, we continue working to deepen and prepare our diverse talent bench and workforce, which is necessary to support our Value Creation Plan and business strategy. We believe every employee is a leader and is critical to our success in transforming communities. Our leadership model sets expectations for what it means to lead at Centene and through Centene University, we build skills for how to lead. Centene is committed to developing a workforce who can thrive in the evolving world of work, enabling our organization to further accelerate growth, inclusivity, and innovation. Through Centene University, we've designed learning and development at scale, using new digital tools, real-time virtual learnings and customized leadership development programs, accessible to all employees, in a modern learning environment. Employees can explore more than 10,000 resources on a variety of leadership and skill development topics. Additionally, in 2021, we further emphasized critical skills needed to future-ready our talent through our flagship leadership program, APEX. This multi-day, business-led leadership development program was redesigned into a virtual environment, ensuring further emphasis and development on key capabilities (e.g., customer-centricity, innovation at scale, inspirational leadership and emotional and social intelligence) necessary to future-ready the organization.

In addition to building new workforce skills, we utilize our ongoing enterprise talent reviews, succession planning, career development planning and comprehensive workforce analytics to provide insights to senior leaders to inform actions and drive intentional talent results through our People Plans, the integrated human capital component of our annual operating plans.

Organizational Culture – Meaningful Connections between Employees and the Communities We Serve

We, our health plans, and our subsidiaries have long been leaders in transforming the health of our members and the communities where they live. We believe in local partnerships and value the innovative programs and services that they provide for underserved and at-risk populations. We attract a workforce that is purpose-driven and passionate about transforming communities and we recognize the importance of volunteering and supporting the communities in which we serve. We support our workforce by providing paid time off benefits for employees to participate in individual and work-related community volunteer programs.

With a largely remote workforce in 2020 and 2021, we took additional steps to ensure a highly connected workforce, including monthly forums for people leaders, weekly communications for all employees, and employee programming to help amplify multiple perspectives and lived experiences. Our monthly speaker series provides for one-hour virtual events featuring a variety of Centene and community leaders, offering employees an opportunity to learn ways to build more inclusive behaviors in their daily lives. We hold a Real Talk series focused on honest dialogue about pressing issues impacting diversity, equity and inclusion at our company and in our communities. As part of our commitment to honoring rich histories, cultures and heritages in our communities, we host a monthly history and heritage month speaker series.

In our most recent Shaping Centene Employee Engagement pulse survey, 81% of employees reported strong engagement, surpassing the average Fortune 100 benchmark companies (benchmark data from 2018-2020). Based on their responses, we surpassed the 75th percentile of Fortune 100 benchmark companies in a number of areas, including but not limited to the Company's commitment to and people leaders support of diversity, equity and inclusion in the workplace, and having a clear understanding of the Company's goals and objectives.

Information about our Executive Officers

The following table sets forth information regarding our executive officers, including their ages, at February 18, 2022:

Name	Age	Position
Michael F. Neidorff	79	Chairman and Chief Executive Officer
Andrew L. Asher	53	Executive Vice President, Chief Financial Officer
Mark J. Brooks	52	Executive Vice President and Chief Information Officer
Brandy L. Burkhalter	49	Executive Vice President
Katie N. Casso	40	Senior Vice President, Corporate Controller and Chief Accounting Officer
Christopher A. Koster	57	Executive Vice President, General Counsel and Secretary
Brent D. Layton	54	President and Chief Operating Officer
Sarah M. London	41	Vice Chairman, Centene Board of Directors
David P. Thomas	56	Executive Vice President, Markets
Colin A. Toney	36	Executive Vice President, Mergers and Acquisitions

Michael F. Neidorff. Mr. Neidorff has served as our Chairman and Chief Executive Officer since September 2021. Mr. Neidorff served as Chairman, President and Chief Executive Officer from April 2019 to September 2021. 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. He served as President, Chief Executive Officer and as a member of our Board of Directors from May 1996 to May 2004. In July 2021, Mr. Neidorff informally communicated to the board that he may decide for personal reasons to step down before the end of his contract, after which the board and Mr. Neidorff established a succession planning initiative to ensure a full continuity plan. This succession planning process was discussed in the Company's Preliminary Prospectus Supplement, filed July 29, 2021. Subsequently, in December 2021, Mr. Neidorff communicated his intent to retire as Chief Executive Officer in 2022. Mr. Neidorff will serve as Executive Chairman throughout the remainder of 2022, upon his retirement as Chief Executive Officer.

Andrew L. Asher. Mr. Asher has served as our Executive Vice President, Chief Financial Officer since May 2021. From January 2020 to May 2021, he served as Executive Vice President, Specialty. Prior to joining Centene, he served as the Chief Financial Officer of WellCare from November 2014 to January 2020.

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 since June 2018. From December 2015 to June 2018, she served as Executive Vice President, Internal Audit & Risk Management.

Katie N. Casso. Ms. Casso has served as our Senior Vice President, Corporate Controller and Chief Accounting Officer since April 2021. From January 2016 to March 2021, she served as Vice President, Assistant Controller.

Christopher A. Koster. Mr. Koster has served as Executive Vice President, Secretary and General Counsel since December 2021. From February 2020 to December 2021, he served as Senior Vice President and General Counsel. From February 2017 to February 2020, he served as Senior Vice President, Corporate Services. Prior to joining Centene, Mr. Koster served as Missouri Attorney General for eight years.

Brent D. Layton. Mr. Layton has served as our President and Chief Operating Officer since September 2021. He served as President of Centene U.S. Health plans, Products and International and Executive Vice President from March 2021 to September 2021. From January 2021 to March 2021, he served as Executive Vice President, Markets, Products, International, and Chief Business Development Officer. From July 2016 to December 2020, he served as Executive Vice President and Chief Business Development Officer. From September 2011 to June 2016, he served as Senior Vice President, Business Development.

Sarah M. London. Ms. London has served as our Vice Chairman since September 2021. She served as President, Centene Health Care Enterprises and Executive Vice President, Advanced Technology from March 2021 to September 2021. From September 2020 to February 2021, she served as Senior Vice President, Technology Innovation and Modernization. Prior to joining Centene, she served as both Senior Principal and Partner for Optum Ventures from May 2018 to March 2020 and Chief

Product Officer of Optum from March 2016 to May 2018. From March 2014 to March 2016, she served as Vice President, Client Management and Operations for Humedica.

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.

Colin A. Toney. Mr. Toney has served as our Executive Vice President, Mergers and Acquisitions since July 2021. From July 2020 through July 2021, he served as Senior Vice President, Enterprise Strategy Group. From June 2018 through June 2020, he served as Regional Vice President, Mergers and Acquisitions. Prior to joining Centene, he served as Vice President at Allen & Company, where he worked for eight years.

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 https://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 (https://www.sec.gov) that contains our annual, quarterly and current reports and other information we file electronically with the SEC. *Please note: Information on our website does not constitute part of this Annual Report on Form 10-K.*

Item 1A. ***Risk Factors.***

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 Centene Corporation, together with its consolidated subsidiaries.

Risks Relating to Our Business

Our business could be materially adversely affected by the effects of widespread public health pandemics, such as COVID-19.

Public health pandemics or widespread outbreaks of contagious diseases, such as COVID-19, could materially adversely impact our business. Our business has been affected by the spread of COVID-19, and the extent to which COVID-19 continues to impact our business will depend on future developments, which are highly uncertain and cannot be predicted with confidence. Factors that may determine the severity of the impact include the duration and scale of the outbreak, new information which may emerge concerning the severity of COVID-19, (including new strains, which may be more contagious, more severe or less responsive to treatment or vaccines), the costs of prevention and treatment of COVID-19 and the potential that we will not receive government reimbursement of additional expenses incurred by our members who contract or require testing for COVID-19 or who experience other health impacts as a result of the pandemic, employee retention, mobility, productivity and utilization of leave and other benefits, financial and other impacts on the healthcare provider community, disruptions or delays in the supply chain for testing and treatment supplies, protective equipment and other products and services, and the actions to contain COVID-19 or address its impact (including laws, regulations and emergency orders, such as stay at home orders, physical distancing requirements, forced business closures and vaccine requirements or mandates and directives related to the timing and scope of vaccine distribution), among other factors. In addition, increased utilization patterns (including deferred demand) have had, and may continue to have, an impact on our business as members' pattern of seeking healthcare fluctuates. For example, risk adjustment could be adversely impacted by COVID-19 related impacts such as disrupted member utilization patterns, access to members for in-home assessments and regulatory changes such as the retroactive disallowance of Hydroxychloroquine adversely impacting our second quarter 2021 results. Additionally, the spread of COVID-19 has previously caused disruption and volatility in the global capital markets, and future disruptions could adversely impact our access to capital. Similarly, a decline in interest rates has reduced, and could further reduce, our investment income. Finally, the impact of the above items on our government partners could result in program changes or delays or reduced capitation payments to us. We cannot at this time predict the ultimate impact of the COVID-19 pandemic, but it could have a material adverse effect on our business, including our financial position, results of operations and cash flows.

Our Medicare programs are subject to a variety of unique 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, penalties or other actions; if we do not submit adequate bids in our existing markets or any expansion markets; if our existing contracts are modified or 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, in October 2021, the CMS published updated Medicare Star quality ratings for the 2022 rating year. Over 50% of our Medicare members are in a 4 star or above plan for the 2023 bonus year, compared to approximately 30% for the 2022 bonus year, and 46% for the 2021 bonus year. The increase in Star quality ratings for the 2022 rating year is primarily due to certain disaster relief provisions, which we do not expect to be applicable in future years. As a result, we expect to experience a meaningful decrease to our Star ratings for the 2023 Star rating year, which impacts the 2024 bonus year. Our quality bonus and rebates may be negatively impacted and the attractiveness of our Medicare Advantage plans may be reduced if we are unable to maintain or improve these ratings.

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 health insurance system or other major healthcare reform provisions will be enacted by the current Congress or state regulators, certain members of Congress and certain state regulators have proposed legislative initiatives 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. Additionally, the potential impact of the current administration on healthcare reform efforts is unknown. We are unable to predict the nature and success of these or other initiatives or political changes, which could have an adverse effect on our business.

Failure to accurately estimate and price our medical expenses or effectively manage our medical costs or related administrative costs could have a material adverse effect on our results of operations, financial position 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 government-sponsored health programs 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, out-of-network utilization and pricing, hospital and pharmaceutical costs, unexpected events, such as disasters, the effects of climate change, major epidemics, pandemics or newly emergent diseases (such as COVID-19), 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 the ACA, including legal challenges to the ACA or potential changes in premium subsidies.

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 or region or launch a new 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.

Risk-adjustment payment systems make our revenue and results of operations more difficult to estimate and could result in retroactive adjustments that have a material adverse effect on our results of operations, financial condition and cash flows.

Most of our government customers employ risk-adjustment models to determine the premium amount they pay for each member. This model pays more for members with predictably higher costs according to the health status of each beneficiary enrolled. Premium payments are generally established at fixed intervals according to the contract terms and then adjusted on a retroactive basis. We reassess the estimates of the risk adjustment settlements each reporting period and any resulting

adjustments are made to premium revenue. In addition, revisions by our government customers to the risk-adjustment models have reduced, and may continue to reduce, our premium revenue.

As a result of the variability of certain factors that determine estimates for risk-adjusted premiums, including plan risk scores, the actual amount of retroactive payments could be materially more or less than our estimates. Consequently, our estimate of our plans' risk scores for any period, and any resulting change in our accrual of premium revenues related thereto, could have a material adverse effect on our results of operations, financial condition and cash flows. The data provided to our government customers to determine the risk score are subject to audit by them even after the annual settlements occur. These audits may result in the refund of premiums to the government customer previously received by us, which could be significant and would reduce our premium revenue in the year that repayment is required. For example, risk adjustment could be adversely impacted by COVID-19 related impacts such as disrupted member utilization patterns, access to members for in-home assessments and regulatory changes such as the retroactive disallowance of Hydroxychloroquine adversely impacting our second quarter 2021 results.

Government customers have performed and continue to perform audits of selected plans to validate the provider coding practices under the risk adjustment model used to calculate the premium paid for each member. In 2018, CMS proposed the removal of the fee for service adjuster from the risk adjustment data validation audit methodology. If adopted, this proposal, or any similar CMS rule making initiative, could increase our audit error scores. We anticipate that CMS will continue to conduct audits of our Medicare contracts and contract years on an on-going basis. An audit may result in the refund of premiums to CMS. It is likely that a payment adjustment could occur as a result of these audits; and any such adjustment could have a material adverse effect on our results of operations, financial condition and cash flows.

Any failure to adequately price products offered or any reduction in products offered in the Health Insurance Marketplaces may have a material adverse effect on our results of operations, financial position and cash flows.

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 Health Insurance 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, changes to member eligibility in the program design or changes in the financial incentives of individuals to participate in such products 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, out-of-network costs, 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.

We derive a portion of our cash flow and gross margin from our prescription drug plan (PDP) operations, for which we submit annual bids for participation. The results of our bids could have a material adverse effect on our results of operations, financial condition and cash flows.

A significant portion of our PDP membership is obtained from the auto-assignment of beneficiaries in CMS-designated regions where our PDP premium bids are below benchmarks of other plans' bids. In general, our premium bids are based on assumptions regarding PDP membership, utilization, drug costs, drug rebates and other factors for each region. Our 2022 PDP bids resulted in 34 of the 34 CMS regions in which we were below the benchmarks, compared with our 2021 PDP bids in which we were below the benchmarks in 33 regions, and within the de minimis range in the remaining region.

If our future Part D premium bids are not below the CMS benchmarks, we risk losing PDP members who were previously assigned to us and we may not have additional PDP members auto-assigned to us, which could materially reduce our revenue and profits.

Our encounter data may be inaccurate or incomplete, which could have a material adverse effect on our results of operations, financial condition, cash flows and ability to bid for, and continue to participate in, certain programs.

Our contracts require the submission of complete and correct encounter data. The accurate and timely reporting of encounter data is increasingly important to the success of our programs because more states are using encounter data to determine

compliance with performance standards and to set premium rates. We have expended and may continue to expend additional effort and incur significant additional costs to collect or correct inaccurate or incomplete encounter data and have been, and continue to be, exposed to operating sanctions and financial fines and penalties for noncompliance. In some instances, our government clients have established retroactive requirements for the encounter data we must submit. There also may be periods of time in which we are unable to meet existing requirements. In either case, it may be prohibitively expensive or impossible for us to collect or reconstruct this historical data.

We may experience challenges in obtaining complete and accurate encounter data, due to difficulties with providers and third-party vendors submitting claims in a timely fashion in the proper format, and with state agencies in coordinating such submissions. As states increase their reliance on encounter data, these difficulties could adversely affect the premium rates we receive and how membership is assigned to us and subject us to financial penalties, which could have a material adverse effect on our results of operations, financial condition, cash flows and our ability to bid for, and continue to participate in, certain programs.

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, compliance with contract terms and law, 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; harm to our reputation; or required changes to the way we do business. For example, March 2021, the State of Ohio filed a civil action against us. The complaint alleged breaches of contract with the Ohio Department of Medicaid relating to the provision of pharmacy benefits management (PBM) services and violations of Ohio law relating to such contracts including among other things, by (i) seeking payment for services already reimbursed, (ii) not accurately disclosing to the Ohio Department of Medicaid the true cost of the PBM services and (iii) inflating dispensing fees for prescription drugs. We have reached no-fault agreements with the Attorneys General of nine states, including Ohio, to resolve claims made by the states related to services provided by Envolve, our pharmacy benefits manager subsidiary. As a result of the settlement, the Ohio Attorney General's litigation against us was dismissed. Additionally, we are in discussions to bring final resolution to these concerns in other affected states. Consistent with those discussions, we recorded a reserve estimate of $1,250 million in the second quarter of 2021 related to the issue, inclusive of the above settlements and rebates that we determined in the course of the matter are payable across our products. Notwithstanding such settlement and other ongoing discussions, additional claims, reviews or investigations relating to our PBM business may still be brought by other states, the federal government or shareholder litigants, and there is no guarantee we will have the ability to settle such claims with other states within the reserve estimate we have recorded and on other acceptable terms, or at all. 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.

Execution of our value creation strategy may create disruptions in our business.

Our value creation strategy has included, and may continue to include 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. While we may continue to pursue opportunistic acquisitions to expand into new geographies and complementary business lines as well as to augment existing operations, our acquisition strategies may shift as we implement our Value Creation Plan. 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, including due to conditions on regulatory approval of such acquisitions, 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, including those related to the impacts of COVID-19. As a result of these factors, start-up operations may decrease our profitability. The timing of operating our new East Coast headquarters in Charlotte, and the expected benefits of its completion, may also be negatively impacted as a result of these factors.

Although our Value Creation Plan is designed to enable us to build upon our strong foundation and unlock value and drive margin expansion through various initiatives, including, without limitation, targeted SG&A initiatives; share repurchases; divestitures; refinancing activities; using data-driven and innovative approaches to enhance efficiency, lower costs, and drive better health outcomes for our members and providers; streamlining procurement and improving our bid process; and further scaling through standardization of our operating model and consolidation of our platform, these initiatives are subject to a variety of risks including, without limitation: anticipated benefits not being realized or not at the levels or on the timing anticipated; that implementation will be materially delayed or more difficult than expected; the diversion of management’s time and attention; and initiatives being more expensive to complete than anticipated, including as a result of unexpected factors or events.

If we are unable to effectively implement or integrate our value creation strategy, including as a result of the continued impact of COVID-19, 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 have sought and continue to seek 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.

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 or delay 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 results of operations, financial position 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, and access to services, be able to provide effective telehealth services, maintain financial solvency, including due to the impact of COVID-19, 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.

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, which may include cyber-attacks by terrorists or other governmental or non-governmental actors. 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.

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.

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 a material 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.

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 may be adversely impacted if we are unable to adequately plan for the succession of our executives and senior management. In July 2021, Mr. Neidorff informally communicated to the board that he may decide for personal reasons to step down before the end of his contract, after which the board and Mr. Neidorff established a succession planning initiative to ensure a full continuity plan. This succession planning process was discussed in the Company's Preliminary Prospectus Supplement, filed July 29, 2021. Subsequently, in December 2021, Mr. Neidorff communicated his intent to retire as Chief Executive Officer in 2022. Mr. Neidorff will serve as Executive Chairman throughout the remainder of 2022, upon his retirement as Chief Executive Officer. While we have succession plans in place for members of our executive and senior management team, including our Chief Executive Officer in 2022, 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.

Risks Relating to Regulatory and Legal Matters

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 have a material adverse effect on our results of operations, financial position 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 or modify 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; 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; and other regulatory, legislative or judicial actions that may have an impact on the operations of government subsidized healthcare programs including ongoing litigation involving the ACA. 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 2019 through 2029. The Coronavirus Aid, Relief, and Economic Security Act of 2020 temporarily suspended the Medicare sequestration for the period of May 1, 2020 through December 31, 2020, while also extending the mandatory sequestration policy by an additional one year, through 2030. The Bipartisan-Bicameral Omnibus COVID Relief Deal passed in December 2020 further extended the suspension of the Medicare sequestration until March 31, 2021, and the Protecting Medicare and American Farmers from Sequester Cuts Act passed in December 2021 extended the sequester through March 31, 2022 and will adjust the sequester to 1% between April 1, 2022 and June 30, 2022.

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 change the number of persons enrolled in or eligible for these programs and increase our administrative and healthcare costs under these programs. For example, we expect Medicaid eligibility redeterminations, which have been suspended during COVID, to begin in 2022, which we expect to reduce our membership. 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.

Significant changes 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 ACA has faced, and continues to face, administrative, judicial and legislative challenges 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 constitutional and other legal challenges, as well as the uncertainty generated by such actual or potential challenges, could materially and adversely affect our business and financial position, results of operations or cash flows.

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 Department of Health and Human Services (the HHS) additionally indicated that it would consider a limited number of premium assistance demonstration proposals from states that want to privatize Medicaid expansion. Several states in which we operate 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 from the previous administration to repeal or amend certain provisions of the ACA through changes in regulations. Such initiatives included 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 became able to use employer-funded ICHRAs to buy individual-market insurance, including insurance purchased on the public exchanges formed under the ACA.

It remains uncertain whether the current administration will propose changes to restrict these insurance plan options that are not required to meet ACA requirements, and what the impact of such potential changes may be. There have also been efforts by the previous administration to address the ACA's non-deductible tax imposed on health insurers based on prior year net premiums written (the HIF). Congress passed a spending bill in December 2019, which repealed the health insurance tax indefinitely, effective in 2021.

The constitutionality of the ACA itself continues to face judicial challenge. The ultimate content, timing or effect of any potential future legislation or litigation and the outcome of other lawsuits cannot be predicted and may be delayed as a result of court closures and reduced court dockets as a result of the COVID-19 pandemic.

In contrast to previous executive and legislative efforts to restrict or limit certain provisions of the ACA, the American Rescue Act, enacted on March 11, 2021, contained provisions aimed at leveraging Medicaid and the Health Insurance Marketplace to expand health insurance coverage and affordability to consumers. The American Rescue Act authorized an additional $1.9 trillion in federal spending to address the COVID-19 public health emergency, and contained several provisions designed to increase coverage of certain healthcare services, expand eligibility and benefits, incentivize state Medicaid expansion, and adjust federal financing for state Medicaid programs, the ultimate impact of which remain uncertain. The American Rescue Act enhanced eligibility for the advance premium tax credit for certain enrollees in the Health Insurance Marketplace currently expires on December 31, 2022, and if it is not extended, our Health Insurance Marketplace membership may be reduced.

These changes and other potential changes involving the functioning of the Health Insurance Marketplace as a result of additional new legislation, regulation, executive action or litigation, including those related to extending enrollment periods, increasing eligibility in the program design, changing the eligibility and amount of the advanced premium tax credit and expanding navigator services, could impact our business and results of operations adversely or in other ways that we do not currently anticipate.

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 local and international 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.

We are often required to maintain a minimum HBR or share profits in excess of certain levels, which may be retroactive. In certain circumstances, our plans have returned premiums back to the states, enrollees or other beneficiaries in the event profits exceed established levels or HBR does not meet the minimum requirement. The amount of premium returned may 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. Regulators require numerous steps 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. On November 13, 2020, CMS finalized revisions to the Medicaid managed care regulations, many of which became effective in December 2020. While not a wholesale revision of the 2016 regulations, the November 2020 final rule adopted changes in areas including network adequacy, beneficiary protections, quality oversight, and the establishment of capitation rates and payment policies. 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 benefits 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 PBM and specialty pharmacy services, including through our Envolve Pharmacy Solutions product and Magellan Health. These businesses are subject to federal and state laws and regulations that, among other requirements, govern the relationships of the business with pharmaceutical manufacturers, physicians, pharmacies, customers and consumers. For example, in March 2021, the State of Ohio filed a civil action against us. The complaint alleged breaches of contract with the Ohio Department of Medicaid relating to the provision of PBM services and violations of Ohio law relating to such contracts, including among other things, by (i) seeking payment for services already reimbursed, (ii) not accurately disclosing to the Ohio Department of Medicaid the true cost of the PBM services and (iii) inflating dispensing fees for prescription drugs. We have reached no-fault agreements with the Attorneys General of nine states, including Ohio, to resolve claims made by the states related to services provided by Envolve, our pharmacy benefits manager subsidiary. As a result of the settlement, the Ohio Attorney General’s litigation against us was dismissed. Additionally, we are in discussions to bring final resolution to these concerns in other affected states. Consistent with those discussions, we recorded a reserve estimate of $1,250 million in the second quarter of 2021 related to this issue, inclusive of the above settlements and rebates that we determined in the course of the matter are payable across our products. Notwithstanding such settlement and other ongoing discussions, additional claims, reviews or investigations relating to our PBM business may still be brought by other states, the federal government or shareholder litigants, and there is no guarantee we will have the ability to settle such claims with other states within the reserve estimate we have recorded and on other acceptable terms, or at all.

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.

We have been and may from time to time become involved in costly and time-consuming litigation and other regulatory proceedings, which require significant attention from our management and could adversely affect our business.

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 related to network adequacy, claims alleging bad faith, investigations regarding our submission of risk adjuster claims, putative securities class actions, protests and appeals related to Medicaid procurement awards, employment-related disputes, including wage and hour claims, submissions to state agencies related to payments or state false claims acts and claims related to the imposition of new taxes, including but not limited to claims that may have retroactive application. For example, in March 2021, the State of Ohio filed a civil action against us. The complaint alleged breaches of contract with the Ohio Department of Medicaid relating to the provision of PBM services and violations of Ohio law relating to such contracts, including among other things, by (i) seeking payment for services already reimbursed, (ii) not accurately disclosing to the Ohio Department of Medicaid the true cost of the PBM services and (iii) inflating dispensing fees for prescription drugs. We have reached no-fault agreements with the Attorneys General of nine states, including Ohio, to resolve claims made by the states related to services provided by Envolve, our pharmacy benefits manager subsidiary. As a result of the settlement, the Ohio Attorney General’s litigation against us was dismissed. Additionally, we are in discussions to bring final resolution to these concerns in other affected states. Consistent with those discussions, we recorded a reserve estimate of $1,250 million in the second quarter of 2021 related to this issue, inclusive of the above settlements and rebates that we determined in the course of the matter are payable across our products. Additional claims, reviews or investigations relating to our PBM business may be brought by other states, the federal government or shareholder litigants, and there is no guarantee we will have the ability to settle such claims with other states within the reserve estimate we have recorded and on other acceptable terms, or at all. 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 have a material adverse effect on our business and financial position, results of operations or cash flows.

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, regulations, rules and contractual requirements 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 European Union's General Data Protection Regulation, 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. For example, in 2021, we learned that Accellion, a third-party data transfer provider with whom we contract, had a system vulnerability that resulted in unauthorized access to certain sensitive data of our customers, including protected health information, as well as unauthorized access to the data of several of Accellion’s other clients. This incident led to putative class action lawsuits that were filed against us and our subsidiaries, Health Net, LLC, Health Net of California, Inc., Health Net Life Insurance Company, Health Net Community Solutions, Inc., and California Health & Wellness, and Accellion on behalf of the affected customers. We do not believe that this incident is likely to have a material adverse effect on our business, reputation, results of operations, financial position and

cash flows. However, there can be no assurance that this incident and other privacy or security breaches will not require us to expend significant resources to remediate any damage, interrupt our operations and damage our business or reputation, subject us to state, federal, or international agency review, and result in enforcement actions, material fines and penalties, litigation or other actions which could have a material adverse effect on our business, reputation, results of operations, financial position and cash flows.

In addition, HIPAA broadened the scope of fraud, waste and abuse laws applicable to healthcare companies and established 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. 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 other companies involved in public healthcare programs, have been, and from time to time are, the subject of federal and state fraud, waste and abuse investigations. 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 fraud, waste and abuse laws, including 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.

Risks Relating to Conditions in the Financial Markets and Economy

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. Furthermore, COVID-19 has impacted, and may continue to impact, the global economy resulting in significant market volatility and fluctuating interest rates. 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.

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, including due to the effects of COVID-19. 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 revolving 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.

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, 2021, we had consolidated indebtedness of $18.8 billion. We may further increase our indebtedness in the future.

This may 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 Facility) and the indentures governing our notes require us to comply with various covenants that impose restrictions on our operations, including our ability to incur additional indebtedness, create liens, pay dividends, make 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 our 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 the phasing out of LIBOR 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, 2021, borrowings under our Company Credit Facility bear interest based upon various reference rates, including LIBOR, which is in the process of being phased out. The U.K. Financial Conduct Authority, which regulates LIBOR, has announced that it intends to phase out LIBOR. Banks currently reporting information used to set U.S. dollar LIBOR are currently expected to stop doing so during 2023, and in 2021, the U.S. Federal Reserve Board and other regulatory bodies issued guidance encouraging banks and other financial market participants to cease entering into new contracts that use U.S. dollar LIBOR as a reference rate as soon as practicable and in any event no later than December 31, 2021.

While various bodies, including government agencies, are seeking to identify an alternative rate to replace LIBOR, including the Secured Overnight Financing Rate (SOFR), there is uncertainty regarding which alternative reference rate will replace LIBOR. We may need to amend certain agreements that use LIBOR as a benchmark, and we cannot predict what alternative index or other amendments may be negotiated with our counterparties. As a result, our interest expense could increase and our available cash flow for general corporate requirements may be adversely affected. Additionally, uncertainty as to the nature of the discontinuation or modification of LIBOR, alternative reference rates or other reforms could have an adverse impact on the market for, or value of, any LIBOR-linked securities, loans, and other financial obligations or extensions of credit held by or due to us or on our overall financial condition or results of operations.

Risks Associated with Mergers, Acquisitions, and Divestitures

Mergers and acquisitions may not be accretive and may cause dilution to our earnings per share, which may cause the market price of our common stock to decline.

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 cost and revenue synergies or growth in earnings, the operational cost savings estimates in connection with the integration of acquired businesses with ours are not realized as rapidly or to the extent anticipated, 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, including the Magellan Acquisition, 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, including Magellan Health, 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;
- achieving actual cost savings at the anticipated levels; 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, including the Magellan 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 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.

Our business and results of operations may be materially adversely affected if we fail to manage and complete divestitures.

We regularly evaluate our portfolio in order to determine whether an asset or business is still consistent with our business strategy or whether there may be a more advantaged owner for that asset or business. When we decide to sell assets or a business, we may encounter difficulty finding buyers or alternative exit strategies, which could delay the achievement of our business strategy. Further, divestitures may be delayed due to failure to obtain required approvals on a timely basis, if at all, from governmental authorities, or may become more difficult to execute due to conditions placed upon approval that could, among other things, delay or prevent us from completing a transaction, or otherwise restrict our ability to realize the expected financial or strategic goals of a transaction. We might have financial exposure in a divested business, such as through minority equity ownership, financial or performance guarantees, indemnities or other obligations, such that conditions outside of our control might negate the expected benefits of the disposition. We could also incur higher costs or charges than planned or incur unexpected charges and could experience greater dis-synergies than expected, which could have a material adverse effect on our results of operations.

General Risk Factors

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

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

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

None.

Item 2. ***Properties***

We own our corporate office headquarters buildings and land located in St. Louis, Missouri, which is used by each of our reportable segments, and we are in the process of completing our East coast headquarters in Charlotte, North Carolina. 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

Our common stock has been traded and quoted on the New York Stock Exchange under the symbol "CNC" since October 16, 2003. The high and low prices, as reported by the NYSE, are set forth below for the periods indicated.

	2022 Stock Price (through February 18, 2022)		2021 Stock Price		2020 Stock Price	
	High	Low	High	Low	High	Low
First Quarter	$ 86.81	$ 74.47	$ 70.26	$ 57.16	$ 68.64	$ 43.96
Second Quarter			75.25	59.33	74.70	53.83
Third Quarter			75.59	59.67	68.45	53.60
Fourth Quarter			85.44	60.81	72.31	57.56

As of February 18, 2022, there were 1,078 holders of record of our common stock.

Issuer Purchases of Equity Securities

In February 2021, our Board of Directors approved an increase in the Company's existing share repurchase program for its common stock. With the increase, the Company is authorized to repurchase up to $1.0 billion of shares of the Company's common stock, inclusive of the previously approved stock repurchase program. No duration has been placed on the repurchase program. We reserve the right to discontinue the repurchase program at any time.

During the fourth quarter of 2021, we used proceeds from divestiture of U.S. Medical Management (USMM) and cash on hand to repurchase 2.4 million shares of Centene common stock for $200 million through our stock repurchase program. We have $800 million remaining under the program for repurchases as of December 31, 2021.

Issuer Purchases of Equity Securities
Fourth Quarter 2021
(shares in thousands)

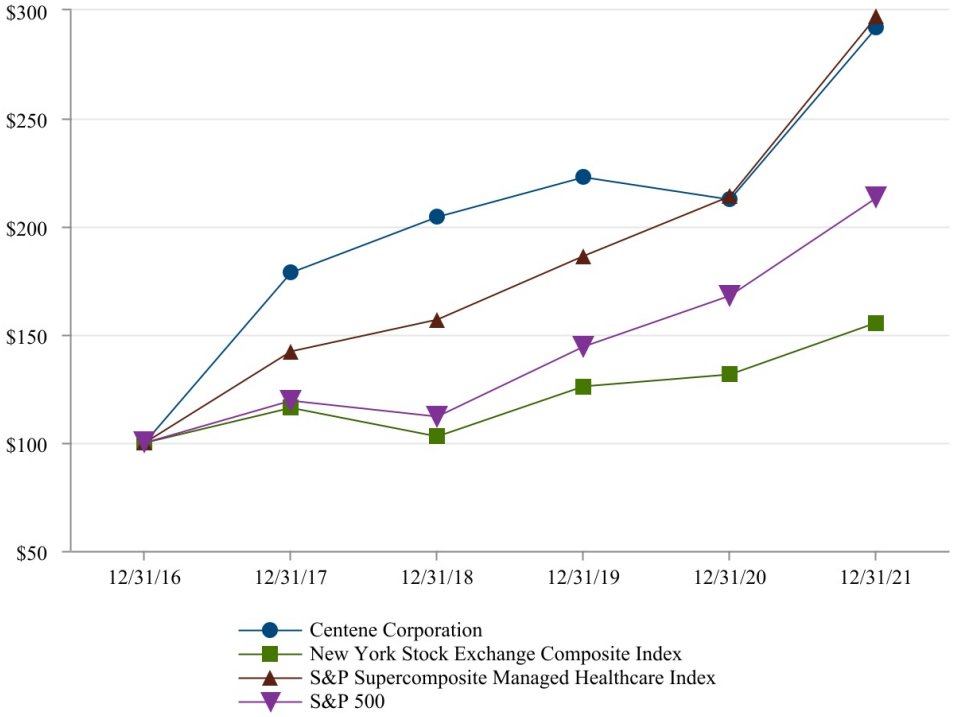
Period	Total Number of Shares Purchased[1]	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Approximate $ Value of Shares that May Yet Be Purchased Under the Plans or Programs (in millions)[2]
October 1 – October 31, 2021	3	$ 64.90	—	$ 1,000
November 1 – November 30, 2021	2	73.94	—	1,000
December 1 – December 31, 2021	3,012	82.42	2,402	800
Total	3,017	$ 79.10	2,402	$ 800

(1) Shares purchased through a publicly announced plan or program and 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 14,160 thousand shares. As of January 2021, a remaining amount of 5,488 thousand shares were available under the program. In February 2021, the Company's Board of Directors approved an increase in the Company's existing share repurchase program for its common stock. With the increase, the Company was authorized to repurchase up to $1.0 billion worth of shares of the Company's common stock, inclusive of the previously approved stock repurchase program. A remaining amount of $800 million is available under the program. No duration has been placed on the repurchase program.

Stock Performance Graph

The graph below compares the cumulative total stockholder return on our common stock for the period from December 31, 2016 to December 31, 2021 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, 2016 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,					
	2016	2017	2018	2019	2020	2021
Centene Corporation	$ 100.00	$ 178.55	$ 204.07	$ 222.55	$ 212.50	$ 291.68
New York Stock Exchange Composite Index	100.00	115.84	102.87	125.83	131.36	155.23
S&P Supercomposite Managed Healthcare Index	100.00	142.26	156.88	186.13	213.81	296.76
S&P 500	100.00	119.42	111.97	144.31	167.77	212.89
Centene Corporation closing stock price	$ 28.25	$ 50.44	$ 57.65	$ 62.87	$ 60.03	$ 82.40
Centene Corporation annual stockholder return	(14.1) %	78.5 %	14.3 %	9.1 %	(4.5) %	37.3

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

Item 6. ***Reserved.***

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, 2019, including year-to-year comparisons between the year ended December 31, 2020 and the year ended December 31, 2019. For a comparison of our results of operations for the fiscal years ended December 31, 2020 and December 31, 2019, 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, 2020, filed with the SEC on February 22, 2021.

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 (HIF) 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.

Prior to 2021, before the Affordable Care Act (ACA) health insurer fee repeal was effected, our insurance subsidiaries were subject to the HIF. We recognized revenue for reimbursement of the HIF, including the "gross-up" to reflect the non-deductibility of the HIF. Collectively, this revenue was 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 were not pass-through payments and were 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 health insurer fee, one of the primary drivers of the year-over-year variances discussed throughout this section is related to the repeal of the HIF in 2021.

Magellan Acquisition

On January 4, 2022, we acquired all of the issued and outstanding shares of Magellan Health, Inc. (Magellan). Total consideration for the acquisition was approximately $2.6 billion, consisting of $2.5 billion in cash ($95.00 per share) and an estimated $67 million related to the fair value replacement equity awards associated with pre-combination service. The Magellan acquisition enables us to provide whole-health, integrated healthcare solutions to deliver better health outcomes at lower costs for complex, high-cost populations.

Acquisitions and Divestitures

In June 2019, we acquired 40% of Circle Health, one of the U.K.’s largest independent operators of hospitals. The initial 40% investment was accounted for as an equity method investment. In July 2021, we acquired the remaining 60% interest of Circle Health for $705 million. Beginning in July 2021, we consolidate 100% of Circle Health.

In the fourth quarter of 2020, we acquired PANTHERx and Apixio. PANTHERx is one of the largest and fastest-growing specialty pharmacies in the United States specializing in orphan drugs and treating rare diseases. PANTHERx and its management team operate independently as part of our Envolve Pharmacy Solutions business unit. Apixio is a healthcare analytics company offering artificial intelligence technology solutions. Apixio remains an operationally independent entity as part of our Health Care Enterprises group, bringing value to its clients and the industry, while also realizing the benefits of enhanced scale.

One of the primary drivers of the year-over-year variances discussed throughout this section are related to the acquisitions of Circle Health and PANTHERx.

In December 2021, we sold a majority stake in U.S. Medical Management, LLC (USMM) and recognized a pre-tax gain of $150 million. We believe this best positions USMM to expand its reach and impact while helping us to deliver on our Value

Creation Plan. We used proceeds from the divestiture of USMM and cash on hand to repurchase 2.4 million shares of Centene common stock for $200 million.

Value Creation Plan

As introduced in June 2021, the Value Creation Plan is designed to drive margin expansion by leveraging our scale and generating sustainable profitable growth. In order to execute the Value Creation Plan, we created the Value Creation Office, which includes members of executive leadership. The three major pillars of the Value Creation Plan are: SG&A expense savings, gross margin expansion and strategic capital management. The first pillar, SG&A expense savings, includes initiatives targeting improving productivity, driving efficiencies and reducing costs throughout the organization, including real estate optimization. The second pillar, gross margin expansion, will be achieved through initiatives including bid discipline, clinical initiatives, quality improvement and pharmacy cost management. The third pillar, strategic capital management, focuses on value-creating capital deployment activities such as share repurchases, portfolio optimization and debt and investment management.

COVID-19 Trends and Uncertainties

The COVID-19 outbreak has created unique and unprecedented challenges. In 2020, we saw significant decreases in traditional utilization as stay-at-home orders were put in place, partially offset by COVID-19 treatment costs. As stay-at-home orders were lifted and vaccinations became available in 2021, utilization has returned in varying degrees. As a result, one of the primary drivers of the year-over-year variances discussed throughout this section is related to COVID-19. In 2021, we launched several initiatives which encourage our health plan members, as well as all Americans, to receive the COVID-19 vaccine.

The impact of COVID-19 on our business in both the short-term and long-term is uncertain and difficult to predict. The outlook for 2022 depends on future developments, including but not limited to: the length and severity of the outbreak (including new variants, which may be more contagious, more severe or less responsive to treatment or vaccines), the effectiveness of containment actions, the timing and effectiveness of vaccinations and achievement of herd immunity, and the timing and rate at which members return to accessing healthcare. The pandemic and these future developments have impacted and will continue to affect our membership and medical utilization. From March 31, 2020 through December 31, 2021, our Medicaid membership has increased by 2.5 million members (excluding the new North Carolina membership). In addition, the pandemic has and continues to have the potential to impact the administration of state and federal healthcare programs, premium rates and risk sharing mechanisms. We continue to have active dialogues with our state partners to ensure our rates are actuarially sound.

Medical utilization continues to lack consistency and will be influenced by the intensity of additional waves of the pandemic. We continue to watch external trends closely, as COVID-19 costs could increase based upon macro trends. New variants and additional waves of the pandemic could create new dynamics and uncertainties around our expectations.

We are confident we have the team, systems, expertise and financial strength to continue to effectively navigate this challenging pandemic landscape.

Regulatory Trends and Uncertainties

The United States government, politicians, and healthcare experts continue to discuss and debate various elements of the United States healthcare model. 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 seven 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*."

2021 Highlights

Our financial performance for 2021 is summarized as follows:

- Year-end managed care membership of 26.6 million, an increase of 1.1 million members, or 4% over 2020.
- Total revenues of $126.0 billion, representing 13% growth year-over-year.
- Premium and service revenues of $118.0 billion, representing 14% growth year-over-year.
- HBR of 87.8% for 2021, compared to 86.2% for 2020.
- SG&A expense ratio of 8.6% for 2021, compared to 9.5% for 2020.
- Adjusted SG&A expense ratio of 8.4% for 2021, compared to 8.9% for 2020.
- Diluted EPS of $2.28 for 2021, compared to $3.12 for 2020.
- Adjusted Diluted EPS of $5.15 for 2021, compared to $5.00 for 2020.
- Operating cash flows of $4.2 billion, or 3.1 times net earnings, for 2021.

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

	Year Ended December 31,	
	2021	**2020**
GAAP diluted EPS attributable to Centene	$ 2.28	$ 3.12
Amortization of acquired intangible assets	1.00	0.95
Acquisition related expenses	0.24	0.86
Other adjustments [(1)]	1.63	0.07
Adjusted Diluted EPS	$ 5.15	$ 5.00

(1) Other adjustments include the following items:

2021:

(a) legal settlement expense and related legal fees of $1,264 million, or $1.76 per diluted share, net of an income tax benefit of $0.38;

(b) debt extinguishment costs of $125 million, or $0.16 per diluted share, net of an income tax benefit of $0.05;

(c) severance costs due to a restructuring of $54 million, or $0.06 per diluted share, net of an income tax benefit of $0.03;

(d) a reduction to the previously reported gain due to the finalization of the working capital adjustment related to the divestiture of certain products of our Illinois health plan of $62 million, or $0.08 per diluted share, net of an income tax benefit of $0.02;

(e) non-cash gain related to the acquisition of the remaining 60% interest of Circle Health of $309 million, or $0.52 per diluted share, net of income tax expense of $0.00;

(f) non-cash impairment of our equity method investment in RxAdvance of $229 million, or $0.32 per diluted share, net of an income tax benefit of $0.07; and

(g) gain related to the divestiture of U.S. Medical Management (USMM) of $150 million, or $0.23 per diluted share, net of income tax expense of $0.02.

2020:

(a) debt extinguishment costs of $61 million, or $0.07 per diluted share, net of an income tax benefit of $0.04;

(b) gain related to the divestiture of certain products of our Illinois health plan of $104 million, or $0.10 per diluted share, net of income tax expense of $0.08; and

(c) non-cash impairment of $72 million, or $0.10 per diluted share, net of an income tax benefit of $0.02.

The following items contributed to our revenue and membership growth in 2021:

- *Apixio.* In December 2020, we acquired Apixio Inc., a healthcare analytics company offering artificial intelligence technology solutions. With this transaction, we intend to continue to digitize the administration of healthcare and accelerate innovation.

- *Circle Health.* In July 2021, we acquired the remaining interest in our equity method investment in Circle Health, one of the U.K.'s largest independent operators of hospitals.

- *Correctional.* In July 2021, Centurion commenced a contract with the Indiana Department of Corrections. In October 2021, Centurion commenced a contract with the Idaho Department of Corrections. In November 2021, Centurion commenced a contract with the Missouri Department of Corrections. In July 2020, Centurion commenced a two-year contract with the Kansas Department of Administration to provide healthcare services in the Department of Corrections' facilities. In April 2020, Centurion began providing medical services, behavioral healthcare, and substance abuse treatment within four prisons and six community corrections centers across the state of Delaware.

- *Hawaii.* In July 2021, we began operating under two new statewide contracts in Hawaii to continue administering covered services to eligible Medicaid and Children's Health Insurance Program (CHIP) members for medically necessary medical, behavioral health, and long-term services and support and to continue administering services through the Community Care Services program in partnership with the Hawaii Department of Human Services' Med-QUEST Division.

- *Health Insurance Marketplace.* In January 2021, we expanded our offerings in the Health Insurance Marketplace. We expanded our Marketplace product, branded Ambetter, in nearly 400 new counties across 13 existing states. In addition, Ambetter-branded Marketplace products are now offered in two new states, New Mexico and Michigan. Centers for Medicare and Medicaid Services (CMS) extended the Health Insurance Marketplace special enrollment period until August 15, 2021, which resulted in membership growth.

- *Illinois.* In July 2020, Meridian Health Plan of Illinois, Inc. (Meridian) began serving Medicaid members in Cook County, Illinois, as a result of a member transfer agreement under which Meridian was assigned 100% of NextLevel Health Partners, Inc.'s approximately 54,000 members who access benefits from the Illinois Department of Healthcare and Family Services' HealthChoice Illinois Program. 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 Illinois Department of Healthcare and Family Services and Foster Care.

- *North Carolina.* In July 2021, WellCare of North Carolina commenced operations under a new statewide contract in North Carolina providing Medicaid managed care services. In addition, we also began operating under a new contract to provide Medicaid managed care services in three regions in North Carolina through our provider-led North Carolina joint venture, Carolina Complete Health.

- *PANTHERx*. In December 2020, we acquired PANTHERx, one of the largest and fastest-growing specialty pharmacies in the United States specializing in orphan drugs and treating rare diseases.

- *Spain.* In September 2021, our Spanish subsidiary, Ribera Salud, acquired the remaining 65% interest in Marina Salud, S.A., which is public-private partnership in Denia.

- *TRICARE*. In January 2021, we began administering the Buckley Prime Service Area Pilot in the Denver, Colorado area, which is a TRICARE pilot program for value-based payment arrangements not currently an option in the fee-for-service T2017 reimbursement model.

- *WellCare*. On January 23, 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.

- In addition, revenue growth was significantly driven by Medicaid membership increases resulting from the ongoing suspension of eligibility redeterminations as well as Medicare membership growth.

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

- Effective January 2021, we no longer serve non-risk members under our management services program in Maryland.

- Effective October 2020, we no longer serve members under the correctional contract in Mississippi.

- In October 2020, CMS published Medicare Star quality ratings for the 2021 rating year. Approximately 30% of our Medicare members are in a 4.0 star or above plan for the 2022 bonus year compared to 46% for the 2021 bonus year.

- In September 2020, our Oregon subsidiary, Trillium Community Health Plan, began operating under an expanded contract serving 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 decreased.

- Effective August 2020, we no longer serve members under the Military & Family Life Counseling Program contract.

- Effective July 2020, we no longer serve members under the state-wide correctional contract in Vermont.

- 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.

- We experienced a decrease in our 2021 Health Insurance Marketplace membership driven primarily by a reduction of members in the state of Florida, resulting from price competition in three highly populated counties.

- Beginning in the second quarter of 2020, we experienced Medicaid state premium rate reductions and risk corridor actions as a result of the COVID-19 pandemic.

We expect the following items to contribute to our future results of operations:

- We expect to realize the benefit in 2022 of acquisitions, investments, and business commenced during 2021, as discussed above.

- In February 2022, our Louisiana subsidiary, Louisiana Healthcare Connections was awarded a Medicaid contract by the Louisiana Department of Health to continue administering quality, integrated healthcare services to members across the state. The contract is expected to commence in July 2022.

- In January 2022, we acquired all of the issued and outstanding shares of Magellan for a total purchase price of approximately $2.6 billion. The Magellan acquisition enables us to provide whole-health, integrated healthcare solutions to deliver better health outcomes at lower costs for complex, high-cost populations.

- In January 2022, our Nevada subsidiary, SilverSummit Healthplan, Inc., commenced the contract awarded from the Nevada Department of Health and Human Services - Health Care Financing and Policy to continue providing managed care services for its Medicaid Managed Care program in both Clark and Washoe Counties.

- In December 2021, we converted our equity method investment in RxAdvance, a pharmacy benefit manager, into a secured note receivable. This conversion was consistent with our focus on the simplification of our pharmacy operations.

- In October 2021, CMS published updated Medicare Star quality ratings for the 2022 rating year. Over 50% of our Medicare members are in a 4.0 star or above plan for the 2023 bonus year, compared to approximately 30% for the 2022 bonus year. This increase in Star quality ratings is primarily due to certain disaster relief provisions, which we do not expect to be applicable in future years. As a result, we expect to experience a meaningful decrease to our Star ratings for the 2023 Star rating year, which impacts the 2024 bonus year, followed by a subsequent increase to our Star

ratings for the 2024 Star rating year, which impacts the 2025 bonus year.

- In October 2021, we announced the expansion of our Medicare Advantage offerings for 2022. Our Medicare plans expect to operate in 1,575 counties across 36 states in 2022, a 26% increase in counties and three new states compared to 2021.

- In August 2021, we announced that our North Carolina subsidiaries, Carolina Complete Health and WellCare of North Carolina, will coordinate physical and/or other health services with Local Management Entities/Managed Care Organizations under the state's new Tailored Plans. The Tailored Plans, which are expected to launch in December 2022, are integrated health plans designed for individuals with significant behavioral health needs and intellectual/developmental disabilities.

- In August 2021, our Ohio subsidiary, Buckeye Health Plan, was awarded a Medicaid contract by the Ohio Department of Medicaid to continue servicing members with quality healthcare, coordinated services, and benefits. The contract is expected to commence in July 2022.

- We expect Medicaid eligibility redeterminations to begin in 2022.

- The anticipated and previously disclosed carve out of California pharmacy services in January 2022 in connection with the state’s transition of pharmacy services from managed care to fee for service.

- The anticipated carve out of Ohio pharmacy services in July 2022 in connection with the state’s transition of pharmacy services from managed care to a single pharmacy benefit manager.

- Potential Medicaid state rate actions and risk corridor mechanisms as a result of the COVID-19 pandemic.

In addition, in December 2021, we sold a majority stake in USMM, our physician home health business. We believe this best positions USMM to expand its reach and impact while helping to deliver on our Value Creation Plan.

MEMBERSHIP

From December 31, 2020 to December 31, 2021, we increased our managed care membership by 1.1 million, or 4%. The following table sets forth our membership by line of business:

	December 31,	
	2021	**2020**
Traditional Medicaid [1]	13,328,400	12,055,400
High Acuity Medicaid [2]	1,686,100	1,554,700
Total Medicaid	15,014,500	13,610,100
Commercial	2,602,600	2,633,600
Medicare [3]	1,252,200	955,400
Medicare PDP	4,070,500	4,469,400
International	597,600	597,700
Correctional	194,500	147,200
Total at-risk membership	23,731,900	22,413,400
TRICARE eligibles	2,874,700	2,877,900
Non-risk membership	4,000	231,600
Total	26,610,600	25,522,900

[1] Membership includes TANF, Medicaid Expansion, CHIP, Foster Care and Behavioral Health.
[2] Membership includes ABD, IDD, LTSS and MMP Duals.
[3] Membership includes Medicare Advantage and Medicare Supplement.

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

	December 31,	
	2021	2020
Dual-eligible [4]	1,178,000	1,066,800
Health Insurance Marketplace	2,140,500	2,131,600
Medicaid Expansion	2,468,100	2,181,400

[4] Membership that is eligible for both Medicaid and Medicare benefits.

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, 2021, and 2020, respectively, prepared in accordance with generally accepted accounting principles in the United States ($ in millions, except per share data in dollars):

	2021	2020	% Change 2020-2021
Premium	$ 112,319	$ 100,055	12 %
Service	5,664	3,745	51 %
Premium and service revenues	117,983	103,800	14 %
Premium tax and health insurer fee	7,999	7,315	9 %
Total revenues	125,982	111,115	13 %
Medical costs	98,602	86,264	14 %
Cost of services	4,894	3,303	48 %
Selling, general and administrative expenses	10,166	9,867	3 %
Amortization of acquired intangible assets	770	719	7 %
Premium tax expense	8,287	6,332	31 %
Health insurer fee expense	—	1,476	n.m.
Goodwill and intangible impairment	229	72	218 %
Legal settlement	1,250	—	n.m.
Earnings from operations	1,784	3,082	(42)%
Other income (expense):			
Investment and other income	819	480	71 %
Debt extinguishment costs	(125)	(61)	105 %
Interest expense	(665)	(728)	(9)%
Earnings before income tax expense	1,813	2,773	(35)%
Income tax expense	477	979	(51)%
Net earnings	1,336	1,794	(26)%
Loss attributable to noncontrolling interests	11	14	(21)%
Net earnings attributable to Centene Corporation	$ 1,347	$ 1,808	(25)%
Diluted earnings per common share attributable to Centene Corporation:	$ 2.28	$ 3.12	(27)%

n.m.: not meaningful

Year Ended December 31, 2021 Compared to Year Ended December 31, 2020

Total Revenues

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

	2021	2020	% Change 2020-2021
Medicaid	$ 84,139	$ 74,785	13 %
Commercial	16,956	17,071	(1)%
Medicare [1]	17,512	14,379	22 %
Other	7,375	4,880	51 %
Total Revenues	$ 125,982	$ 111,115	13 %

[1] Medicare includes Medicare Advantage, Medicare Supplement and Medicare PDP.

Total revenues increased 13% in the year ended December 31, 2021, over the corresponding period in 2020, primarily due to Medicaid membership growth resulting from the ongoing suspension of eligibility redeterminations, membership growth in the Medicare business, our acquisitions of PANTHERx and Circle Health in 2021 and the commencement of our contracts in North Carolina, partially offset by the repeal of the health insurer fee. During the twelve months ended December 31, 2021, we received premium rate adjustments which yielded approximately a net 2.5% composite increase across all of our markets.

Operating Expenses

Medical Costs

The HBR for the year ended December 31, 2021 was 87.8%, an increase of 160 basis points over the comparable period in 2020. The HBR for 2021 was negatively impacted by higher traditional medical utilization in the Marketplace business, higher testing and treatment costs associated with COVID-19, and the repeal of the health insurer fee. The HBR in 2020 was favorably impacted by the ACA risk corridor receivable settlement from the federal government based on the Supreme Court ruling in 2020.

Cost of Services

Cost of services increased by $1.6 billion in the year ended December 31, 2021, compared to the corresponding period in 2020, primarily attributable to the acquisitions of PANTHERx and Circle Health, which was partially offset by the expiration of the pharmacy contract with our previously divested Illinois health plan.

The cost of service ratio for the year ended December 31, 2021 was 86.4%, compared to 88.2% in 2020. The decrease in the cost of service ratio was driven by the acquisition of the Circle Health business, which operates at a lower cost of service ratio.

Selling, General & Administrative Expenses

The SG&A expense ratio was 8.6% for the year ended December 31, 2021, compared to 9.5% for the year ended December 31, 2020. The Adjusted SG&A expense ratio was 8.4% for the year ended December 31, 2021, compared to 8.9% for the year ended December 31, 2020. The SG&A ratios in 2021 benefited from leveraging of expenses over higher revenues as a result of increased membership and the acquisition of PANTHERx, partially offset by addition of the Circle Health business, which operates at a significantly higher SG&A ratio due to the nature of the business. The SG&A expense ratio in 2021 also benefited from lower acquisition related costs. The SG&A expense ratios in 2020 were negatively impacted by the $275 million charitable contribution to our foundation.

Health Insurer Fee Expense

As a result of the repeal of the health insurer fee, we did not have health insurer fee expense for the twelve months ended December 31, 2021, compared to $1.5 billion in the corresponding period in 2020.

Impairment

During the third quarter of 2021, we recorded a $229 million non-cash impairment of our equity method investment in RxAdvance, a pharmacy benefit manager. The impairment was the result of our focus on simplification of our pharmacy operations. Specifically, during the third quarter, we made a strategic decision to transition from using the RxAdvance platform and consolidate our business on an alternative external platform. During the fourth quarter of 2021, we converted our equity method investment in RxAdvance into a secured note receivable. During the first quarter of 2020, we recorded $72 million of non-cash impairment of our third-party care management software business.

Legal Settlement

During the second quarter of 2021, we recorded a legal settlement reserve of $1.25 billion (inclusive of the nine states with which we have reached no-fault agreements) related to services provided by Envolve, our pharmacy benefits manager subsidiary, essentially during 2017 and 2018.

Other Income (Expense)

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

	2021	2020
Investment and other income	$ 819	$ 480
Debt extinguishment costs	(125)	(61)
Interest expense	(665)	(728)
Other income (expense), net	$ 29	$ (309)

Investment and other income. Investment and other income increased by $339 million for year ended December 31, 2021 compared to 2020. The increase in investment income in 2021 was due to a gain related to the acquisition of the remaining 60% interest of Circle Health of $309 million and a gain related to the divestiture of USMM of $150 million, partially offset by a $62 million reduction related to the gain due to the finalization of the working capital adjustment related to the divestiture of certain products of our Illinois health plan recorded for the year ended December 31, 2021 compared to the previously reported $104 million gain recorded in the year-ended 2020. The increase was also partially offset by lower interest rates.

Debt extinguishment costs. In August 2021, we redeemed all of our outstanding 5.375% senior notes due 2026 and all of WellCare Health Plans, Inc.'s outstanding 5.375% senior notes due 2026, including all premiums, accrued interest and costs and expenses related and recognized a pre-tax loss on extinguishment of approximately $79 million. The loss includes the call premium and the write-off of the unamortized premium and debt issuance costs, and expenses related to the redemption.

In February 2021, we tendered or redeemed all of our outstanding $2.2 billion 4.75% Senior Notes, due 2025 and recognized a pre-tax loss on extinguishment of approximately $46 million. The loss includes the call premium and the write-off of unamortized premium and debt issuance costs.

In October 2020, we redeemed all of the $1.0 billion 4.75% Senior Notes due 2022 (the 2022 Notes) and the $1.2 billion 5.25% Senior Notes due 2025 (the 2025 Notes). We recognized a pre-tax loss on extinguishment of $17 million on the redemption of the 2022 Notes and the 2025 Notes in the fourth quarter of 2020, including the call premiums and write-off of unamortized debt issuance costs.

In February 2020, we redeemed all of our outstanding $1.0 billion 6.125% Senior Notes, due February 15, 2024 (the 2024 Notes) and recognized a pre-tax loss on extinguishment of $44 million. The loss includes the call premium, the write-off of unamortized debt issuance costs and the loss on the termination of the $1.0 billion interest rate swap associated with the 2024 Notes.

Interest expense. Interest expense decreased by $63 million in the year ended December 31, 2021, compared to the corresponding period in 2020. The decrease was driven by our senior note refinancing actions.

Income Tax Expense

For the year ended December 31, 2021, we recorded income tax expense of $477 million on pre-tax earnings of $1.8 billion, or an effective tax rate of 26.3%. The effective tax rate for the year ended December 31, 2021 reflects the repeal of the health insurer fee, the non-taxable gain related to the acquisition of the remaining 60% interest in Circle Health, the partial non-deductibility of the legal settlement reserve, and the gain on the sale of our majority stake in USMM. For the year ended December 31, 2020, we recorded income tax expense of $979 million on pre-tax earnings of $2.8 billion, or an effective tax rate of 35.3%, which reflects the tax impact associated with the Illinois divestiture and the reinstatement of the health insurer fee in 2020, partially offset by a favorable tax settlement.

Segment Results

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

	2021	2020	% Change 2020-2021
Total Revenues			
Managed Care	$ 120,125	$ 106,867	12 %
Specialty Services	18,652	14,994	24 %
Eliminations	(12,795)	(10,746)	n.m.
Consolidated Total	$ 125,982	$ 111,115	13 %
Earnings from Operations			
Managed Care	$ 1,789	$ 3,031	(41)%
Specialty Services	(5)	51	(110)%
Consolidated Total	$ 1,784	$ 3,082	(42)%

n.m.: not meaningful

Managed Care

Total revenues increased 12% in the year ended December 31, 2021, compared to the corresponding period in 2020, primarily due to Medicaid membership growth resulting from the ongoing suspension of eligibility redeterminations, membership growth in the Medicare business, our recent acquisition of Circle Health and the commencement of our contracts in North Carolina, partially offset by the repeal of the health insurer fee. Earnings from operations decreased $1.2 billion between years primarily due to a legal settlement reserve of $1.25 billion related to services provided by Envolve, higher utilization in the Marketplace business in 2021, the repeal of the health insurer fee in 2021 and an unfavorable 2020 risk adjustment in 2021. These decreases were partially offset by lower acquisition related expenses and a full twelve months of WellCare results.

Specialty Services

Total revenues increased 24% in the year ended December 31, 2021, compared to the corresponding period in 2020, resulting primarily from newly acquired businesses, including PANTHERx, increased services associated with membership growth in the Managed Care segment and newly awarded contracts in our correctional business. These increases were partially offset by the expiration of the pharmacy contract with our previously divested Illinois health plan. Earnings from operations decreased $56 million between years. The decline in earnings from operations was negatively affected by the previously discussed impairment of our equity method investment in RxAdvance, a pharmacy benefits manager, partially offset by favorable results related to the shared savings programs in our physician home health business. Earnings from operations in 2020 was negatively affected by the previously discussed $72 million impairment related to our third-party care management software business.

LIQUIDITY AND CAPITAL RESOURCES

Shown below is a condensed schedule of cash flows for the years ended December 31, 2021 and 2020, used in the discussion of liquidity and capital resources ($ in millions).

	Year Ended December 31,	
	2021	2020
Net cash provided by operating activities	$ 4,205	$ 5,503
Net cash used in investing activities	(3,299)	(6,955)
Net cash provided by financing activities	1,362	260
Effect of exchange rate changes on cash and cash equivalents	(11)	18
Net increase in cash, cash equivalents, and restricted cash and equivalents	$ 2,257	$ (1,174)

Cash Flows Provided by Operating Activities

Normal operations are funded primarily through operating cash flows and borrowings under our Revolving Credit Facility. In 2021, operating activities provided cash of $4.2 billion, or 3.1 times net earnings, compared to $5.5 billion in 2020. Cash flow provided by operations in 2021 was due to net earnings before the legal settlement reserve, the majority of which is expected to be paid in future periods, an increase in state risk sharing payables, partially offset by risk adjustment and minimum MLR payments for the Health Insurance Marketplace 2020 plan year.

Cash flows provided by operations in 2020 was primarily due to net earnings, an increase in medical claims liabilities from growth and expansions, and an increase in other long-term liabilities related to minimum MLR payables and a delay in employer payroll tax payments related to the COVID-19 extensions to payment deadlines.

Cash Flows Used in Investing Activities

Investing activities used cash of $3.3 billion for the year ended December 31, 2021 and $7.0 billion in 2020. Cash flows used in investing activities in 2021 consisted of the net additions to the investment portfolio of our regulated subsidiaries (including transfers from cash and cash equivalents to long-term investments), capital expenditures, and acquisition and divestiture activity primarily related to the acquisition of the remaining 60% interest of Circle Health for $705 million, offset by proceeds received related to the sale of our majority interest in USMM.

We spent $910 million and $869 million in the years ended December 31, 2021 and 2020, respectively, on capital expenditures for system enhancements, market growth, and corporate headquarters expansions.

As of December 31, 2021, our investment portfolio consisted primarily of fixed-income securities with a weighted average duration of 3.6 years. We had unregulated cash and investments of $3.4 billion at December 31, 2021, including $538 million in our International subsidiaries, compared to $1.9 billion at December 31, 2020. Unregulated cash and investments include private equity investments and company owned life insurance contracts.

Cash flows used in investing activities in 2020 were driven by our acquisitions of WellCare, PANTHERx and Apixio, partially offset by divestiture proceeds. Cash flows used in investing activities in 2020 also consisted of net additions to the investment portfolio of our regulated subsidiaries (including transfers from cash and cash equivalents to long-term investments) and capital expenditures.

Cash Flows Provided by Financing Activities

Our financing activities provided cash of $1.4 billion in 2021, compared to $260 million in 2020. During 2021, our net financing activities were primarily related to the issuance of $1.8 billion 2.45% Senior Notes due 2028 (the 2028 Notes) to fund a portion of cash consideration for the Magellan Acquisition, which closed in January 2022, and a $750 million increase to our unsecured term loan facility. This was partially offset by the repayment and refinancing of senior notes, resulting in a net decrease in debt of $800 million, along with common stock repurchases, including the repurchase of $200 million of common stock through our stock repurchase program.

During 2020, our net financing activities were primarily driven by net proceeds from the issuance and refinancing of senior notes resulting in a net increase in senior debt of $1.0 billion, offset by common stock repurchases, including the repurchase of $500 million of common stock through our stock repurchase program.

Liquidity Metrics

The credit agreement underlying our Revolving Credit Facility and Term Loan Facility contains customary covenants as well as financial covenants, including a minimum fixed charge coverage ratio and a maximum debt-to-EBITDA ratio. Our maximum debt-to-EBITDA ratio under the credit agreement may not exceed 4.0 to 1.0. As of December 31, 2021, we had $149 million of borrowings outstanding under our Revolving Credit Facility, $2.2 billion of borrowings outstanding under our Term Loan Facility, and we were in compliance with all covenants. As of December 31, 2021, there were no limitations on the availability of our Revolving Credit Facility as a result of the debt-to-EBITDA ratio.

In October 2017, we executed a $200 million non-recourse construction loan to fund the expansion of our corporate headquarters. Until the final completion of the project, which occurred in July 2021, the loan bore interest based on the one month LIBOR plus 2.70%, which reduced to LIBOR plus 2.00% at the time construction completed. The agreement contains financial and non-financial covenants similar to those contained in our Credit Facility. We guaranteed completion of the construction project associated with the loan. In April 2021, we finalized the one year extension of the construction loan maturing in April 2022. As of December 31, 2021, we had $184 million in borrowings outstanding under the loan, which is included in the current portion of long-term debt.

We had outstanding letters of credit of $128 million as of December 31, 2021, which were not part of our Revolving Credit Facility. The letters of credit bore weighted interest of 0.6% as of December 31, 2021. In addition, we had outstanding surety bonds of $1.3 billion as of December 31, 2021.

The indentures governing our various maturities of senior notes contain limited restrictive covenants. As of December 31, 2021, we were in compliance with all covenants.

At December 31, 2021, we had working capital, defined as current assets less current liabilities, of $2.7 billion, compared to $1.8 billion at December 31, 2020. Unregulated cash was substantially reduced in January 2022 upon the closing of the Magellan Acquisition for the purchase price payment and corresponding closing costs. 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, 2021, our debt to capital ratio, defined as total debt divided by the sum of total debt and total equity, was 41.2%, compared to 39.3% at December 31, 2020. Excluding $184 million of non-recourse debt, our debt to capital ratio was 40.9% as of December 31, 2021, compared to 39.0% at December 31, 2020. 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. We have $800 million remaining under the program for repurchases as of December 31, 2021. No duration has been placed on the repurchase program. We reserve the right to discontinue the repurchase program at any time. In 2021, we used proceeds from the divestiture of USMM to repurchase 2.4 million shares of Centene common stock for $200 million through our stock repurchase program. In 2020 we used proceeds from divestitures to repurchase 8.7 million shares of Centene common stock for $500 million through our stock repurchase program.

During the year ended December 31, 2021 and 2020, we received dividends of $2.5 billion and $1.3 billion, respectively, from our regulated subsidiaries.

2022 Expectations

During 2022, we expect to receive net dividends of approximately $1.1 billion from our regulated subsidiaries and expect to spend approximately $1.1 billion in capital expenditures primarily associated with system enhancements and the completion of our offices in Charlotte, North Carolina. In February 2021, our Board of Directors approved an increase in our existing share repurchase program for our common stock. With the increase, we are authorized to repurchase up to $1.0 billion of shares of our common stock, inclusive of the previously approved stock repurchase program. We have $800 million remaining under the program for repurchases as of December 31, 2021. No duration has been placed on the repurchase program.

On January 4, 2022, we acquired all of the issued and outstanding shares of Magellan Health. Total consideration for the

acquisition was approximately $2.6 billion, consisting of $2.5 billion in cash ($95.00 per share) and an estimated $67 million related to the fair value replacement equity awards associated with pre-combination service. In January 2022, we paid off Magellan's debt of $535 million acquired in the transaction using Magellan's cash on hand.

We have material debt, lease, contingencies and short-term medical claims obligations. Refer to Note 10. *Debt*, Note 11. *Leases*, Note 18. *Contingencies* and Note 8. *Medical Claims Liability*, respectively, for further information. In addition, we have material commitments as a result of our Fidelis Care acquisition. Refer to Note 17. *Commitments* for detail.

Based on our operating plan, we expect that our available cash, cash equivalents and investments, cash from our operations and cash available under our Revolving Credit Facility will be sufficient to finance our general operations and capital expenditures for at least 12 months from the date of this filing. While we are currently in a strong liquidity position and believe we have adequate access to capital, we may elect to increase borrowings on our Revolving Credit Facility. In addition, 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 or redemption opportunities to extend maturities and/or improve terms of our indebtedness if we believe such opportunities are favorable to us.

We intend to continue to evaluate strategic actions in connection with our Value Creation Plan, targeting initiatives to improve productivity, efficiencies and reduced organizational costs, as well as capital deployment activities, including share repurchases, portfolio optimization and the evaluation of refinancing opportunities.

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.

As of December 31, 2021, our subsidiaries had aggregate statutory capital and surplus of $14.0 billion, compared with the required minimum aggregate statutory capital and surplus requirements of $6.7 billion. During the year ended December 31, 2021, we received $1.5 billion of net dividends from our regulated subsidiaries. For our subsidiaries that file with the National Association of Insurance Commissioners (NAIC), we estimate our Risk Based Capital (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.

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, 2021, 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, 2021, the amount of capital and surplus or net worth that was unavailable for the payment of dividends or return of capital to us was $6.7 billion 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 purchased contract rights and customer relationships, provider contracts, trade names, developed technologies, 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, 2021, we had $19.8 billion of goodwill and $7.8 billion of other intangible assets.

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

Intangible Asset	Amortization Period
Purchased contract rights and customer relationships	3 - 21 years
Provider contracts	4 - 15 years
Trade names	7 - 20 years
Developed technologies	2 - 7 years

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

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

If a reporting unit’s carrying amount exceeds its fair value, an entity will record an impairment charge based on that difference. The impairment charge will be limited to the 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.

We do not believe any of our reporting units are currently at risk for impairment. However, as part of our Value Creation Plan, we are completing a portfolio review and may identify changes in strategic focus, which could result in future impairments of goodwill or intangibles based on market indicators at that time.

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 have a material adverse effect on our results of operations, financial position 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, 2021 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)%	$ 718	(1.00)%	$ (188)
(0.75)	537	(0.75)	(141)
(0.50)	357	(0.50)	(94)
(0.25)	178	(0.25)	(47)
0.25	(177)	0.25	47
0.50	(354)	0.50	94
0.75	(529)	0.75	141
1.00	(703)	1.00	188

(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 $105 million for the year ended December 31, 2021, 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,		
	2021	2020	2019
Balance, January 1,	$ 12,438	$ 7,473	$ 6,831
Less: reinsurance recoverable	23	20	27
Balance, January 1, net	12,415	7,453	6,804
Acquisitions	—	3,856	59
Incurred related to:			
Current year	100,385	86,765	59,539
Prior years	(1,783)	(501)	(677)
Total incurred	98,602	86,264	58,862
Paid related to:			
Current year	87,427	78,838	52,453
Prior years	9,370	6,320	5,819
Total paid	96,797	85,158	58,272
Balance, December 31, net	14,220	12,415	7,453
Plus: reinsurance recoverable	23	23	20
Balance, December 31,	$ 14,243	$ 12,438	$ 7,473
Days in claims payable [1]	52	51	45

(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, 2021 will be known by the end of 2022.

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 $492 million, $86 million and $49 million of the "Incurred related to: Prior years" was recorded as a reduction to premium revenues in 2021, 2020 and 2019, 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 evidence based criteria or clinical policy.
- Management of our pre-authorization list, monitoring for over utilized services, and stringent review of durable medical equipment and injectables.
- Emergency department program designed to collaboratively work with hospitals and members to steer non-emergent care to a more appropriate and cost effective setting (through patient education, on-site alternative urgent care settings, etc.).
- Increased emphasis on care management and clinical rounding where nurse or social worker care managers assist selected high risk members 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 such as our *Start Smart For Your Baby* program.

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 our 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.

For qualifying low income PDP members, CMS pays for some, or all, of the member's monthly premium. We receive certain Part D prospective subsidy payments from CMS for our PDP members as a fixed monthly per member amount, based on the estimated costs of providing prescription drug benefits over the plan year, as reflected in our bids. Approximately nine to ten months subsequent to the end of the plan year, or later in the case of the coverage gap discount subsidy, a settlement payment is made between CMS and our plans based on the difference between the prospective payments and actual claims experience.

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, 2018 and 2020. The HIF was suspended in 2017 and 2019. Beginning in 2021, the HIF was permanently repealed. 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, 2021, we had short-term investments of $1.5 billion and long-term investments of $15.1 billion, including restricted deposits of $1.1 billion. 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, equity securities and private equity investments 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, 2021, the fair value of our fixed income investments would decrease by approximately $365 million. Declines in interest rates over time, including those that have occurred as markets experienced volatility related to the COVID-19 pandemic, will reduce our investment income.

We have a foreign currency swap for a notional amount of $705 million with a creditworthy financial institution to manage foreign exchange risk related to a Great British Pound denominated note receivable from a consolidated international subsidiary. As a result, the fair value of the swap varies with foreign exchange rate fluctuations. Assuming a 1% increase in the Great British Pound to US Dollar foreign exchange rate at December 31, 2021, the fair value of our swap would decrease by approximately $7 million. An increase in the US Dollar to Great British Pound foreign exchange rate decreases the fair value of the swap and conversely, a decrease in the foreign currency exchange rate increases the value. The offsetting changes in fair value of the foreign currency swap and the remeasurement of the underlying intercompany note receivable were both recognized in investment and other income in the Consolidated Statements of Operations. The Company does not hold or issue any derivative instruments for trading or speculative purposes.

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.***"

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, 2021 and 2020, 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, 2021, 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, 2021 and 2020, and the results of its operations and its cash flows for each of the years in the three-year period ended December 31, 2021, 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, 2021, 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 22, 2022 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 Note 2 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. As discussed in Note 8 to the consolidated financial statements, the balance at December 31, 2021 was $14,243 million.

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 following are the primary procedures we performed to address this critical audit matter. We evaluated the design and tested the operating effectiveness of certain internal controls related to the critical audit matter. This included 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 actuarial methods used by the Company to estimate the medical claims liability. 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 for certain health plans using the Company's medical claims data, 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 Note 2 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. The final settlement of the December 31, 2021 ACA risk adjustment accruals is scheduled to be determined by the Centers for Medicare and Medicaid Services (CMS) in June 2022, based on data submitted by insurance companies through April 2022. As discussed in Note 9, the Company recorded an estimated asset and liability (the ACA risk adjustment accruals) of $522 million, and $536 million, respectively at December 31, 2021.

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 CMS for settlement.

The following are the primary procedures we performed to address this critical audit matter. We evaluated the design and tested the operating effectiveness of 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 industry 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 22, 2022

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

	December 31, 2021	December 31, 2020
ASSETS		
Current assets:		
Cash and cash equivalents	$ 13,118	$ 10,800
Premium and trade receivables	12,238	9,696
Short-term investments	1,539	1,580
Other current assets	1,602	1,317
Total current assets	28,497	23,393
Long-term investments	14,043	12,853
Restricted deposits	1,068	1,060
Property, software and equipment, net	3,391	2,774
Goodwill	19,771	18,652
Intangible assets, net	7,824	8,388
Other long-term assets	3,781	1,599
Total assets	$ 78,375	$ 68,719
LIABILITIES, REDEEMABLE NONCONTROLLING INTERESTS AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims liability	$ 14,243	$ 12,438
Accounts payable and accrued expenses	8,493	7,069
Return of premium payable	2,328	1,458
Unearned revenue	434	523
Current portion of long-term debt	267	97
Total current liabilities	25,765	21,585
Long-term debt	18,571	16,682
Deferred tax liability	1,407	1,534
Other long-term liabilities	5,610	2,956
Total liabilities	51,353	42,757
Commitments and contingencies		
Redeemable noncontrolling interests	82	77
Stockholders' equity:		
Preferred stock, $0.001 par value; authorized 10,000 shares; no shares issued or outstanding at December 31, 2021 and December 31, 2020	—	—
Common stock, $0.001 par value; authorized 800,000 shares; 602,704 issued and 582,479 outstanding at December 31, 2021, and 598,249 issued and 581,479 outstanding at December 31, 2020	1	1
Additional paid-in capital	19,672	19,459
Accumulated other comprehensive earnings	77	337
Retained earnings	8,139	6,792
Treasury stock, at cost (20,225 and 16,770 shares, respectively)	(1,094)	(816)
Total Centene stockholders' equity	26,795	25,773
Noncontrolling interest	145	112
Total stockholders' equity	26,940	25,885
Total liabilities, redeemable noncontrolling interests and stockholders' equity	$ 78,375	$ 68,719

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 shares in thousands and per share data in dollars)

	Year Ended December 31,		
	2021	**2020**	**2019**
Revenues:			
Premium	$ 112,319	$ 100,055	$ 67,439
Service	5,664	3,745	2,925
Premium and service revenues	117,983	103,800	70,364
Premium tax and health insurer fee	7,999	7,315	4,275
Total revenues	125,982	111,115	74,639
Expenses:			
Medical costs	98,602	86,264	58,862
Cost of services	4,894	3,303	2,465
Selling, general and administrative expenses	10,166	9,867	6,533
Amortization of acquired intangible assets	770	719	258
Premium tax expense	8,287	6,332	4,469
Health insurer fee expense	—	1,476	—
Impairment loss	229	72	271
Legal settlement	1,250	—	—
Total operating expenses	124,198	108,033	72,858
Earnings from operations	1,784	3,082	1,781
Other income (expense):			
Investment and other income	819	480	443
Debt extinguishment costs	(125)	(61)	(30)
Interest expense	(665)	(728)	(412)
Earnings before income tax expense	1,813	2,773	1,782
Income tax expense	477	979	473
Net earnings	1,336	1,794	1,309
Loss attributable to noncontrolling interests	11	14	12
Net earnings attributable to Centene Corporation	$ 1,347	$ 1,808	$ 1,321
Net earnings per common share attributable to Centene Corporation:			
Basic earnings per common share	$ 2.31	$ 3.17	$ 3.19
Diluted earnings per common share	$ 2.28	$ 3.12	$ 3.14
Weighted average number of common shares outstanding:			
Basic	582,832	570,722	413,487
Diluted	590,516	579,135	420,409

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,		
	2021	**2020**	**2019**
Net earnings	$ 1,336	$ 1,794	$ 1,309
Reclassification adjustment, net of tax	(20)	(3)	(5)
Change in unrealized gain (loss) on investments, net of tax	(221)	191	203
Defined benefit pension plan net gain (loss), net of tax	2	—	(6)
Foreign currency translation adjustments	(21)	15	(2)
Other comprehensive earnings (loss)	(260)	203	190
Comprehensive earnings	1,076	1,997	1,499
Comprehensive loss attributable to noncontrolling interests	11	14	12
Comprehensive earnings attributable to Centene Corporation	$ 1,087	$ 2,011	$ 1,511

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			
	$0.001 Par Value Shares	Amt	Additional Paid-in Capital	Accumulated Other Comprehensive Earnings (Loss)	Retained Earnings	$0.001 Par Value Shares	Amt	Non controlling Interest	Total
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
Net earnings (loss)	—	—	—	—	1,808	—	—	(24)	1,784
Other comprehensive earnings, net of $60 tax	—	—	—	203	—	—	—	—	203
Common stock issued for acquisitions	171,225	1	11,526	—	—	—	—	—	11,527
Common stock issued for employee benefit plans	5,923		29						29
Common stock repurchases	(407)	—	(24)	—	—	10,310	(602)	—	(626)
Stock compensation expense	—	—	281	—	—	—	—	—	281
Contribution from noncontrolling interest	—	—	—	—	—	—	—	28	28
Balance, December 31, 2020	598,249	$ 1	$ 19,459	$ 337	$ 6,792	16,770	$ (816)	$ 112	$ 25,885
Net earnings (loss)	—	—	—	—	1,347	—	—	(21)	1,326
Other comprehensive loss, net of $(75) tax	—	—	—	(260)	—	—	—	—	(260)
Common stock issued for employee benefit plans	4,781	—	38	—	—	—	—	—	38
Common stock repurchases	(326)	—	(19)	—	—	3,455	(278)	—	(297)
Stock compensation expense	—	—	203	—	—	—	—	—	203
Contribution from noncontrolling interest	—	—	—	—	—	—	—	46	46
Divestiture of noncontrolling interest	—	—	(9)	—	—	—	—	5	(4)
Acquisition resulting in noncontrolling interest	—	—	—	—	—	—	—	3	3
Balance, December 31, 2021	602,704	$ 1	$ 19,672	$ 77	$ 8,139	20,225	$ (1,094)	$ 145	$ 26,940

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,		
	2021	**2020**	**2019**
Cash flows from operating activities:			
Net earnings	$ 1,336	$ 1,794	$ 1,309
Adjustments to reconcile net earnings to net cash provided by operating activities			
Depreciation and amortization	1,476	1,259	643
Stock compensation expense	203	281	177
Impairment	229	72	271
Loss on debt extinguishment	125	57	30
Gain on acquisition	(309)	—	—
Deferred income taxes	(132)	(51)	55
Gain on divestitures	(88)	(104)	—
Other adjustments, net	(11)	—	—
Changes in assets and liabilities			
Premium and trade receivables	(2,453)	(52)	(1,076)
Other assets	(99)	(30)	(234)
Medical claims liabilities	1,802	1,117	578
Unearned revenue	(109)	(528)	(9)
Accounts payable and accrued expenses	1,141	585	(421)
Other long-term liabilities	1,093	1,078	185
Other operating activities, net	1	25	(25)
Net cash provided by operating activities	4,205	5,503	1,483
Cash flows from investing activities:			
Capital expenditures	(910)	(869)	(730)
Purchases of investments	(7,400)	(7,402)	(2,575)
Sales and maturities of investments	5,458	4,921	1,809
Acquisitions, net of cash acquired	(534)	(4,049)	(36)
Divestiture proceeds, net	68	466	—
Other investing activities, net	19	(22)	—
Net cash used in investing activities	(3,299)	(6,955)	(1,532)
Cash flows from financing activities:			
Proceeds from long-term debt	9,267	5,107	24,721
Payments of long-term debt	(7,434)	(4,067)	(17,803)
Common stock repurchases	(297)	(626)	(75)
Payments for debt extinguishment	(157)	(81)	(23)
Debt issuance costs	(72)	(120)	(25)
Other financing activities, net	55	47	37
Net cash provided by financing activities	1,362	260	6,832
Effect of exchange rate changes on cash, cash equivalents, and restricted cash	(11)	18	(2)
Net increase (decrease) in cash, cash equivalents and restricted cash and cash equivalents	2,257	(1,174)	6,781
Cash, cash equivalents, and restricted cash and cash equivalents, beginning of period	10,957	12,131	5,350
Cash, cash equivalents, and restricted cash and cash equivalents, end of period	$ 13,214	$ 10,957	$ 12,131
Supplemental disclosures of cash flow information:			
Interest paid	$ 658	$ 725	$ 374
Income taxes paid	$ 678	$ 1,191	$ 612
Equity issued in connection with acquisitions	$ —	$ 11,526	$ —

The following table provides a reconciliation of cash, cash equivalents, and restricted cash and cash equivalents reported within the Consolidated Balance Sheets to the totals above:

	2021	**2020**	**2019**
Cash and cash equivalents	$ 13,118	$ 10,800	$ 12,123
Restricted cash and cash equivalents, included in restricted deposits	96	157	8
Total cash, cash equivalents, and restricted cash and cash equivalents	$ 13,214	$ 10,957	$ 12,131

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 Medicaid and Medicare, the Supplemental Security Income Program, also known as the Aged, Blind or Disabled Program (ABD), Medicare (including Medicare Prescription Drug Plans), 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 the Company's own subsidiaries. The Specialty Services 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 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 2021 presentation. These reclassifications have no effect on net earnings, cash flow, 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, the 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. The Company monitors the difference between the carrying value and fair value of its available-for-sale debt investments and whether declines in fair value are credit related. 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. If a loss is deemed to be credit related, the Company recognizes an allowance through earnings. 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 recorded in earnings through investment and other income. Premiums and discounts are amortized or accreted over the life of the related security using the effective interest method. 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. Generally, under the equity method, original investments in these entities are recorded at cost and subsequently adjusted by the Company's share of equity in income or losses after the date of acquisition as well as capital contributions to and distributions from these companies.

Restricted Deposits

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

Fair Value Measurements

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

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

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

- Foreign currency swap: Estimated based on Great British Pound to US Dollar foreign exchange rates.
- 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	3 - 5 years
Furniture and equipment	3 - 10 years
Land improvements	10 - 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 and customer relationships, provider contracts, 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 and customer relationships	3 - 21 years
Provider contracts	4 - 15 years
Trade names	7 - 20 years
Developed technologies	2 - 7 years

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

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

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 and other various assumptions. 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 or COVID-19, 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 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. For purposes of determining premium deficiencies, contracts are grouped in a manner consistent with the method of acquiring, servicing, and measuring the profitability of such contracts.

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 it to maintain a minimum health benefits ratio (HBR) or may require it 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 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.

For qualifying low income PDP members, CMS pays for some, or all, of the member's monthly premium. The Company receives certain Part D prospective subsidy payments from CMS for its PDP members as a fixed monthly per member amount, based on the estimated costs of providing prescription drug benefits over the plan year, as reflected in its bids. Approximately nine to ten months subsequent to the end of the plan year, or later in the case of the coverage gap discount subsidy, a settlement payment is made between CMS and the Company's plans based on the difference between the prospective payments and actual claims experience.

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, when inventory is shipped 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 (ACA) annual health insurer fee (HIF), absent a HIF moratorium. The ACA imposed the HIF in 2014, 2015, 2016, 2018 and 2020. The HIF was suspended in 2017 and 2019. Beginning in 2021, the HIF was permanently repealed. 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 has little visibility to the timing of these payments until they are paid by the state.

Affordable Care Act

The 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 a FPL less than 300% and eliminate cost sharing for Indians/Alaska Natives regardless of FPL 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 beginning in 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 collectability 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):

	2021	2020	2019
Allowances, beginning of year	$ 243	$ 157	$ 123
Amounts charged to expense	62	121	76
Recoveries	(43)	—	—
Write-offs of uncollectible receivables	(123)	(35)	(42)
Allowances, end of year	$ 139	$ 243	$ 157

Significant Customers

The Company 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% for the year ended December 31, 2019; and the state of New York, where the percentage of the Company's total revenue was 10%, 11% and 15% for the years ended December 31, 2021, 2020 and 2019.

Other Income (Expense)

Other income (expense) consists routinely 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, credit facilities, mortgage and construction loans, and capital leases. Further, other income (expense) includes gains or losses sales of investments, divestitures, and acquisitions as well as debt extinguishment costs.

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

Stock based compensation expense is recognized at grant date fair value 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 Great 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 December 2019, the Financial Accounting Standards Board (FASB) issued an Accounting Standards Update (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 adopted the new guidance in the first quarter of 2021. The new guidance did not have a material impact on the Company's consolidated financial position, results of operations and cash flows.

Recent Accounting Guidance Not Yet Adopted

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

3. Acquisitions

Magellan Acquisition

On January 4, 2022, the Company acquired all of the issued and outstanding shares of Magellan. Total consideration for the acquisition was approximately $2,566 million, consisting of $2,499 million in cash ($95.00 per share) and an estimated $67 million related to the fair value replacement equity awards associated with pre-combination service.

The acquisition of Magellan 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 acquired and liabilities assumed is not yet complete.

WellCare Acquisition

On January 23, 2020, the Company acquired all of the issued and outstanding shares of WellCare. The transaction was valued at $19,555 million, including the assumption of debt. The WellCare Acquisition brought a high-quality Medicare platform and further extended the Company’s robust Medicaid offerings. The WellCare Acquisition also enables the Company 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, the Company further broadened its product offerings by adding a Medicare prescription drug plan (PDP) to its existing business lines.

Total consideration paid 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 shares of validly issued, fully paid, non-assessable 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 was funded through the issuance of long-term debt as further discussed in Note 10. Debt. The Company recognized $602 million of acquisition related costs, primarily related to WellCare, that are included in the Consolidated Statements of Operations for the year ended December 31, 2020.

The acquisition of WellCare 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 fourth quarter of 2020.

The Company's allocation of the fair value of assets acquired and liabilities assumed as of the acquisition date of January 23, 2020 is as follows ($ in millions):

Assets acquired and liabilities assumed		
Cash and cash equivalents	$	2,947
Premium and related receivables		3,699
Short-term investments		355
Other current assets		1,205
Long-term investments		2,725
Restricted deposits		320
Property, software and equipment		237
Intangible assets [(a)]		6,632
Other long-term assets		338
Total assets acquired		18,458
Medical claims liability		4,122
Accounts payable and accrued expenses		3,035
Return of premium payable		192
Unearned revenue		657
Long-term debt [(b)]		2,055
Deferred tax liabilities [(c)]		1,428
Other long-term liabilities		475
Total liabilities assumed		11,964
Total identifiable net assets		6,494
Goodwill [(d)]		11,111
Total assets acquired and liabilities assumed	$	17,605

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 $6,632 million with a weighted average life of 14 years. The identifiable intangible assets include purchased contract rights and 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)**
Purchased contract rights and customer relationships	$	5,737	14
Provider contracts		227	15
Trade names		561	16
Developed technologies		107	3
Total intangible assets acquired	$	6,632	14

(b) Debt is required to be measured at fair value under the acquisition method of accounting. The fair value of WellCare's aggregate principle of $1,950 million Senior Notes assumed in the acquisition was $2,055 million. The $105 million increase is amortized as a reduction to interest expense over the remaining life of the debt. In 2021, the Company redeemed WellCare Health Plans, Inc.'s outstanding 5.375% Senior Notes due 2026 (together the 2026 Notes).

(c) The deferred tax liabilities are presented net of $355 million of deferred tax assets.

(d) The acquisition resulted in $11,111 million of goodwill primarily related to synergies expected from the acquisition and the assembled workforce of WellCare. Substantially all of the goodwill has been assigned to the Managed Care segment. The majority of the goodwill is not deductible for income tax purposes.

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. The Company recorded $104 million in pre-tax gains for the year ended December 31, 2020, as a result of the Illinois divestiture, which is included in investment and other income on the Consolidated Statements of Operations. In 2021, the Company recorded a reduction to the previously reported gain due to the finalization of the working capital adjustment related to the divestiture of certain products of the Company's Illinois health plan of $62 million.

Statement of Operations

From the acquisition date through December 31, 2020, the Company's Consolidated Statement of Operations include total WellCare revenues of $30,709 million. It is impracticable for the Company to determine the effect on net income resulting from the WellCare acquisition for the year ended December 31, 2020, as the Company immediately began integrating WellCare into its ongoing operations.

Unaudited Pro Forma Financial Information

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

	Year Ended December 31, 2019
Total revenues	$ 102,379
Net earnings attributable to common stockholders	1,496
Diluted earnings per share	$ 2.53

The unaudited pro forma total revenues for the year ended December 31, 2020 was $112,905 million. It is impracticable for the Company to determine the pro forma earnings information for the year ended December 31, 2020 due to the nature of obtaining that information as the Company immediately began integrating WellCare into its ongoing operations.

The unaudited pro forma financial information reflects the historical results of Centene and WellCare adjusted as if the acquisition had occurred on January 1, 2019, 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 fair value of identifiable intangible assets of approximately $6,632 million.
- 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).

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, 2019 and is not a projection of future results. The unaudited pro forma financial information does not reflect the previously discussed divestitures as the impact would be impracticable to quantify.

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, 2021				December 31, 2020			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
Debt securities:								
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ 642	$ —	$ (2)	$ 640	$ 907	$ 4	$ —	$ 911
Corporate securities	8,145	130	(75)	8,200	6,560	262	(8)	6,814
Restricted certificates of deposit	4	—	—	4	105	—	—	105
Restricted cash equivalents	96	—	—	96	157	—	—	157
Short-term time deposits	109	—	—	109	53	—	—	53
Municipal securities	3,398	85	(15)	3,468	2,970	129	(2)	3,097
Asset-backed securities	1,308	5	(5)	1,308	1,154	13	(3)	1,164
Residential mortgage-backed securities	850	10	(7)	853	1,068	27	—	1,095
Commercial mortgage- backed securities	870	13	(10)	873	748	30	(5)	773
Equity securities [1]	326	—	—	326	318	—	—	318
Private equity investments	587	—	—	587	838	—	—	838
Life insurance contracts	186	—	—	186	168	—	—	168
Total	$ 16,521	$ 243	$ (114)	$ 16,650	$ 15,046	$ 465	$ (18)	$ 15,493

(1) Investments in equity securities primarily consists of exchange traded funds in fixed income securities.

The Company's investments are debt securities classified as available-for-sale with the exception of equity securities, certain private equity investments and life insurance contracts. 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, 2021, 98% of the Company's investments in rated securities carry an investment grade rating by nationally recognized statistical rating organizations. At December 31, 2021, the Company held certificates of deposit, equity securities, private equity investments and life insurance contracts, which did not carry a credit rating. Accrued interest income on available-for-sale debt securities was $96 million and $86 million at December 31, 2021 and 2020, respectively, and is included in other current assets on the Consolidated Balance Sheet.

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, 2021.

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, 2021				December 31, 2020			
	Less Than 12 Months		12 Months or More		Less Than 12 Months		12 Months or More	
	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ (2)	$ 598	$ —	$ 3	$ —	$ —	$ —	$ —
Corporate securities	(66)	4,209	(9)	209	(7)	953	(1)	24
Municipal securities	(14)	1,173	(1)	39	(2)	238	—	—
Asset-backed securities	(5)	770	—	33	(2)	302	(1)	105
Residential mortgage- backed securities	(7)	472	—	15	—	59	—	2
Commercial mortgage- backed securities	(8)	380	(2)	32	(5)	147	—	13
Total	$ (102)	$ 7,602	$ (12)	$ 331	$ (16)	$ 1,699	$ (2)	$ 144

As of December 31, 2021, the gross unrealized losses were generated from 2,692 positions out of a total of 6,605 positions. The change in fair value of available-for-sale debt 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 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, the Company did not record an impairment for these securities.

In addition, the Company monitors available-for-sale debt securities for credit losses. 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 allowance when evidence demonstrates that the decline in fair value is credit related. Evidence of a credit related loss may include rating agency actions, adverse conditions specifically related to the security, or failure of the issuer of the security to make scheduled payments.

In June 2019, the Company acquired 40% of Circle Health, one of the U.K.’s largest independent operators of hospitals. The initial 40% investment was accounted for as an equity method investment. In July 2021, the Company acquired the remaining 60% interest of Circle Health for $705 million. As a result of the acquisition, the Company recorded a non-cash gain of $309 million on its original investment in the twelve months ended December 31, 2021. The gain was included in investment and other income on the Consolidated Statement of Operations. Beginning in July 2021, the Company consolidates 100% of Circle Health.

In September 2021, the Company recorded a $229 million impairment of its equity method investment in RxAdvance, a pharmacy benefit manager. During the third quarter, the Company made a strategic decision to transition from using the RxAdvance platform and consolidate its business on an alternative external platform as a result of the Company's focus on simplification of its pharmacy operations. The impairment was based on the Company’s estimate of RxAdvance’s future cash flows and other market indicators of fair value.

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

	December 31, 2021				December 31, 2020			
	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	$ 1,390	$ 1,396	$ 368	$ 368	$ 1,407	$ 1,414	$ 817	$ 818
One year through five years	6,212	6,294	460	457	4,748	4,937	221	223
Five years through ten years	3,647	3,681	244	243	3,460	3,639	18	19
Greater than ten years	73	78	—	—	81	87	—	—
Asset-backed securities	3,028	3,034	—	—	2,970	3,032	—	—
Total	$ 14,350	$ 14,483	$ 1,072	$ 1,068	$ 12,666	$ 13,109	$ 1,056	$ 1,060

Actual maturities may differ from contractual maturities due to call or prepayment options. Equity securities, private equity investments and life insurance contracts are excluded from the table above because they do not have a contractual maturity. 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.

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, 2021, 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	$ 13,118	$ —	$ —	$ 13,118
Investments:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ 171	$ —	$ —	$ 171
Corporate securities	—	8,170	—	8,170
Municipal securities	—	2,999	—	2,999
Short-term time deposits	—	109	—	109
Asset-backed securities	—	1,308	—	1,308
Residential mortgage-backed securities	—	853	—	853
Commercial mortgage-backed securities	—	873	—	873
Equity securities	324	2	—	326
Total investments	$ 495	$ 14,314	$ —	$ 14,809
Restricted deposits:				
Cash and cash equivalents	$ 96	$ —	$ —	$ 96
Certificates of deposit	—	4	—	4
Corporate securities	—	30	—	30
Municipal securities	—	469	—	469
U.S. Treasury securities and obligations of U.S. government corporations and agencies	469	—	—	469
Total restricted deposits	$ 565	$ 503	$ —	$ 1,068
Other current assets:				
Foreign currency swap agreement	$ —	$ 15	$ —	$ 15
Total assets at fair value	$ 14,178	$ 14,832	$ —	$ 29,010

The following table summarizes fair value measurements by level at December 31, 2020, 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	$ 10,800	$ —	$ —	$ 10,800
Investments:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ 165	$ —	$ —	$ 165
Corporate securities	—	6,789	—	6,789
Municipal securities	—	3,070	—	3,070
Short-term time deposits	—	53	—	53
Asset-backed securities	—	1,164	—	1,164
Residential mortgage-backed securities	—	1,095	—	1,095
Commercial mortgage-backed securities	—	773	—	773
Equity securities	316	2	—	318
Total investments	$ 481	$ 12,946	$ —	$ 13,427
Restricted deposits:				
Cash and cash equivalents	$ 157	$ —	$ —	$ 157
Certificates of deposit	—	105	—	105
Corporate securities	—	25	—	25
Municipal securities	—	27	—	27
U.S. Treasury securities and obligations of U.S. government corporations and agencies	746	—	—	746
Total restricted deposits	$ 903	$ 157	$ —	$ 1,060
Total assets at fair value	$ 12,184	$ 13,103	$ —	$ 25,287

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 private equity investments and life insurance contracts, which approximates fair value, was $773 million and $1,006 million as of December 31, 2021, and December 31, 2020, respectively.

6. Property, Software and Equipment

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

	2021	2020
Computer software	$ 1,825	$ 1,465
Building	1,116	891
Furniture and office equipment	753	600
Leasehold improvements	732	532
Computer hardware	617	525
Land	248	238
Property, software and equipment, at cost	5,291	4,251
Less: accumulated depreciation	(1,900)	(1,477)
Property, software and equipment, net	$ 3,391	$ 2,774

Depreciation expense for the years ended December 31, 2021, 2020 and 2019 was $565 million, $487 million and $342 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, 2019	$ 5,730	$ 1,133	$ 6,863
Acquisitions and purchase accounting adjustments	11,114	756	11,870
Divestitures	(68)	(5)	(73)
Reallocation	197	(197)	—
Impairments	—	(9)	(9)
Translation impact	1	—	1
Balance as of December 31, 2020	16,974	1,678	18,652
Acquisitions and purchase accounting adjustments	1,139	29	1,168
Divestitures	—	(24)	(24)
Reallocation	250	(250)	—
Translation impact	(25)	—	(25)
Balance as of December 31, 2021	$ 18,338	$ 1,433	$ 19,771

The majority of the increase in the managed care segment goodwill in 2021 was related to the acquisition of the remaining 60% interest in Circle Health.

The majority of the increase in the managed care segment goodwill in 2020 was related to the acquisition and fair value allocations related to the WellCare acquisition discussed in Note 3. *Acquisitions*. The majority of the increase in the specialty services segment goodwill related to the acquisitions of Apixio and PANTHERx.

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

	2021	2020	Weighted Average Life in Years 2021	Weighted Average Life in Years 2020
Purchased contract rights and customer relationships	$ 8,068	$ 8,102	13.5	13.4
Provider contracts	492	526	13.8	13.5
Trade names	1,107	939	13.3	13.8
Developed technologies	369	336	5.4	4.8
Intangible assets	10,036	9,903	13.2	13.1
Less accumulated amortization:				
Purchased contract rights and customer relationships	(1,642)	(1,046)		
Provider contracts	(139)	(152)		
Trade names	(206)	(140)		
Developed technologies	(225)	(177)		
Total accumulated amortization	(2,212)	(1,515)		
Intangible assets, net	$ 7,824	$ 8,388		

The majority of the increase in intangible assets in 2021 was related to the acquisition of the remaining 60% interest of Circle Health.

Amortization expense was $770 million, $719 million and $258 million for the years ended December 31, 2021, 2020 and 2019, respectively. Estimated total amortization expense related to the December 31, 2021 intangible assets for each of the five succeeding fiscal years is as follows ($ in millions):

Year	Expense
2022	$ 768
2023	720
2024	715
2025	707
2026	685

8. Medical Claims Liability

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

	Year Ended December 31,		
	2021	2020	2019
Balance, January 1	$ 12,438	$ 7,473	$ 6,831
Less: Reinsurance recoverable	23	20	27
Balance, January 1, net	12,415	7,453	6,804
Acquisitions and divestitures	—	3,856	59
Incurred related to:			
Current year	100,385	86,765	59,539
Prior years	(1,783)	(501)	(677)
Total incurred	98,602	86,264	58,862
Paid related to:			
Current year	87,427	78,838	52,453
Prior years	9,370	6,320	5,819
Total paid	96,797	85,158	58,272
Balance at December 31, net	14,220	12,415	7,453
Plus: Reinsurance recoverable	23	23	20
Balance, December 31	$ 14,243	$ 12,438	$ 7,473

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. The impact from COVID-19 on healthcare utilization and medical claims submission patterns continues to provide increased estimation uncertainty on the incurred but not reported liability. Additionally, as a result of minimum HBR and other return of premium programs, the Company recorded approximately $492 million, $86 million, and $49 million of the "Incurred related to: Prior years" as a reduction to premium revenues in 2021, 2020, and 2019, 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 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.

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.

Information about incurred and paid claims development as of December 31, 2021 is included in the table below and is inclusive of claims incurred and paid related to the WellCare business 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, 2021 is as follows ($ in millions):

Cumulative Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance			
For the Years Ended December 31,			
Claim Year	2019 (unaudited)	2020 (unaudited)	2021
2019	$ 84,027	$ 83,329	$ 83,250
2020		88,206	86,502
2021			100,385
		Total incurred claims	$ 270,137

Cumulative Paid Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance			
For the Years Ended December 31,			
Claim Year	2019 (unaudited)	2020 (unaudited)	2021
2019	$ 73,889	$ 82,690	$ 82,954
2020		76,722	85,593
2021			87,427
		Total payment of incurred claims	$ 255,974
		All outstanding liabilities prior to 2019, net of reinsurance	57
		Medical claims liability, net of reinsurance	$ 14,220

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, 2021 are included in the following table and are inclusive of the acquired WellCare 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, 2021		
	Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance	Total IBNR Plus Expected Development on Reported Claims	Cumulative Paid Claims
2019	$ 83,250	$ 3	516.2
2020	86,502	92	568.2
2021	100,385	9,544	597.3

9. Affordable Care Act

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

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

	December 31, 2021	December 31, 2020
Risk adjustment receivable	$ 522	$ 340
Risk adjustment payable	(536)	(1,224)
Minimum medical loss ratio	(196)	(238)
Cost sharing reduction receivable	69	101
Cost sharing reduction payable	(42)	(1)

In June 2021, CMS announced the final risk adjustment transfers for the 2020 benefit year. As a result of the announcement, the Company increased its risk adjustment net payables by $83 million from December 31, 2020. After consideration of minimum MLR and other related impacts, the net pre-tax expense recognized was approximately $80 million in the second quarter of 2021.

10. Debt

Debt consists of the following ($ in millions):

	December 31, 2021	December 31, 2020
$2,200 million 4.75% Senior Notes, due January 15, 2025	$ —	$ 2,230
$1,800 million 5.375% Senior Notes, due June 1, 2026	—	1,800
$750 million 5.375% Senior Notes, due August 15, 2026	—	794
$2,500 million 4.25% Senior Notes, due December 15, 2027	2,484	2,482
$2,300 million 2.45% Senior Notes due July 15, 2028	2,304	—
$3,500 million 4.625% Senior Notes, due December 15, 2029	3,500	3,500
$2,000 million 3.375% Senior Notes, due February 15, 2030	2,000	2,000
$2,200 million 3.00% Senior Notes due October 15, 2030	2,200	2,200
$2,200 million 2.50% Senior Notes, due March 1, 2031	2,200	—
$1,300 million 2.625% Senior Notes due August 1, 2031	1,300	—
Total senior notes	15,988	15,006
Term loan credit facility	2,195	1,450
Revolving credit agreement	149	97
Mortgage notes payable	—	50
Construction loan payable	184	180
Finance leases and other	493	153
Debt issuance costs	(171)	(157)
Total debt	18,838	16,779
Less current portion	(267)	(97)
Long-term debt	$ 18,571	$ 16,682

Of the Company's total debt, approximately 15% is variable rate debt tied to London Interbank Offered Rate (LIBOR). The debt agreements that may be impacted by the discontinuation of LIBOR have provisions included that are sufficient for the Company to transition from the existing LIBOR rates to the prevailing successor market rates as necessary.

Senior Notes

2021

In February 2021, the Company issued $2,200 million 2.50% Senior Notes due 2031 (the 2031 Notes). In conjunction with the 2031 Notes offering, the Company completed a tender offer (the Tender Offer) to purchase for cash, subject to certain conditions, any and all of the outstanding aggregate principal amount of the $2,200 million 4.75% Senior Notes due 2025 (the 2025 Notes). The Company used the net proceeds from the 2031 Notes, together with available cash on hand, to fund the purchase price for the 2025 Notes accepted for purchase in the Tender Offer (approximately 36% of the aggregate principal amount outstanding) and used the remaining proceeds to redeem any of the 2025 Notes that remained outstanding following the Tender Offer, including all premiums, accrued interest and costs and expenses related to the redemption. The Company

recognized a pre-tax loss on extinguishment of $46 million on the redemption of the 2025 Notes, including the call premium, the write-off of the unamortized premium and debt issuance costs, and expenses related to the redemption.

In July 2021, the Company issued $1,800 million 2.45% Senior Notes due 2028 (the 2028 Notes). The Company used the net proceeds from the offering of the 2028 Notes to finance a portion of the cash consideration payable in connection with the acquisition of Magellan Health Inc., which closed in January 2022, and to pay related fees and expenses. In January 2022, the Company paid off Magellan's debt of $535 million acquired in the transaction using Magellan's cash on hand.

In August 2021, the Company issued $1,800 million aggregate principal amount of Senior Notes which included $500 million aggregate principal amount of additional 2028 Notes at a premium to yield 2.31% and $1,300 million aggregate principal amount of new 2.625% Senior Notes due 2031. The Company used the net proceeds of the offering, together with cash on hand and term loan facility borrowings, to redeem all of its outstanding 5.375% Senior Notes due 2026 and WellCare Health Plans, Inc.'s outstanding 5.375% Senior Notes due 2026 (together the 2026 Notes), including all premiums, accrued interest and costs and expenses. The Company recognized a pre-tax loss on extinguishment of $79 million on the redemptions of the 2026 Notes, including the call premium, the write-off of the unamortized premium and debt issuance costs, and expenses related to the redemptions.

2020

In connection with the WellCare Acquisition, in January 2020, the Company completed an exchange offer for up to $1,200 million of 5.25% Senior Notes due April 1, 2025 and $750 million of 5.375% Senior Notes due August 15, 2026 (collectively, the WellCare Notes) issued by WellCare and issued $1,146 million aggregate principal amount of 5.25% Senior Notes due April 1, 2025 and $747 million aggregate principal amount of 5.375% Senior Notes due August 15, 2026. Additionally, the Company's wholly owned subsidiary, WellCare Health Plans, Inc., assumed the remaining unexchanged WellCare Notes. The WellCare Notes were recorded at the acquisition date fair value of $2,055 million. The Company redeemed the $1,200 million of 5.25% Senior Notes due April 1, 2025 in October 2020.

In February 2020, the Company issued $2,000 million 3.375% Senior Notes due February 15, 2030 (the $2,000 million 2030 Notes). The Company used the net proceeds from the $2,000 million 2030 Notes to redeem and all of its outstanding $1,000 million 6.125% Senior Notes, due February 15, 2024 (the 2024 Notes). The Company recognized a pre-tax loss on extinguishment of $44 million, including the call premium, the write-off of unamortized debt issuance costs and the loss on the termination of the $1,000 million interest rate swap associated with the 2024 Notes. The Company intended to use remaining proceeds to redeem the 2022 Notes. However, as a result of the spread of COVID-19 and the resulting disruption and volatility in the global capital markets, the Company deferred the redemption of the 2022 Notes. The 2022 Notes were redeemed in the fourth quarter of 2020 in connection with an additional offering of senior notes as further described above, and the Company decided to increase liquidity with the remaining proceeds of the $2,000 million 2030 Notes.

In May 2020, the Company completed an exchange offer, whereby it exchanged substantially all of the outstanding $2,000 million 3.375% Senior Notes due February 15, 2030, $1,000 million 4.75% Senior Notes due January 15, 2025, $2,500 million 4.25% Senior Notes due December 15, 2027, and $3,500 million 4.625% Senior Notes due December 15, 2029 for identical securities that have been registered under the Securities Act of 1933.

In October 2020, the Company issued $2,200 million 3.0% Senior Notes due October 2030 (the $2,200 million 2030 Notes). The Company used the net proceeds from the offering, together with cash on hand, to redeem all of the $1,000 million 4.75% Senior Notes due May 15, 2022 (the 2022 Notes) and the $1,200 million 5.25% Senior Notes due 2025, including all premiums, accrued interest and expenses related to the redemptions. The Company recognized a pre-tax loss on extinguishment of $17 million on the redemption of the 2022 Notes and the $1,200 million 5.25% Senior Notes due 2025 in the fourth quarter of 2020, including the call premium and write-off of unamortized debt issuance costs.

The indentures governing the senior notes listed in the table above contain restrictive covenants of Centene Corporation. At December 31, 2021, the Company was in compliance with all covenants.

Interest Rate Swaps

In February 2020, the Company terminated the interest rate swap agreements associated with the 2022 Notes and $2,200 million 4.75% Senior Notes, due January 15, 2025, (the 2025 Notes). The interest rate swaps associated with the 2024 Notes were also terminated in connection with the redemption of those notes as discussed above. In total, the Company terminated three interest rate swap contracts with a notional amount of $2,100 million. The swaps effectively converted $2,100 million of fixed rate notes to floating rates. As a result of the interest rate swap terminations, the Company received $9 million in cash.

Foreign Currency Swap

In connection with the July 2021 acquisition of the remaining 60% interest of Circle Health, the Company funded an intercompany note receivable with an international subsidiary, which is denominated in Great British Pounds and remeasured through earnings each period. In order to manage the resulting foreign exchange risk associated with the note receivable, the Company entered into a foreign currency swap agreement for a notional amount of $705 million, to purchase £509 million. The swap agreement is formally designated and qualifies as a fair value hedge. Gains and losses due to changes in the fair value of the foreign currency swap completely offset changes in the remeasurement of the intercompany note receivable within investment and other income in the Consolidated Statement of Operations. Therefore, there is no net impact to the Consolidated Statement of Operations. The swap expires on March 31, 2022.

The fair value of the swap agreement as of December 31, 2021 was $15 million, which was recorded in other current assets in the Consolidated Balance Sheet. The offsetting changes in fair value of the foreign currency swap and the remeasurement on the underlying intercompany note receivable were both recognized in investment and other income in the Consolidated Statements of Operations. The Company does not hold or issue any derivative instruments for trading or speculative purposes.

The fair value of the swap contract excludes accrued interest and considers the swap counterparty’s credit risk and the current likelihood of the counterparty’s compliance with its contractual obligations.

Revolving Credit Facility and Term Loan Credit Facility

In August 2021, the Company amended and restated its existing credit agreement to, among other things, (i) extend the various maturities under the existing Credit Agreement until 2026, (ii) increase the aggregate principal amount of the U.S. dollar unsecured term loan facility under the existing Credit Agreement from $1,450 million to $2,200 million, (iii) increase the maximum total net leverage ratio permitted under the total debt to EBITDA financial covenant from 3.5:1.0 to 4.0:1.0, (iv) reduce the applicable margin with respect to borrowings to between 1.50% to 1.125%, based on the total debt to EBITDA ratio and type of borrowing and (v) include scheduled amortization payments with respect to the term loan facility equal to 0% for the first year following closing, 2.5% for the second year following closing and 5% thereafter until maturity.

The Company has (i) unsecured $2,000 million 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 $2,200 million unsecured delayed-draw term loan facility (the Term Loan Facility, and, together with the Revolving Credit Facility, the Company Credit Facility). Borrowings under the 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 between 1.50% to 1.125%, based on the total debt to EBITDA ratio and type of borrowing. 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 Facility 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 not to exceed 4.0 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, 2021, the Company was in compliance with all financial and non-financial covenants under the Company Credit Facility.

As of December 31, 2021, the Company had $149 million of borrowings outstanding under the Revolving Credit Facility, with a weighted average interest rate of 1.29%.

The Revolving Credit Facility and the Term Loan Facility will mature on August 16, 2026.

Mortgage Notes Payable

The Company paid its non-recourse mortgage note of $50 million in January 2021. The mortgage note was collateralized by its corporate headquarters building and bore a 5.14% interest rate.

Construction Loan

In October 2017, the Company executed a $200 million non-recourse construction loan to fund the expansion of the Company's corporate headquarters. Until final completion of the project, which occurred in July 2021, the loan bore interest based on the one month LIBOR plus 2.70%, which reduced to LIBOR plus 2.00% at the time construction completed. The agreement contains financial and non-financial covenants similar to those contained in the Company Credit Facility. The Company guaranteed completion of the construction project associated with the loan. In April 2021, the Company finalized the one year extension of the construction loan maturing in April 2022. As of December 31, 2021, the Company had $184 million in borrowings outstanding under the loan, which is included in the current portion of long-term debt.

Letters of Credit & Surety Bonds

The Company had outstanding letters of credit of $128 million as of December 31, 2021, which were not part of the Revolving Credit Facility. The letters of credit bore interest at 0.61% as of December 31, 2021. The Company had outstanding surety bonds of $1,257 million as of December 31, 2021.

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

2022	$	267
2023		115
2024		139
2025		138
2026		2,061
Thereafter		16,306
Total	$	19,026

The fair value of outstanding debt was approximately $19,256 million and $17,717 million at December 31, 2021 and 2020, respectively.

11. Leases

The Company records right of use (ROU) assets and lease 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. The Company recognized operating lease expense of $390 million and $341 million during the years ended December 31, 2021 and 2020, respectively.

The Company considers the existence of options to extend or terminate leases in its analysis of the lease term for the purposes of measuring its right of use assets and lease liabilities. The renewal options are not included in the measurement of the right of use assets and lease liabilities unless the Company is reasonably certain to exercise the optional renewal periods.

The following table sets forth the ROU assets and lease liabilities ($ in millions):

	December 31, 2021	December 31, 2020
Assets		
ROU assets (recorded within other long-term assets)	$ 3,566	$ 1,311
Liabilities		
Short-term (recorded within accounts payable and accrued expenses)	$ 204	$ 204
Long-term (recorded within other long-term liabilities)	3,619	1,334
Total lease liabilities	$ 3,823	$ 1,538

Cash paid for amounts included in the measurement of lease liabilities, recorded as operating cash flows in the Consolidated Statements of Cash Flows, was $385 million and $276 million during the years ended December 31, 2021 and 2020, respectively. New operating leases commenced resulting in the recognition of ROU assets and lease liabilities of $177 million and $349 million during the years ended December 31, 2021 and 2020, respectively. In connection with the Company’s acquisition of the remaining 60% interest in its investment in Circle Health that occurred in July 2021, the Company acquired $2,380 million in ROU assets and lease liabilities. As of December 31, 2021, the Company had additional operating leases that have not yet commenced of $28 million. These operating leases will commence in 2022 with lease terms ranging from five to nine years.

Prior to the acquisition of the remaining Circle Health portfolio, the average remaining lease term of the Company’s operating lease population was 9.2 years. The average remaining lease term of the Circle Health portfolio is 28.2 years resulting in a weighted average remaining lease term for the Company of 21.1 and 9.3 years as of December 31, 2021 and 2020, respectively. The lease liabilities reflect a weighted average discount rate of 5.7% and 3.1% as of December 31, 2021 and 2020, respectively. Lease payments over the next five years and thereafter are as follows ($ in millions):

	December 31, 2021
2022	$ 389
2023	389
2024	372
2025	341
2026	320
Thereafter	5,481
Total lease payments	7,292
Less: imputed interest	(3,469)
Total lease liabilities	$ 3,823

12. Stockholders' Equity

The Company has 10 million authorized shares of preferred stock at $.001 par value. At December 31, 2021, 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 million shares. 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. In February 2021, the Company's Board of Directors approved an increase in the Company's existing share repurchase program for its common stock. With the increase, the Company is authorized to repurchase up to $1,000 million of shares of the Company's common stock, inclusive of the previously approved stock repurchase program. As of December 31, 2021, the Company has $800 million remaining 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, 2021, the Company used divestiture proceeds to purchase 2.4 million shares of Centene common stock for $200 million. During the year end December 31, 2020, the Company used divestiture proceeds to repurchase 8.7 million shares of Centene common stock for $500 million.

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 1.1 million shares at an aggregate cost of $78 million in 2021 and 1.6 million shares at an aggregate cost of $102 million in 2020. These shares are included in the Company's treasury stock. In addition, the Company withheld 326 thousand shares at aggregate cost of $19 million, and 407 thousand at an aggregate cost of $24 million, for the years ended December 31, 2021 and 2020, respectively, to meet applicable tax withholding requirements related to the vesting of shares assumed in connection with the WellCare acquisition. Although these withheld shares are not issued or considered common stock repurchases under a stock repurchase program, they are treated as common stock repurchases as they reduce the number of shares that would have been issued upon vesting.

In January 2020, the Company issued 171 million shares of Centene common stock with a fair value of $11,431 million and paid $6,079 million in cash in exchange for all the outstanding shares of WellCare common stock. In addition, the Company recorded $95 million related to the fair value of replacement equity awards associated with pre-combination service.

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, 2021 and 2020, Centene's subsidiaries had aggregate statutory capital and surplus of $14,039 million and $14,163 million, respectively, compared with the required minimum aggregate statutory capital and surplus of $6,706 million and $5,945 million, respectively. As of December 31, 2021, 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 $6,706 million in the aggregate.

14. Income Taxes

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

	2021	2020	2019
Current provision			
Federal	$ 507	$ 959	$ 381
State and local	114	152	41
International	7	4	—
Total current provision	628	1,115	422
Deferred provision	(151)	(136)	51
Total income tax expense	$ 477	$ 979	$ 473

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):

	2021	2020	2019
Earnings before income tax expense	$ 1,813	$ 2,773	$ 1,782
Loss (earnings) attributable to flow through noncontrolling interest	2	9	11
Earnings less noncontrolling interest before income tax expense	1,815	2,782	1,793
Tax provision at the U.S. federal statutory rate	381	584	377
State income taxes, net of federal income tax benefit	63	106	49
Nondeductible compensation	40	54	42
Nondeductible pharmacy settlement	78	—	—
Nontaxable divestiture gains and losses	(95)	—	—
ACA Health Insurer Fee	—	316	—
Audit settlement	—	(71)	—
Valuation Allowance	29	(11)	—
Nondeductible goodwill	—	16	30
Other, net	(19)	(15)	(25)
Income tax expense	$ 477	$ 979	$ 473

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):

	2021	2020
Deferred tax assets:		
Medical claims liability	$ 120	$ 107
Nondeductible liabilities	215	145
Net operating loss and tax credit carryforwards	357	124
Compensation accruals	205	205
Premium and trade receivables	143	161
Operating lease liability	445	386
Other	112	69
Deferred tax assets	1,597	1,197
Valuation allowance	(212)	(73)
Net deferred tax assets	$ 1,385	$ 1,124
Deferred tax liabilities:		
Goodwill and intangible assets	$ 1,794	$ 1,805
Prepaid assets	46	33
Fixed assets	409	351
Right of use asset	444	337
Unrealized gain/loss	29	105
Other	70	27
Deferred tax liabilities	2,792	2,658
Net deferred tax assets (liabilities)	$ (1,407)	$ (1,534)

As of December 31, 2021, the Company's undistributed earnings from non-U.S. subsidiaries are intended to be indefinitely reinvested in non-U.S. operations, and therefore no U.S. deferred taxes have been recorded.

Increases to the net operating loss and tax credit carryforwards and operating lease liability deferred tax assets, as well as the right of use asset deferred tax liability are primarily related to balances acquired in the Circle transaction.

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, federal and state capital loss, and tax credit carryforwards. The $139 million increase in valuation allowance primarily relates to tax losses acquired in the Circle transaction that are unlikely to be available to be utilized by the Company due to restrictions on the ability to utilize portions of the carryforward balances.

Federal net operating loss and credit carryforwards of $78 million expire beginning in 2022 through 2041; state net operating loss and tax credit carryforwards of $66 million expire beginning in 2022 through 2041. Substantially all the non-U.S. tax loss carryforwards of $213 million 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,	
	2021	2020
Gross unrecognized tax benefits, beginning of period	$ 354	$ 305
Gross increases:		
Current year tax positions	9	31
Acquired reserves	—	118
Prior year tax positions	12	7
Gross decreases:		
Settlements	(13)	(96)
Prior year tax positions	(4)	(11)
Statute of limitation lapses	(3)	—
Gross unrecognized tax benefits, end of period	$ 355	$ 354

As of December 31, 2021, $308 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 $1 million as a result of the expiration of statutes of limitations and projected audit settlements in certain jurisdictions.

The table above excludes interest and penalties, net of related tax benefits, which are treated as income tax expense (benefit) under the Company's accounting policy. The Company recognized net interest expense and penalties related to uncertain positions of $1 million expense and $2 million benefit for the years ended December 31, 2021 and 2020, respectively. The Company had $43 million and $42 million of accrued interest and penalties for uncertain tax positions as of December 31, 2021 and 2020, respectively.

The Company files tax returns for federal as well as numerous state and international tax jurisdictions. As of December 31, 2021, the Company's tax returns are under federal examination for the tax years 2014 through 2018. The Company is engaged in multiple audit proceedings for its state and foreign filings. Generally, no further state or foreign audit activity is expected for years prior to 2015.

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 2021. The plans have 17 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 $203 million, $281 million and $177 million for the years ended December 31, 2021, 2020 and 2019, respectively. The total income tax benefit recognized in the Statements of Operations for stock-based compensation arrangements was $35 million, $34 million and $22 million for the years ended December 31, 2021, 2020 and 2019, respectively.

A summary of the Company's non-vested restricted stock and restricted stock unit shares as of December 31, 2021, and changes during the year ended December 31, 2021, is presented below (shares in thousands):

	Shares	Weighted Average Grant Date Fair Value
Non-vested balance as of December 31, 2020	7,685	$ 62.74
Granted	4,478	66.39
Vested	(3,809)	62.82
Forfeited	(1,212)	60.95
Non-vested balance as of December 31, 2021	7,142	$ 65.30

The total fair value of restricted stock and restricted stock units vested during the years ended December 31, 2021, 2020 and 2019, was $264 million, $364 million and $202 million, respectively.

As of December 31, 2021, there was $263 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 2.1 years.

The Company maintains an employee stock purchase plan and issued 516 thousand shares, 487 thousand shares, and 416 thousand shares in 2021, 2020 and 2019, respectively.

16. Retirement Plan

Centene has a defined contribution plan which covers substantially all employees who are at least 21 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 $105 million, $91 million and $64 million during the years ended December 31, 2021, 2020 and 2019, 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. 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 of December 31, 2021, the Company has paid $272 million.

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, and the Company fulfilled this undertaking in 2020;
- 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 $89 million through 2021;
- 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 $43 million through 2021 and expects to contribute the remaining portion by March 31, 2022; and
- invest $75 million of its investment portfolio in vehicles supporting California's healthcare infrastructure, of which the Company has invested $64 million through 2021.

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, the calculation of minimum medical loss ratios and rebates related thereto, submissions to state agencies related to payments or state false claims acts, 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 and other federal and state fraud, waste and abuse laws;

- 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; and

- 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, claims related to network adequacy 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, except for the reserve estimate as described below with respect to claims or potential claims involving services provided by Envolve Pharmacy Solutions, Inc. (Envolve), as the Company's pharmacy benefits manager subsidiary. 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. Upon the return of the matter to the Los Angeles County Superior Court, motions for summary judgment were scheduled. Health Net California's motion for summary judgment was heard by the Court in March 2020. In March 2020, the Court granted Health Net California's motion for summary judgment. In September 2020, the plaintiff appealed the Court's decision. The Company intends to continue its vigorous defense 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.

Beginning in April 2021, several lawsuits have been filed against the Company and its subsidiaries, alleging that the defendants failed to prevent Health Net members' personal and health data from being exposed in connection with a data breach involving Accellion's File Transfer Appliance. The Company denies any wrongdoing and has filed a separate lawsuit against Accellion in Delaware seeking indemnity for these claims. In December 2021, the plaintiffs in three of the pending actions filed a motion for preliminary approval of a settlement with the Company and its subsidiaries, which, if approved by the court, should resolve most or all of the pending litigation. In addition, claims related to these lawsuits are anticipated to be covered in part by the Company's insurance carrier. As a result, while these matters are subject to many uncertainties, the Company does not believe that an adverse outcome in these matters is likely to have a materially adverse impact on the Company's financial position, results of operations and cash flows.

Pharmacy Benefits Management Matters

On March 11, 2021, the State of Ohio filed a civil action against the Company and the Company's subsidiaries, Buckeye Health Plan Community Solutions, Inc. and Envolve, in Franklin County Court of Common Pleas, captioned as Ohio Department of Medicaid, et al. v. Centene Corporation, et al. The complaint alleged breaches of contract with the Ohio Department of Medicaid relating to the provision of pharmacy benefits management (PBM) services and violations of Ohio law relating to such contracts, including among other things, by (i) seeking payment for services already reimbursed, (ii) not accurately disclosing to the Ohio Department of Medicaid the true cost of the PBM services and (iii) inflating dispensing fees for prescription drugs. The plaintiffs sought an undisclosed sum of money in damages, penalties, and possible termination of the contract with Buckeye Health Plan.

The Company has reached no-fault agreements with the Attorney Generals in nine states, including Ohio, to resolve claims and/or allegations made by the states related to services provided by Envolve. As a result of the settlement, the Ohio Attorney General's litigation against the Company was dismissed. Additionally, the Company is in discussions to bring final resolution to similar concerns in other affected states. Consistent with those discussions, the Company recorded a reserve estimate of $1,250 million in the second quarter of 2021 related to this issue, inclusive of the above settlements and rebates that the Company determined in the course of the matter are payable across products. Additional claims, reviews or investigations relating to the Company's PBM business across products may be brought by other states, the federal government or shareholder litigants, and there is no guarantee the Company will have the ability to settle such claims with other states within the reserve estimate the Company has recorded and on other acceptable terms, or at all. This matter is subject to many uncertainties, and an adverse outcome in this matter could have an adverse impact on the Company's financial position, results of operations and cash flows.

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 per share data in dollars and shares in thousands):

	2021	2020	2019
Earnings attributable to Centene Corporation	$ 1,347	$ 1,808	$ 1,321
Shares used in computing per share amounts:			
Weighted average number of common shares outstanding	582,832	570,722	413,487
Common stock equivalents (as determined by applying the treasury stock method)	7,684	8,413	6,922
Weighted average number of common shares and potential dilutive common shares outstanding	590,516	579,135	420,409
Net earnings per common share attributable to Centene Corporation:			
Basic earnings per common share	$ 2.31	$ 3.17	$ 3.19
Diluted earnings per common share	$ 2.28	$ 3.12	$ 3.14

The calculation of diluted earnings per common share for 2021, 2020 and 2019 excludes the impact of 44 thousand shares, 398 thousand shares and 1,048 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. The Company does not report total assets by segment since this is not a metric used to allocate resources or evaluate segment performance. Segment information for the year ended December 31, 2020 and 2019 have been conformed to the 2021 presentation of segment eliminations.

Segment information for the year ended December 31, 2021, follows ($ in millions):

	Managed Care	Specialty Services	Eliminations	Consolidated Total
Total revenues from external customers	$ 120,119	$ 5,863	$ —	$ 125,982
Total revenues from internal customers	6	12,789	(12,795)	—
Total revenues	$ 120,125	$ 18,652	$ (12,795)	$ 125,982
Earnings from operations	$ 1,789	$ (5)	$ —	$ 1,784

Segment information for the year ended December 31, 2020, follows ($ in millions):

	Managed Care	Specialty Services	Eliminations	Consolidated Total
Total revenues from external customers	$ 106,862	$ 4,253	$ —	$ 111,115
Total revenues from internal customers	5	10,741	(10,746)	—
Total revenues	$ 106,867	$ 14,994	$ (10,746)	$ 111,115
Earnings from operations	$ 3,031	$ 51	$ —	$ 3,082

Segment information 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 from internal customers	4	9,348	(9,352)	—
Total revenues	$ 71,213	$ 12,778	$ (9,352)	$ 74,639
Earnings from operations	$ 1,806	$ (25)	$ —	$ 1,781

21. Condensed Financial Information of Registrant

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

	December 31, 2021	December 31, 2020
ASSETS		
Current assets:		
Cash and cash equivalents	$ 9	$ 668
Short-term investments	1	1
Other current assets	738	24
Total current assets	748	693
Long-term investments	128	129
Investment in subsidiaries	45,117	41,565
Other long-term assets	271	101
Total assets	$ 46,264	$ 42,488
LIABILITIES, REDEEMABLE NONCONTROLLING INTERESTS AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Current liabilities	$ 619	$ 133
Current portion of long-term debt	14	—
Total current liabilities	633	133
Long-term debt	18,148	16,393
Other long-term liabilities	461	—
Total liabilities	19,242	16,526
Redeemable noncontrolling interest	82	77
Stockholders' equity:		
Preferred stock, $0.001 par value; authorized 10,000 shares; no shares issued or outstanding at December 31, 2021 and December 31, 2020	—	—
Common stock, $0.001 par value; authorized 800,000 shares; 602,704 issued and 582,479 outstanding at December 31, 2021, and 598,249 issued and 581,479 outstanding at December 31, 2020	1	1
Additional paid-in capital	19,672	19,459
Accumulated other comprehensive earnings	77	337
Retained earnings	8,139	6,792
Treasury stock, at cost (20,225 and 16,770 shares, respectively)	(1,094)	(816)
Total Centene stockholders' equity	26,795	25,773
Noncontrolling interest	145	112
Total stockholders' equity	26,940	25,885
Total liabilities, redeemable noncontrolling interests and stockholders' equity	$ 46,264	$ 42,488

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,		
	2021	**2020**	**2019**
Expenses:			
Selling, general and administrative expenses	$ 9	$ 13	$ 11
Contingent consideration	—	(1)	(24)
Legal settlement	1,116	—	—
Other income (expense):			
Investment and other income	38	5	11
Gain on divestiture	118	104	—
Debt extinguishment costs	(125)	(61)	(30)
Interest expense	(641)	(723)	(394)
Loss before income taxes	(1,735)	(687)	(400)
Income tax benefit	(308)	(331)	(172)
Net (loss) before equity in subsidiaries	(1,427)	(356)	(228)
Equity in earnings from subsidiaries	2,763	2,150	1,537
Net earnings	1,336	1,794	1,309
Loss attributable to noncontrolling interests	11	14	12
Net earnings attributable to Centene	$ 1,347	$ 1,808	$ 1,321
Net earnings per share:			
Basic earnings per common share	$ 2.31	$ 3.17	$ 3.19
Diluted earnings per common share	$ 2.28	$ 3.12	$ 3.14

See notes to condensed financial information of registrant.

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

	Year Ended December 31,		
	2021	**2020**	**2019**
Cash flows from operating activities:			
Dividends from subsidiaries, return on investment	$ 2,194	$ 739	$ 429
Payments for legal settlement	(298)	—	—
Other operating activities, net	(582)	(287)	(231)
Net cash provided by operating activities	1,314	452	198
Cash flows from investing activities:			
Capital contributions to subsidiaries	(1,217)	(761)	(731)
Purchases of investments	(723)	(111)	(124)
Sales and maturities of investments	66	11	—
Dividends from subsidiaries, return of investment	241	87	291
Investments in acquisitions	(151)	(7,188)	(302)
Proceeds from divestitures, net	130	533	—
Intercompany activities	(1,709)	1,185	140
Other investing activities, net	—	(12)	—
Net cash used in investing activities	(3,363)	(6,256)	(726)
Cash flows from financing activities:			
Proceeds from long-term debt	9,066	4,870	24,647
Payments of long-term debt	(7,207)	(3,875)	(17,778)
Common stock repurchases	(297)	(626)	(75)
Payments for debt extinguishment	(157)	(81)	(23)
Debt issuance costs	(72)	(120)	(25)
Other financing activities, net	57	47	33
Net cash provided by financing activities	1,390	215	6,779
Net increase (decrease) in cash and cash equivalents	(659)	(5,589)	6,251
Cash and cash equivalents, beginning of period	668	6,257	6
Cash and cash equivalents, end of period	$ 9	$ 668	$ 6,257

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 either on a percentage of the restricted subsidiaries' revenue or a cost basis reimbursement.

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, 2021. 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, 2021, our Chief Executive Officer and Chief Financial Officer concluded that, as of such date, our disclosure controls and procedures were effective.

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, 2021. Our management's assessment of the effectiveness of our internal control over financial reporting as of December 31, 2021, 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, 2021, 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, 2021, 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, 2021, 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, 2021 and 2020, 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, 2021, and the related notes (collectively, the consolidated financial statements), and our report dated February 22, 2022 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 22, 2022

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

None.

Item 9C. ***Disclosure Regarding Foreign Jurisdictions that Prevent Inspections***

Not applicable

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 2022 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 401 of Regulation S-K, information regarding our executive officers is provided in Item 1 of Part I of this Annual Report on Form 10-K under the caption "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 2022 annual meeting of stockholders under "Delinquent Section 16(a) Reports", if applicable.

(c) Corporate Governance

Information concerning certain corporate governance matters will appear in our Proxy Statement for our 2022 annual meeting of stockholders under "Corporate Governance and Risk Management." These portions of our Proxy Statement are incorporated herein by reference.

Information concerning our audit committee financial expert and identification of our audit committee will appear in our Proxy Statement for our 2022 annual meeting of stockholders under "Board of Directors Committees." Information concerning our code of ethics will appear in our Proxy Statement for our 2022 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 2022 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 2022 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 2022 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 2022 annual meeting of stockholders under "Corporate Governance and Risk Management," "Director Independence" and "Related Party Transactions." These portions of our Proxy Statement are incorporated herein by reference.

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

Our independent registered public accounting firm is KPMG LLP, St. Louis, MO. The Auditor Firm ID is 185.

Information concerning principal accountant fees and services will appear in our Proxy Statement for our 2022 annual meeting of stockholders under "Proposal Three: 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, 2021 and 2020
Consolidated Statements of Operations for the years ended December 31, 2021, 2020 and 2019
Consolidated Statements of Comprehensive Earnings for the years ended December 31, 2021, 2020 and 2019
Consolidated Statements of Stockholders' Equity for the years ended December 31, 2021, 2020 and 2019
Consolidated Statements of Cash Flows for the years ended December 31, 2021, 2020 and 2019
Notes to Consolidated Financial Statements

2. Financial Statement Schedules:

None.

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

EXHIBIT INDEX

EXHIBIT NUMBER		DESCRIPTION	FILED WITH THIS FORM 10-K	INCORPORATED BY REFERENCE		
				FORM	FILING DATE WITH SEC	EXHIBIT NUMBER
2.1		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.		8-K	March 27, 2019	2.1
2.2	+	Agreement and Plan of Merger, dated as of January 4, 2021, by and among Centene Corporation, Mayflower Merger Sub, Inc. and Magellan Health, Inc.		8-K	January 4, 2021	2.1
3.1		Amended and Restated Certificate of Incorporation of Centene Corporation, dated April 27, 2021		8-K	April 30, 2021	3.1
3.2		By-laws of Centene Corporation, as amended and restated effective as of December 14, 2021		8-K	December 14, 2021	3.1
4.1		Description of Securities of the Company	X			
4.2		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
4.3		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
4.4		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
4.5		Base Indenture, dated as of October 7, 2020, between the Company and The Bank of New York Mellon Trust Company, N.A., as trustee		8-K	October 7, 2020	4.1
4.6		First Supplemental Indenture, dated as of October 7, 2020, between the Company and The Bank of New York Mellon Trust Company, N.A., as trustee		8-K	October 7, 2020	4.2
4.7		Second Supplemental Indenture, dated as of February 17, 2021, between the Company and The Bank of New York Mellon Trust Company, N.A., as trustee		8-K	February 17, 2021	4.2
4.8		Third Supplemental Indenture, dated as of July 1, 2021, between the Company and The Bank of New York Mellon Trust Company, N.A., as trustee		8-K	July 1, 2021	4.2
4.9		Fourth Supplemental Indenture, dated as of August 12, 2021, between the Company and The Bank of New York Mellon Trust Company, N.A., as trustee		8-K	August 12, 2021	4.4
10.1	*	2002 Employee Stock Purchase Plan, As Amended and Restated		10-Q	July 23, 2019	10.1
10.2	*	Amendment No.1 to the 2002 Employee Stock Purchase Plan, As Amended and Restated		S-8	May 22, 2020	4.2
10.3	*	Centene Corporation 2012 Stock Incentive Plan, as amended		8-K	April 30, 2021	10.1
10.4	*	Amended and Restated Non-Employee Directors Deferred Stock Compensation Plan		10-Q	July 28, 2015	10.1

10.5 *	Amended and Restated Voluntary Nonqualified Deferred Compensation Plan		10-K	February 19, 2019	10.6
10.6 *	Centene Corporation 2007 Long-Term Incentive Plan, as Amended		10-K	February 22, 2021	10.6
10.7 *	Centene Corporation Short-Term Executive Compensation Plan		10-K	February 22, 2011	10.12
10.8 *	Executive Employment Agreement between Centene Corporation and Michael F. Neidorff, dated November 8, 2004		8-K	November 9, 2004	10.1
10.8a *	Amendment No. 1 to Executive Employment Agreement between Centene Corporation and Michael F. Neidorff		10-Q	October 28, 2008	10.2
10.8b *	Amendment No. 2 to Executive Employment Agreement between Centene Corporation and Michael F. Neidorff		10-Q	April 28, 2009	10.2
10.8c *	Amendment No. 3 to Executive Employment Agreement between Centene Corporation and Michael F. Neidorff		10-Q	October 23, 2012	10.2
10.8d *	Amendment No. 4 to Executive Employment Agreement between Centene Corporation and Michael F. Neidorff		8-K	May 16, 2013	10.1
10.8e *	Amendment No. 5 to Executive Employment Agreement between Centene Corporation and Michael F. Neidorff		8-K	December 14, 2016	10.1
10.8f *	Amendment No. 6 to Executive Employment Agreement between Centene Corporation and Michael F. Neidorff		8-K	February 4, 2019	10.1
10.8g *	Amendment No 7. to Executive Employment Agreement between Centene Corporation and Michael F. Neidorff	X			
10.8h *	Amendment No.8 to Executive Employment Agreement between Centene Corporation and Michael F. Neidorff	X			
10.9 *	Form of Executive Severance and Change in Control Agreement		10-Q	October 28, 2008	10.3
10.9a *	Amendment No. 1 to Form of Executive Severance and Change in Control Agreement		10-Q	October 23, 2012	10.3
10.9b *	Amendment No. 2 to Form of Executive Severance and Change in Control Agreement		10-Q	April 28, 2015	10.1
10.10 *	Form of Non-statutory Stock Option Agreement (Employees)		10-Q	October 28, 2008	10.5
10.11 *	Form of Non-statutory Stock Option Agreement (Employees) #2		10-K	February 22, 2021	10.11
10.12	Form of Non-statutory Stock Option Agreement (Employees) #3	X			
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 Restricted Stock Unit Agreement #1		10-K	February 21, 2017	10.20
10.16 *	Form of Restricted Stock Unit Agreement #2 (under the 2012 Stock Incentive Plan, As Amended)		8-K	December 21, 2020	10.1
10.17 *	Form of Performance Based Restricted Stock Unit Agreement #1		10-K	February 21, 2017	10.23
10.18 *	Form of Performance Based Restricted Stock Unit Agreement #2 (under the 2012 Stock Incentive Plan, As Amended)		8-K	December 21, 2020	10.2
10.19 *	Form of Long-Term Incentive Plan Agreement #1		10-K	February 21, 2017	10.25

10.20 *	Form of Long-Term Incentive Plan Agreement #2 (under the 2007 Long-Term Incentive Plan, As Amended)		8-K	December 21, 2020	10.3
10.21 *	2019 Incentive Compensation Plan of WellCare Health Plans, Inc.		DEF14A[1]	April 8, 2019	A
10.22 *	Amendment No. 1 to the 2019 Incentive Compensation Plan of WellCare Health Plans, Inc., dated as of January 23, 2020		S-8	January 23, 2020	4.4
10.23 *	WellCare Health Plans, Inc. Executive Severance Plan, as amended and restated		10-K[1]	February 12, 2019	10.3(c)
10.24 *	Executive Employment Agreement between Centene Corporation and Kenneth Burdick, dated May 30, 2019		10-K	February 22, 2021	10.24
10.25 *	Transition Services Agreement between Centene Corporation and Kenneth Burdick, dated February 21, 2020		10-K	February 22, 2021	10.25
10.26 *	Consulting Services Agreement between Centene Corporation and Kenneth Burdick, dated January 23, 2021		10-K	February 22, 2021	10.26
10.27	Fourth Amended and Restated Credit Agreement, dated as of August 16, 2021, among the Company, Wells Fargo Bank, National Association, as administrative agent, and the lenders and other parties thereto		8-K	August 18, 2021	1.1
10.28 *	Letter Agreement, dated May 4, 2021, by and between Centene Corporation and Andrew Asher		10-Q	July 27, 2021	10.2
10.29 *	Separation Agreement and Release between Centene Corporation and Jeffrey Schwaneke, dated September 26, 2021		10-Q	October 26, 2021	10.2
10.30 *	Transition Agreement between Centene Corporation and Jesse Hunter, dated October 26, 2021	X			
10.31 *	Separation Agreement and General Release between Centene Management Company LLC and Jesse N. Hunter, dated November 5, 2021	X			
10.32	Cooperation Agreement between Centene Corporation and Politan Capital Management LP, dated December 14, 2021		8-K	December 14, 2021	10.1
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 333-261993, 333-255735, 333-238597, 333-236036, 333-217634, 333-210376, 333-197737, 333-180976, 333-108467, and 333-90976) and on Form S-3 (File Numbers 333-238050 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, 2021, 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. 001-32209
+ Schedules (as similar attachments) have been omitted from this filing pursuant to Item 601(a)(5) of Regulation S-K.
* 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 22, 2022.

CENTENE CORPORATION

By: /s/ Michael F. Neidorff

Michael F. Neidorff
Chairman and Chief Executive Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities as indicated, as of February 22, 2022.

Signature	Title
/s/ Michael F. Neidorff **Michael F. Neidorff**	Chairman and Chief Executive Officer (principal executive officer)
/s/ Andrew L. Asher **Andrew L. Asher**	Executive Vice President, Chief Financial Officer (principal financial officer)
/s/ Katie N. Casso **Katie N. Casso**	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/ Kenneth A. Burdick **Kenneth A. Burdick**	Director
/s/ Christopher J. Coughlin **Christopher J. Coughlin**	Director
/s/ H. James Dallas **H. James Dallas**	Director
/s/ Wayne S. DeVeydt **Wayne S. DeVeydt**	Director
/s/ Fred H. Eppinger **Fred H. Eppinger**	Director
/s/ Richard A. Gephardt **Richard A. Gephardt**	Director
/s/ Sarah M. London **Sarah M. London**	Director
/s/ Leslie V. Norwalk **Leslie V. Norwalk**	Director
/s/ Lori J. Robinson **Lori J. Robinson**	Director
/s/ Theodore R. Samuels **Theodore R. Samuels**	Director
/s/ William L. Trubeck **William L. Trubeck**	Director

Exhibit 4.1

DESCRIPTION OF CENTENE COMMON STOCK

Authorized Capital Stock of Centene

The Centene amended and restated certificate of incorporation 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.

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 amended and restated certificate of incorporation, 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 amended and restated certificate of incorporation 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.

Actions at Meetings of Stockholders; Special Meetings

Centene's amended and restated certificate of incorporation 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 amended and restated certificate of incorporation 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 amended and restated certificate of incorporation 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 14 directors.

Board Vacancies to Be Filled by Remaining Directors and Not Stockholders

Under Centene's amended and restated certificate of incorporation 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 amended and restated certificate of incorporation 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 amended and restated certificate of incorporation 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 amended and restated certificate of incorporation 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 amended and restated certificate of incorporation 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 amended and restated certificate of incorporation, or in one or more certificates of designation relating to each series of the preferred stock.

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 OF EXECUTIVE EMPLOYMENT AGREEMENT

THIS AMENDMENT OF EXECUTIVE EMPLOYMENT AGREEMENT is entered into as of October 26, 2021, by and between **Centene Corporation**, a Delaware corporation, together with its successors and assigns permitted under this Agreement ("**Employer**"), and **Michael F. Neidorff** (the "**Executive**").

WHEREAS, the parties entered into that certain Executive Employment Agreement dated as of November 8, 2004, which has been amended from time to time ("**Agreement**"); and

WHEREAS, the parties desire to amend the Agreement as set forth below.

NOW THEREFORE, the parties hereto agree as follows:

1. Section 1(a) is amended to add the following language at the end thereof to read as follows:

   Upon the Executive ceasing to be Executive Chairman of the Board, the Executive shall be entitled to purchase one of the Company's aircraft on commercially reasonable terms, and the parties shall thereafter enter into the agreement regarding such aircraft as described in Section 3(g) of the Agreement. If the Company acquires a new aircraft after the Executive ceases to be Executive Chairman of the Board, the Executive may also exercise this purchase right with respect to such after-acquired aircraft, and the provisions of Section 3(g) of the Agreement shall also apply to such after-acquired aircraft.

2. The Agreement, including but not limited to Section 13 thereof, is affirmed, ratified and continued, as amended hereby.

IN WITNESS WHEREOF, the parties hereto have signed their names as of the day and year first written above.

CENTENE CORPORATION

By: /s/ Robert K. Ditmore
Its: Lead Director

/s/Michael F. Neidorff
MICHAEL F. NEIDORFF

AMENDMENT OF EXECUTIVE EMPLOYMENT AGREEMENT

THIS AMENDMENT OF EXECUTIVE EMPLOYMENT AGREEMENT is entered into as of December 14, 2021 by and between Centene Corporation, a Delaware corporation, together with its successors and assigns permitted under this Agreement ("Employer"), and Michael F. Neidorff (the "Executive").

WHEREAS, the parties entered into that certain Executive Employment Agreement dated as of November 8, 2004, which has been amended from time to time ("Agreement"); and

WHEREAS, the parties desire to amend the Agreement in order to extend the current term of the Agreement and to make various related changes to the Agreement.

NOW THEREFORE, the parties hereto agree as follows:

1. Section 2(a) of the Agreement is deleted in its entirety and replaced with the following:

"(a) Executive's Position and Title. The Executive's positions and titles shall continue to be Chairman and Chief Executive Officer of the Employer. If elected to the Board of Directors (the "Board") by the Employer's shareholders, the Executive shall continue to be a member of, and Chairman of, the Board. It is expected that the Executive will cease to serve as Chief Executive Officer of the Employer as of 2023 Shareholders' Meeting, but will continue serving as Executive Chairman of the Board until the 2024 Shareholders' Meeting, or such other date as is mutually agreed between the Executive and the Board. Effective with the 2024 Shareholders' Meeting (or such other date as is mutually agreed between the Executive and the Board), Executive will become Non-Executive Chairman of the Board. While Executive serves as Executive Chairman of the Board, the Executive and the Board will mutually agree on his compensation. While Executive serves as Executive Chairman and for five years thereafter, Executive will continue to be subject to the Company's security policy requiring him to use Company provided aircraft for all air travel, as well as the same security measures currently applicable to Executive as Chief Executive Officer. In addition, for the remainder of his life, Executive shall be granted (i) the exclusive use of the office located in the southwest-most corner of the 8th Floor of the building located at 7700 Forsyth Blvd., St. Louis, Missouri, and the restroom and office currently adjoining it as of the date hereof, (ii) a parking space in the secured area of the garage where the Executive parks as of the date hereof, and (iii) use of the Executive's current full-time administrative assistant so long as she desires to remain employed, and in the event such administrative assistant retires, a full-time executive assistant reasonably acceptable to the Executive shall be provided, and the Executive's administrative assistant shall have a parking space in the same secured area of the garage in which the Executive currently parks. Executive will also have use of a part-time administrative assistant reasonably acceptable to the Executive through December 31, 2024."

2. Section 3(g) of the Agreement is deleted in its entirety and replaced with the following:

"(g) Expenses. During the Term, the Executive shall be entitled to receive prompt reimbursement for all expenses incurred by him in accordance with the policies and practices of Employer as in effect from time to time. Employer will pay all professional expenses incurred by the Executive in connection with the negotiation and preparation of this Agreement. Such expense reimbursements shall be made not later than the end of the calendar year following the calendar year in which the expenses were incurred. Upon Executive ceasing to be the Executive Chairman of the Board, he may at his own expense elect to assume the Company's lease on a Company aircraft. Upon Executive ceasing to be the Executive Chairman of the Board, he may on commercially reasonable terms lease (without pilots) an aircraft that he directly or indirectly owns to the Company and the Company shall maintain said aircraft and exercise operational control for all flights on such aircraft when not being used by the Executive. If the Executive uses the aircraft that is being leased to the Company for personal travel, he shall possess operational control for all flights and shall reimburse the Company on commercially reasonable terms pursuant to an aircraft support services agreement for the incremental costs of such usage."

3. The Agreement is affirmed, ratified and continued, as amended hereby.

IN WITNESS WHEREOF, the parties hereto have signed their names as of the day and year first written above.

CENTENE CORPORATION

By: /s/ Robert K. Ditmore
Its: Lead Director

/s/ Michael F. Neidorff
MICHAEL F. NEIDORFF

CENTENE CORPORATION

Nonstatutory Stock Option Agreement Granted Under

2012 Stock Incentive Plan, as amended

THIS AGREEMENT is entered into by and between CENTENE CORPORATION, a Delaware corporation (hereinafter the "Company"), and the undersigned employee of the Company (hereinafter the "Participant").

WHEREAS, the Participant renders important services to the Company and acquires access to Confidential Information (as defined below) of the Company in connection with Participant's relationship with the Company; and

WHEREAS, the Company desires to align the long-term interests of its valued employees with those of the Company by providing the ownership interest granted herein and to prevent former employees whose interest may become adverse to the Company from maintaining an ownership interest in the Company;

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements herein contained, the parties hereto hereby agree as follows:

1. Grant of Option

This agreement evidences the grant by the Company on December 15, 2021 (the "Grant Date") to _____ (the "Participant"), of an option to purchase, in whole or in part, on the terms provided herein and in the Company's 2012 Stock Incentive Plan, as amended (the "Plan"), a total of _____ (the "Shares") of common stock, $0.001 par value per share, of the Company ("Common Stock") at $81.85 per Share. Unless earlier terminated, this option shall expire at 3:00 p.m., Central Time, on December 14, 2031 (the "Final Exercise Date"). If the Final Exercise Date is not an open trading date then this option shall expire at 3:00 p.m., Central Time, on the last open trading date prior to the Final Exercise Date.

It is intended that the option evidenced by this agreement shall not be an incentive stock option as defined in Section 422 of the Internal Revenue Code of 1986, as amended, and any regulations promulgated thereunder (the "Code"). Except as otherwise indicated by the context, the term "Participant," as used in this option, shall be deemed to include any person who acquires the right to exercise this option validly under its terms. Unless the context otherwise requires, capitalized terms not defined herein shall have the meanings ascribed to them in the Plan.

2. Vesting Schedule

This option will become exercisable ("vest") as to 100% of the original number of Shares on the later of (a) the third anniversary of the Grant Date and (b) the date that the Performance Condition is achieved (the later of such date, as applicable, the "Vesting Date"), subject to the Participant's continued service as an Eligible Participant (defined below) through the Vesting Date (the "Service Condition"). For purposes of this option, the Performance Condition shall mean the closing price for one Share as listed on the New York Stock Exchange has equaled or exceeded $100 per Share for a period of 20 consecutive trading days. Notwithstanding anything herein to the contrary, in the event that the option does not vest prior to the Final Exercise Date, the option shall not vest, the Vesting Date shall not occur, and this option shall terminate without becoming exercisable.

The right of exercise shall be cumulative so that to the extent the option is not exercised in any period to the maximum extent permissible it shall continue to be exercisable, in whole or in part, with respect to all Shares for which it is vested until the earlier of the Final Exercise Date or the termination of this option under Section 3 hereof or the Plan.

Notwithstanding anything herein or in the Plan to the contrary, if a Change in Control (as defined in the Plan) occurs while the Participant remains in continued service as an Eligible Participant, to the extent the option hereunder remains outstanding, the Performance Condition shall be deemed to be satisfied (to the extent not already achieved) as of the date of the Change in Control, and the option shall remain subject to the Service Condition until the third anniversary of the Grant Date (to the extent not yet achieved) and for this purpose, service with the Company or an acquirer, as applicable, shall be counted in determining whether the Service Condition is achieved. The foregoing vesting requirements notwithstanding, if a Change in Control occurs and the Participant's employment with the Company or an acquirer (and any parent or subsidiary thereof) is terminated by the Company or the acquirer (or a parent or subsidiary thereof) without cause (as defined herein) or by the Participant for Good Reason (as defined below), and the Participant's date of termination occurs (or in the case of the Participant's termination of employment for Good Reason, the event giving rise to Good Reason occurs) within 24 months following the Change in Control, the Service Condition shall be deemed met and the option shall be vested and exercisable. For purposes hereof, "Good Reason" means: (a) if the Participant is a party to an employment or service agreement with the Company or its affiliates and such agreement provides for a definition of Good Reason, the definition contained therein; or (b) if no such agreement exists or if such agreement does not define Good Reason, the occurrence of one or more of the following without the Participant's express written consent, which circumstances are not remedied by the Company within thirty (30) days of its receipt of a written notice from the Participant describing the applicable circumstances (which notice must be provided by the Participant within ninety (90) days of the Participant's knowledge of the applicable circumstances): (i) any material, adverse change in the Participant's responsibilities, authority, title, status or reporting structure; (ii) a material reduction in the Participant's base salary or short-term cash incentive opportunity; or (iii) a geographical relocation of the Participant's principal office location by more than fifty (50) miles; provided that, the Participant in fact terminates employment for Good Reason within one hundred fifty (150) days following the initial existence of the circumstances giving rise to such Good Reason. Notwithstanding the foregoing, the option may be subject to such adjustments as the Committee may determine, including, without limitation, replacing the underlying Shares with shares of an acquirer, and may be subject to assumption, continuation, or substitution by the Company or its successor, including by substitution of Shares hereunder with shares of an acquirer with corresponding changes to the number of shares, exercise price, and other terms deemed necessary or advisable to reflect any such assumption, continuation, or substitution, in each case,

to the extent and in a manner that complies with applicable law, including Section 409A of the Code. The foregoing provisions shall apply to the option in connection with a Change in Control, except to the extent otherwise provided in the applicable transaction agreement(s) evidencing the Change in Control. Notwithstanding the foregoing, the Committee may take such action as contemplated in Section9(j)3 of the Plan.

3. Exercise of Option

(a) Form of Exercise. Each election to exercise this option shall be in writing, signed by the Participant, and received by the Company at its principal office, accompanied by this agreement, and payment in full in the manner provided in the Plan. Common Stock purchased upon the exercise of this option shall be paid for as follows:

(1) in cash or by check, payable to the order of the Company;

(2) by (i) delivery of an irrevocable and unconditional undertaking by a creditworthy broker to deliver promptly to the Company sufficient funds to pay the exercise price and any required tax withholding or (ii) delivery by the Participant to the Company of a copy of irrevocable and unconditional instructions to a creditworthy broker to deliver promptly to the Company cash or a check sufficient to pay the exercise price and any required tax withholding;

(3) when the Common Stock is registered under the Securities and Exchange Act of 1934, as amended, by delivery of shares of Common Stock owned by the Participant valued at their fair market value as determined by (or in a manner approved by) the board of directors of the Company (the "Board") in good faith ("Fair Market Value"), *provided* (i) such method of payment is then permitted under applicable law and (ii) such Common Stock, if acquired directly from the Company was owned by the Participant at least six months prior to such delivery;

(4) to the extent permitted under applicable law and permitted by the Board, in its sole discretion, *provided* that at least an amount equal to the par value of the Common Stock being purchased shall be paid in cash; or

(5) by any combination of the above permitted forms of payment.

The Participant may purchase less than the number of shares covered hereby, provided that no partial exercise of this option may be for any fractional share or for fewer than ten whole shares.

(b) Continuous Relationship with the Company Required. Except as otherwise provided in this Section 3, this option may not be exercised unless the Participant, at the time he or she exercises this option, is, and has been at all times since the Grant Date, an employee, officer or director of, or consultant or advisor to, the Company or any other entity the employees, officers,
directors, consultants or advisors of which are eligible to receive option grants under the Plan (an "Eligible Participant").

(c) Termination of Relationship with the Company. If the Participant ceases to be an Eligible Participant for any reason, then, except as provided in paragraphs (d), (e), (f), and (g) below, the right to exercise this option shall terminate 30 days after such cessation (but in no event after the Final Exercise Date), *provided* that this option shall be exercisable only to the extent that the Participant was entitled to exercise this option on the date of such cessation. Notwithstanding the foregoing, if the Participant, prior to the Final Exercise Date, violates the non-competition or confidentiality provisions of any employment, consulting, advisory,

nondisclosure, non-competition or other agreement between the Participant and the Company, the right to exercise this option shall terminate immediately upon such violation.

(d) Exercise Period Upon Death or Disability. If the Participant dies or becomes disabled (within the meaning of Section 22(e)(3) of the Code) prior to the Final Exercise Date while he or she is an Eligible Participant and the Company has not terminated such relationship for "cause" as specified in paragraph (e) below, this option shall be deemed to be vested for the Prorated Amount (as defined below) and shall be exercisable within the period of 180 days following the date of death or disability of the Participant, by the Participant (or in the case of death by an authorized transferee), *provided* that this option shall be exercisable only to the extent of the Prorated Amount, and *further provided* that this option shall not be exercisable after the Final Exercise Date. The Prorated Amount shall mean: (i) to the extent the option is not vested on the date of death or disability, a prorated number of Shares subject to the option determined as follows: the total of the original number of Shares subject to the option, multiplied by a fraction where the numerator is the total number of whole calendar months from the Grant Date through the date of death or disability, as applicable, and the denominator is 36 or (ii) to the extent the option is vested on the date of death or disability, 100% of the original number of Shares subject to the option. For the avoidance of doubt, in no event shall the Prorated Amount exceed 100% of the original number of Shares subject to the option, whether determined in accordance with (i) or (ii) above.

(e) Discharge for Cause. If the Participant, prior to the Final Exercise Date, is discharged by the Company for "cause" (as defined below), the right to exercise this option shall terminate immediately upon the effective date of such discharge. "Cause" shall include acts or omissions that the Company determines, after affording the Participant an opportunity to be heard, (i) are criminal, dishonest, fraudulent, constitute misconduct, or reflect negatively on the reputation of the Company (including any parent, subsidiary, affiliate or division of the Company); (ii) could expose the Company or any parent, subsidiary, affiliate or division of the Company to claims of illegal harassment or discrimination in employment; (iii) are material breaches of this Agreement or other agreement with the Company; or (iv) reflect continued and repeated failure to perform substantially the duties of his/her employment.

(f) Exercise Period Upon Qualified or Early Retirement.

(1) If the Participant's service as an Eligible Participant terminates on account of Qualified Retirement prior to the Final Exercise Date and the Company has not terminated such relationship for "cause" as specified in paragraph (e), this option shall be exercisable by the Participant to the extent vested until the Final Exercise Date, *provided* that if the Vesting Date has not occurred as of the date of the Qualified Retirement, the option will continue to remain outstanding following the Qualified Retirement and will become exercisable as to 100% of the original number of Shares subject to the option on the later of (i) the third anniversary of the Grant Date and (ii) the date that the Performance Condition is achieved, without regard to the Participant's termination of service prior to the Vesting Date and, upon any such vesting, shall remain exercisable by the Participant until the Final Exercise Date. . For this purpose, a Qualified Retirement is a retirement made pursuant to a bona-fide notice of retirement made 90 days in advance, by a Participant who is at least 55 years old and has been employed at the Company for at least 10 years.

(2) If the Participant's service as an Eligible Participant terminates on account of Early Retirement prior to the Final Exercise Date and the Company has not terminated such relationship for "cause" as specified in paragraph (e), this option shall be exercisable by the Participant to the extent vested on the date of such Early Retirement until the earlier of the date that is five years after such termination of the Participant's service or the Final Exercise Date, *provided* that if the Vesting Date has not occurred as of the date of the Early Retirement, the option will continue to remain outstanding following the Early Retirement and will become exercisable as to 100% of the original number of Shares subject to the option on the later of (i) the third anniversary of the Grant Date and (ii) the date that the Performance Condition is achieved, without regard to the Participant's termination of service prior to the Vesting Date and, upon any such vesting, shall remain exercisable by the Participant until the earlier of the date that is five years after such termination of the Participant's service or the Final Exercise Date. For this purpose, an Early Retirement is a retirement made pursuant to a bona-fide notice of retirement made 90 days in advance, by a Participant who is at least 55 years old and has been employed at the Company for at least five years.

(g) Exercise Period Upon Change in Control. If a Change in Control occurs while the Participant is an Eligible Participant and such relationship is not terminated on account of "cause" as specified in paragraph (e), death, or disability prior to exercise of the option, this option shall be exercisable by the Participant until the Final Exercise Date, *provided* that this option shall be exercisable (or become exercisable, as applicable) only to the extent provided in Section 2 hereof in connection with the Change in Control.

(h) Right to Exercise. The Participant's right to exercise this option and to retain any gains upon a sale or other disposition of the Shares therefrom is subject to the Participant's compliance with the covenants set forth in Section 4 hereof.

4. Optionee's Covenants. For and in consideration of the option hereunder, the Participant agrees to the provisions of this Section 4.

(a) Confidential Information. As used in this Section 4, "Confidential Information" shall mean the Company's trade secrets and other non-public proprietary information relating to the Company or the business of the Company, including information relating to financial statements, existing or proposed target markets, employee skills and compensation, employee data, acquisition targets, servicing methods, programs, strategies and information, analyses, expansion

plans and strategies, profit margins, financial, promotional, training or operational information, and other information developed or used by the Company that is not known generally to the public or the industry. Confidential Information shall not include any information that is in the public domain or becomes known in the public domain through no wrongful act on the part of the Participant.

(b) Non-Disclosure. The Participant agrees that the Confidential Information is a valuable, special and unique asset of the Company's business, that such Confidential Information is important to the Company and the effective operation of the Company's business, and that during employment with the Company and at all times thereafter, the Participant shall not, directly or indirectly, disclose to any competitor or other person or entity (other than current employees of the Company) any Confidential Information that the Participant obtains while performing services for the Company, except as may be required in the Participant's reasonable judgment to fulfill the Participant's duties hereunder or to comply with any applicable legal obligation.

(c) Non-Competition; Non-Solicitation.

(1) During Participant's employment with the Company and for the period of six (6) months immediately after the termination of Participant's employment with the Company (including any parent, subsidiary, affiliate or division of the Company) for any reason whatsoever, and whether voluntary or involuntary, Participant shall not invest in (other than in a publicly traded company with a maximum investment of no more than 1% of outstanding shares), counsel, advise, consult, be employed or otherwise engaged by or with any entity or enterprise ("Competitor") that competes with (A) the Company's business of providing Medicaid managed care services, Medicaid-related services, behavioral health, nurse triage or pharmacy compliance specialty services or (B) any other business in which, after the date of this Agreement, the Company (or any parent, subsidiary, affiliate or division of the Company) becomes engaged (or has taken substantial steps in which to become engaged) on or prior to the date of termination of Participant's employment. For purposes of paragraph 4, Participant agrees that this agreement not to compete applies to any Competitor that does business within the state of Missouri or and/or any other state or other jurisdiction in the world in which Centene does business, and that such geographical limitation is reasonable.

(2) During the Participant's employment with the Company (or any parent, subsidiary, affiliate or division of the Company) and for the period of twelve months immediately after the termination of the Participant's employment with the Company (or any parent, subsidiary, affiliate or division of the Company) for any cause whatsoever, and whether voluntary or involuntary ("Restricted Period"), the Participant will not, either directly or indirectly, either for himself or for any other person, firm, company or corporation, call upon, solicit, divert, or take away, or attempt to solicit, divert or take away any of the customers, prospective customers, business, vendors or suppliers of the Company that the Participant had dealings with, or responsibility for, or the Participant had access to, confidential information of such customers', vendors' or suppliers' confidential information.

(3) The Participant shall not, at any time during the Restricted Period, without the prior written consent of the Company, (i) directly or indirectly, solicit, recruit or employ (whether as an employee, officer, director, agent, consultant or independent contractor) any person who was or is at any time during the previous six months an employee, representative, officer or director of the Company (or any parent, subsidiary, affiliate or division of the Company); or (ii) take any action to encourage or induce any employee, representative, officer or director of the Company (or any parent, subsidiary, affiliate or division of the Company) to cease their relationship with the Company (or any parent, subsidiary, affiliate or division of the Company) for any reason.

(4) This Section 4(c) shall not apply if a "Change in Control" (as defined in the Plan) occurs under Section (ii) thereof, or if such Change in Control occurs under Section (i) or (iii) thereof without the prior approval, recommendation or consent of the Board of Directors of the Corporation

(d) Enforcement. If any of the provisions of this Section 4 shall be held to be invalid or unenforceable by a court of competent jurisdiction, the remaining provisions or subparts thereof shall nevertheless continue to be valid and enforceable according to their terms. Further, if any restriction contained in the provisions or subparts of this Section 4 is held to be overbroad or unreasonable as written, the parties agree that the applicable provision should be considered to be amended to reflect the maximum period, scope or geographical area deemed reasonable and enforceable by the court and enforced as amended.

(e) Remedy for Breach.

(1) Because the Participant's services are unique and because the Participant has access to the Company's Confidential Information, the parties agree that any breach or threatened breach of this Section 4 will cause irreparable harm to the Company and that money damages alone would be an inadequate remedy. The parties therefore agree that, in the event of any breach or threatened breach of this Section 4, and in addition to all other rights and remedies available to it, the Company may apply to any court of competent jurisdiction for specific performance and/or injunctive or other relief, without a bond, in order to enforce or prevent any violations of the provisions of this Section 4.

(2) The Participant shall immediately repay to the Company a cash sum in the principal amount equal to all gross proceeds (before-tax) realized by the Participant upon the sale or other disposition of shares occurring at any time during the period commencing on the date that is three years before the date of the termination of the Participant's employment with the Company and ending on the date of the breach or threatened breach of this Section 4 (the "Refund Period"), together with interest accrued thereon from the date of such breach or threatened breach, at the prime rate (compounded calendar monthly) as published from time to time in The Wall Street Journal, electronic edition ("Interest"); and

(3) The Participant shall repay to the Company a cash sum equal to the fair market value of all Shares and all or any portion of the option transferred by the Participant as a gift or gifts at any time during the Refund Period, together with Interest, and for which purpose, "fair market value" per Share shall be the Fair Market Value of one Share on the date such gift occurs and per option Share shall be the positive difference, if any, between the Fair Market Value of a Share and the exercise price of such option.

(4) The Participant acknowledges and agrees that nothing contained herein shall be construed to be an excessive remedy to prohibit the Company from pursuing any other remedies available to it for such actual or threatened breach, including but not limited to the recovery of money damages, proximately caused by the Participant's breach of this Section 4.

(f) Survival. The provisions of this Section 4 shall survive and continue in full force in accordance with their terms notwithstanding any forfeiture, termination or expiration of this option in accordance with its terms or any termination of the Participant's employment for any reason (whether voluntary or involuntary).

5. Withholding

No Shares will be issued pursuant to the exercise of this option unless and until the Participant pays to the Company, or makes provision satisfactory to the Company for payment of, any federal, state or local withholding taxes required by law to be withheld in respect of this option.

6. Nontransferability of Option

This option may not be sold, assigned, transferred, pledged or otherwise encumbered by the Participant, either voluntarily or by operation of law, except by will or the laws of descent and distribution, and, during the lifetime of the Participant, this option shall be exercisable only by the Participant.

7. Provisions of the Plan; Entire Agreement

This option is subject to the provisions of the Plan, a copy of which is furnished to the Participant with this option. This agreement and the Plan contain all of the understandings and representations between the Participant and the Company pertaining to the subject matter hereof and supersede all prior and contemporaneous understandings, agreements, representations, and warranties, both written and oral, with respect to such subject matter, including any prior agreement evidencing the stock option granted on the Grant Date to the Participant herein, whether entered into by or otherwise proposed by the parties, and any such prior agreement in any prior form shall be of no force or effect.

In Witness Whereof, the Company has caused this option to be executed under its corporate seal by its duly authorized officer. This option shall take effect as a sealed instrument.

CENTENE CORPORATION

_____
Name:
Title:

PARTICIPANT

_____
Name:

EXHIBIT 10.30

October 26, 2021

Jesse Hunter

Dear Jesse:

At your request, we have summarized our understanding of the termination of your employment effective November 5, 2021 with Centene Management Corporation ("Centene") based on the following terms set forth in this letter agreement (the "Agreement").

1. Term: We confirm you will remain an active employee available to provide transition support through November 5, 2021 (the "Termination Date").

2. Base Salary: Your annual base pay rate will continue to be $830,000 through and until the Termination Date.

3. Employee Benefits: You will be entitled to continue to participate in all employee and executive benefit plans as other similarly situated executives through and until the Termination Date and will be covered under all applicable indemnification agreements and policies and D&O insurance policies.

4. Severance: Following the Termination Date, you will receive severance equal to twelve and one-half (12.5) months of your annual salary of $830,000, and an amount equal to $691,667, representing (i) a pro-rated annual bonus for 2021 and (ii) a pro-rated portion of your outstanding cash award under the Company's 2007 Long-Term Incentive Plan, as amended ("Cash LTIP") for the 2021-2023 performance period payable in a lump sum. Centene shall also provide you with your Accrued Obligations (as defined in your Executive Severance and Change in Control Agreement ("ESA")) and outplacement services under the ESA. In connection with your termination of employment, (a) vesting of outstanding RSUs shall cease on December 31, 2022 and any RSUs that vest during such period shall be payable on the applicable vesting date on which they otherwise would have been paid, (b) a pro-rata amount of PSUs, based on the number of full quarters employed with the Company during the performance period, shall remain eligible to vest, but shall otherwise remain subject to increase or decrease based on the Company's performance and (c) a pro rata amount of your outstanding cash awards under the cash LTIP for the 2019-2021 and 2020-2022 performance periods shall remain eligible to vest, but shall otherwise remain subject to increase or decrease based on the Company's performance. Any such PSUs which are earned shall be distributed in stock as soon as practicable following the termination of the applicable performance period, all as provided in the summary previously provided to you. All payments are to be made in compliance with Section 409A of the Internal Revenue Code of 1986, as amended. The foregoing amounts are subject to the timely execution and non-revocation of a release of claims in favor of the Company.

5. In addition, after your termination on November 5, 2021, if you elect medical, dental and vision coverage through the Consolidated Omnibus Budget Reconciliation Act of 1985

("COBRA"), subject to your timely election of COBRA coverage, the Company shall pay for the portion of coverage that will allow you to pay the same amount as a similarly situated active employee for the first 12 months of coverage from the Termination Date.

6. As part of this Agreement, we have previously provided you with a transition sheet that estimates the dollar value of your additional vesting as discussed. Please note that the calculations are based on an assumed Centene stock price of $63.00 per share and that all amounts are based on targets not actual payouts. You will not be subject to any offset of these payments if you are employed at any time after your termination.

7. This is a reminder of your obligations as stated in Section 8 of your ESA regarding confidential information, non-disclosure, non-competition and non-solicitation period of twelve (12) months immediately after your Termination Date. The parties shall not make any communications regarding your departure inconsistent with any public filings required to comply with the requirements of the Securities and Exchange Commission.

8. Pursuant to its terms, your deferred compensation under the Centene Corporation Voluntary Deferred Compensation Plan shall be paid to you in 2021.

9. This Agreement supersedes all prior understandings, agreements, or representations by or among the parties hereto, written or oral, with respect to the subject matter contained herein.

Jesse, please do not hesitate to contact me should you wish to discuss the terms of this letter further. If you are in agreement, please acknowledge by signing where indicated.

Sincerely,

/s/ H. Robert Sanders
H. Robert Sanders
EVP, Global Human Resources
314-505-6327

Acknowledged by:

/s/ Jesse Hunter	October 27, 2021
Jesse Hunter	Date Signed

SEPARATION AGREEMENT AND GENERAL RELEASE

This Separation Agreement and General Release ("Release") is made by and between Centene Management Company LLC ("Company") and Jesse N. Hunter, the individual signing below ("Employee").

In consideration of the mutual promises, covenants, and agreements contained in this Release, the adequacy and sufficiency of which are hereby acknowledged, Company and Employee agree as follows:

1. TERMINATION OF RELATIONSHIP. The employment relationship between Employee and Company ended on November 5, 2021 ("Termination Date").

2. CONSIDERATION FROM COMPANY. In consideration of Employee's decision to enter into this Release, Company will provide Employee with the following:

a) **Severance Pay.** As soon as administratively feasible after the date this Release becomes effective as provided below, Company shall thereafter pay Employee a single lump sum cash payment in the amount of One million, five hundred fifty-six thousand, two hundred fifty dollars and no cents ($1,556,250), less applicable taxes and withholdings, as follows:

i. Eight hundred sixty-four thousand, five hundred eighty-three dollars and no cents ($864,583) representing twelve and one-half (12 ½) months of Employee's base pay;

ii. Four hundred eighty-four thousand, one hundred sixty-seven dollars and no cents ($484,167) representing a pro-rated annual bonus for the 2021 calendar year; and

iii. Two hundred seven thousand, five hundred dollars and no cents ($207,500) representing a pro-rated portion of Employee's outstanding cash award under the Centene Corporation 2007 Long-Term Incentive Plan, as amended ("Cash LTIP") for the 2021-2023 performance period.

Company shall pay this Severance Pay in a single lump-sum payment no later than the second regular Company payday following the seven day revocation period described in Section 20 hereof. Monetary payments made pursuant to this section are not considered regular compensation for services performed and are therefore not eligible for deferral under Company's 401(k) or deferred compensation plans, may be subject to different income tax withholding rates, and do not entitle Employee to any additional compensation and/or employee benefits except as provided in this Release.

Notwithstanding anything in the Employee's Executive Severance and Change in Control Agreement dated January 26, 2009 to the contrary, Employee shall not be required to seek other employment to mitigate payments hereunder and no mitigation or offset shall apply in the event Employee receives compensation from future employment.

b) **COBRA Subsidy**. If Employee meets all legal and administrative requirements for continued health and dental insurance (collectively "Medical Insurance") coverage under the Consolidated Omnibus Budget Reconciliation Act ("COBRA"), including making a timely election of benefits and following all directions provided by the Company's third-party COBRA administrator, Employee will be eligible for a subsidy of Employee's COBRA premium as described herein. For the first twelve (12) months of COBRA coverage, Employee will be responsible for payment of premiums for Medical Insurance in the same amount as is charged to similar active employees for similar coverage rather than the full COBRA premium amount and the Company shall pay the remainder of the COBRA premium amount, provided that Employee continues to meet all COBRA eligibility requirements. After such time and for any remaining period of COBRA eligibility, Employee will be solely responsible for paying the entire COBRA premium for the coverage elected as stated in the notice from the third-party COBRA Administrator. In the event the Company rehires Employee during the period Employee is receiving a COBRA subsidy, Employee understands that the COBRA subsidy shall cease upon the first of the month after the date of Employee's rehire.

c) **Outplacement**. The Company will provide outplacement services to Employee with an agency mutually agreed upon by Employee and by the Company for six (6) months or until Employee secures alternate employment, whichever occurs first. To the greatest extent applicable, such outplacement services shall be provided in a manner that is exempt from Section 409A of the Code in accordance with Treasury Regulation Section 1.409A-1(b)(9)(v)(A). In the event that the outplacement services constitute nonqualified deferred compensation subject to Section 409A of the Code, the outplacement services shall be provided in a manner that complies with Section 409A of the Code and the provisions of Section 19 hereof.

d) **Restricted Stock Unit Vesting.** Vesting of Employee's outstanding Restricted Stock Unit ("RSU") awards will continue until December 31, 2022 and cease as of such date, and any RSUs that vest during such period shall be payable on the applicable vesting date on which they otherwise would have been paid.

e) **Performance Stock Unit Vesting.** A pro-rata portion of Employee's outstanding Performance Stock Unit ("PSU") awards, based on the number of full quarters employed with the Company during the performance period of each such award, shall remain eligible to vest, but shall otherwise remain subject to increase or decrease based on the Company's performance compared to each award's metrics, and any PSUs that vest pursuant to such awards shall be payable in shares of Company stock on the applicable vesting date on which they otherwise would have been paid.

f) **Cash Long-Term Incentive Plan Vesting.** A pro-rated portion of Employee's outstanding cash awards under the Cash LTIP for the 2019-2021 and 2020-2022 performance periods, based on the number of full quarters employed with the Company during the performance period of each award, shall remain eligible to vest, but shall otherwise remain subject to increase or decrease based on the Company's performance compared to each award's metrics, and any amounts that vest pursuant to such awards shall be payable on the applicable vesting date on which they otherwise would have been paid.

3. NO OBLIGATION. Employee expressly agrees that the consideration specified in Section 2 is consideration in addition to anything of value to which Employee is otherwise entitled without signing this Release, and Employee understands that if Employee does not sign this Release, or if Employee revokes this Release, Employee shall not be entitled to these payments and benefits. In consideration of the payments and benefits specified in Section 2, Employee hereby waives and relinquishes all rights to any additional or different severance payments under an applicable employment agreement or severance plan or practice.

4. EMPLOYEE'S FULL AND FINAL RELEASE. Employee, for Employee and Employee's attorneys, heirs, executors, administrators, successors and assigns, releases and forever discharges Company and any and all related, parent, affiliated or subsidiary corporations, including but not limited to
Centene Corporation, as well as their officers, directors, agents, representatives and employees each in their respective official capacity as such ("the Released Parties" also collectively and individually referred to as "Company") from and against any and all liabilities, claims, grievances, demands, charges, complaints, actions and causes of action whatsoever (collectively, "Claims"), whether known or unknown, which first arose prior to and through the date Employee signs this Release, including, but not limited to, any and all Claims for discrimination, harassment, retaliation, failure to accommodate or other Claims arising under or pursuant to Title VII of the Civil Rights Act of 1964, the Civil Rights Act of

1866, the Family and Medical Leave Act, the Age Discrimination in Employment Act (ADEA), the Americans With Disabilities Act of 1990, the Employee Retirement Income Security Act of 1974 (ERISA), the National Labor Relations Act (NLRA), the Worker Adjustment and Retraining Notification Act, any amendments to the foregoing; and any and all other federal, state or local statues, regulations, and/or ordinances, as well as any claims for alleged wrongful discharge, negligent or intentional infliction of emotional distress, breach of contract, tort, fraud, or any other unlawful behavior. Nothing in this Release, however, is intended to waive (a) Claims for vested benefits under any pension or 401(k) plan or other ERISA-governed benefit plan provided by Company; (b) Claims for unemployment or workers' compensation benefits; (c) Claims that may arise after Employee signs this Release; (d) claims for indemnification and coverage under applicable directors' and officers' liability insurance policies; and/or (e) Claims which cannot be released by private agreement.

The provisions of the State Specific Addendum, attached to this Release, are hereby incorporated into this Release and accepted and agreed to if Employee lives in or worked for Company in CALIFORNIA, ILLINOIS, MASSACHUSETTS, MINNESOTA, MONTANA, NEW JERSEY, NORTH DAKOTA, OREGON, SOUTH DAKOTA, OR WEST VIRGINIA

5. NO OTHER CLAIMS.

(a) Current Claims. Employee represents that Employee has not raised a Claim, including but not limited to, unlawful discrimination; harassment; sexual harassment, abuse, assault, or other criminal conduct; or retaliation in a court or government agency proceeding, in an alternative dispute resolution forum, or through the Company's internal complaint process, involving the Company or any other Released Party.

(b) Additional Claims. Employee further represents that, subject to the protected rights addressed below, Employee will not file a lawsuit or arbitration action to pursue any claim settled, waived, or released by this Release, nor become a member of any class, collective, or other multi-party action or proceeding in which claims are asserted against the Company or any other Released Parties that in any way relate to Employee's employment or the termination of employment with the Company. Employee agrees to pay the Company's costs and expenses (including reasonable attorneys' fees) related to the defense of any such lawsuit or arbitration except this promise not to sue does not apply to actions under the Older Workers Benefit Protection Act (OWBPA) and the ADEA. Although Employee is releasing and waiving claims under the OWBPA and the ADEA by this Release, Employee may challenge the knowing and voluntary nature of this Release under

the OWBPA and the ADEA before a court, the Equal Employment Opportunity Commission (EEOC), or any other federal, state or local agency charged with the enforcement of any employment laws.

(c) The Company acknowledges that as of the date hereof, based upon the knowledge of its general counsel, it has no outstanding claims against Employee.

6. PROTECTED RIGHTS. **Nothing in this Release, including but not limited to the full and final release of claims, promise not to sue, representations, return of company property, confidential information, no disparagement, cooperation, and confidentiality of agreement provisions: (i) limits or affects Employee's right to challenge the validity of this Release under the ADEA or the OWBPA, (ii) limits the rights of any governmental agency or prevents Employee from communicating with, filing a charge or complaint with, cooperating with, or otherwise participating in an investigation or proceeding conducted by the Equal Employment Opportunity Commission, National Labor Relations Board, the Securities and Exchange Commission, the Department of Justice, and/or any other any federal, state or local agency charged with the enforcement of any laws, including providing documents or any other information, or (iii) limits Employee from exercising rights under Section 7 of the NLRA to engage in protected, concerted activity, including discussing the terms and conditions of employment with other employees. By signing this Release, Employee is waiving rights to individual relief (including back pay, front pay, reinstatement or other legal or equitable relief) in any proceeding brought by Employee or on Employee's behalf by any third party, to the extent permitted by law, except for any right Employee may have to receive a payment or award from a government agency for information provided to the government agency or otherwise where prohibited.**

7. REPRESENTATIONS. By signing below, Employee confirms and agrees that as of the Termination Date, (i) Except as provided in Section 2 of this Release, Employee has been paid (subject to withholding for taxes and applicable deductions) all compensation and benefits of any kind (including wages, salary, vacation, sick leave, commissions, bonuses, severance, incentive compensation and equity participation) earned as a result of Employee's employment and owed according to law or policy and is owed no further compensation or benefits of any kind; (ii) Employee has been given the opportunity to take all paid sick or family leave available pursuant to federal, state or local law, (iii) Employee has had the opportunity to provide Company with written notice of any and all concerns regarding suspected ethical and compliance issues or violations on the part of Company or any other Released Parties, and to

the extent Employee is aware of any such misconduct, Employee has reported it to appropriate Company personnel.

8. CONFIDENTIAL INFORMATION AND COMPANY PROPERTY.

(a) Return of Company Property. Employee has returned or destroyed (and has not retained any copies in any form) all Company documents and information (including all Confidential Information and any other information stored on personally owned computer hard drives, portable storage devices or other format). Employee has also returned all tangible items that belong to Company including but not limited to ID badges, cell phones, tablets, computers, software, equipment, vehicles, or other property belonging to Company. Employee may retain his calendar, contacts list, personal files and files needed to submit his income tax returns.

(b) Confidential Information. As further exchange for the consideration provided above, Employee acknowledges obtaining confidential business and proprietary information regarding Company and may have also been bound by one or more non-disclosure or confidentiality agreements. Unless (i) required by applicable law or regulation, governmental investigation or by a court of competent jurisdiction or (ii) reasonably necessary to disclose in connection with any legal process between the Company and Employee, Employee agrees that Employee has not disclosed and will not disclose to anyone outside Company any trade secret or confidential information concerning Company's products or services until such information is publicly known or generally known within the Company's industry, including but not limited to business plans, strategic directions, accounts payable, contracts with or to providers, and financial data regarding Company's performance. Employee further agrees that Employee has not inappropriately disclosed and will not disclose any Protected Health Information about Company's members. Employee further represents that any papers, letters, records, files, computer disks, and other documents or materials containing such trade secrets or confidential technical information or belonging to Company that are in Employee's possession or control have been returned to Company or destroyed and that Employee has provided all passwords necessary for access to encrypted information. Employee also agrees to maintain strict confidentiality concerning and will not use for any purpose any passwords, software, or any information of any kind concerning Company's computer system. Employee is aware of the limitations imposed under the law, including but not limited to under the Computer Fraud and Abuse Act, 18 USC § 1030, the Stored Wire & Electronic Communications Act, 18 USC §2701 et seq. and the Economic Espionage Act of 1996, 18 USC §670, and understands the penalties for violating any of those provisions.

(c) Defend Trade Secrets Act Notice to Employee. Notwithstanding the foregoing, Employee understands that as provided by the Federal Defend Trade Secrets Act, Employee will not be held criminally or civilly liable under any federal or state trade secret law for the disclosure of a trade secret that: (A) is made (i) in confidence to a federal, state or local government official, either directly or indirectly, or to an attorney, and (ii) solely for the purpose of reporting or investigating a suspected violation of law; or (B) is made in a complaint or other document filed in a lawsuit or other proceeding, if such filing is made under seal. In addition, if Employee files a lawsuit for retaliation by Company for reporting a suspected violation of law, Employee may disclose the trade secret to Employee's attorney and use the trade secret information in the court proceeding if Employee files any document containing the trade secret under seal and does not disclose the trade secret except pursuant to court order.

9. NO DISPARAGEMENT. Employee agrees that Employee has not and will not disparage Company or its current or former officers or directors to members of the public or solicit or encourage others to do so. This provision does not prevent Employee from fully and candidly engaging in protected conduct referenced above or from responding to any false or misleading comments made about him. The Company agrees that it will instruct Company officers, managers, and human resources personnel who are aware of this Release not to disparage Employee to members of the public or solicit or encourage others to do so.

10. EMPLOYMENT VERIFICATION. In keeping with Company policies and procedures, Employee should direct all requests for employment verification to Company's third-party employment verification vendor ("work verification vendor"). The work verification vendor will provide only the dates of Employee's employment, positions held, and, where permissible, salary. Any inquiries for employment verification or references that come to Company will be directed to the work verification vendor. Employee understands that Company will not provide additional information regarding Employee's employment unless compelled to do so by law.

11. NON-ADMISSION OF LIABILITY OR WRONGFUL CONDUCT. This Release shall not be construed as an admission by Company of any liability or acts of wrongdoing or discrimination, nor shall it be considered to be evidence of such liability, wrongdoing, or discrimination.

12. COOPERATION. Through December 31, 2024, Employee agrees to reasonably cooperate with Company regarding any pending or subsequently filed internal investigations, litigation, claims, or other

disputes or legal proceedings involving Company that relate to matters within the knowledge or responsibility of Employee during employment with Company. Without limiting the foregoing, Employee agrees: (a) to meet with Company's representatives, its counsel, or other designees at reasonable times and places subject to Employee's then current business and personal commitments or (b) to provide truthful testimony to any court, agency, or other adjudicatory body. Company will reimburse Employee for Employee's time at a reasonable hourly rate and other reasonable expenses in connection with the cooperation described in this Paragraph, including, if applicable, travel and lodging and legal fees and expenses incurred if Employee determines in good faith that he needs to retain counsel in order to cooperate and the Company's counsel would have a conflict of interest in also representing Employee.

13. CONFIDENTIALITY OF AGREEMENT. Company and Employee mutually agree that

without the written consent of the other they will not reveal, disclose, disseminate or otherwise communicate in any manner or means this Release or its terms except to their legal and financial advisors, spouses or domestic partners, or as required or permitted by law or regulation or by a court of competent jurisdiction or as reasonably necessary to disclose in connection with any legal process between the Company and Employee. **Nothing in this Release is intended to or will be used in any way to limit the right for the Employee to make truthful statements or disclosures regarding claims of discrimination, retaliation, harassment, including sexual harassment or abuse, or any other unlawful employment practices**. This provision does not prevent Employee from engaging in protected conduct as provided above.

14. DELEGATION. Employee understands and agrees that Company may assign, delegate or transfer this Release and Company's rights and obligations under this Release to any of its affiliates (so long as the Company remains secondarily liable for its obligations hereunder) or to any business entity that by merger, consolidation, stock acquisition, or otherwise acquires all of substantially all of the assets of Company or to which Company transfers all or substantially all of its assets.

15. NO WAIVER. Failure to insist upon strict compliance with any term, covenant, or condition of this Release shall not be deemed a waiver of such term, covenant, or condition, nor shall any waiver or relinquishment of any right or power in this Release at any one time or more times be deemed a waiver or relinquishment of such right or power at any other time or times.

16. GOVERNING LAW. This Release shall be construed and enforced in accordance with the laws of the State of Missouri and all disputes or actions to enforce this Release will be brought and heard in the

state and federal courts with jurisdiction over matters in St. Louis County. If the state in which Employee last worked for the Company prohibits selection of another state's law or venue, then the law or venue of that state applies.

17. **NO ASSIGNMENT**: Employee represents and warrants that no other person than Employee has or had any interest in the matters referred to in this Release (other than Employee's estate or beneficiaries which shall receive any outstanding payments hereunder in the event of Employee's death) and has the sole right and exclusive authority to execute this Release. Employee represents and warrants that they have not sold, assigned, transferred, conveyed or otherwise disposed of any claim, demand or legal right that is the subject of this Release.

18. **SEVERABILITY**: Should any part, term or provision of this Release, except the release in Section 4, be declared and/or be determined by any court or arbitrator to be illegal or invalid, the validity of the remaining parts, terms or provisions shall not be affected thereby, and said illegal or invalid part, term or provision shall be deemed not to be a part of this Release.

19. **ENTIRE AGREEMENT**. This Release sets forth the entire agreement between the parties and supersedes any severance or payment obligations of Company under any employment agreement or severance plan; however, any of Employee's prior obligations arising out of a previously executed agreement (including, but not limited to, the covenants set forth in Section 8 of Employee's Executive Severance and Change in Control Agreement dated January 26, 2009 and any RSU grant agreements) related to the confidentiality of information, restrictive covenants (such as agreements not to compete and non-solicitation agreements), or intellectual property remain intact and are incorporated by reference herein and enforceable to the full extent permitted by those agreements and the law. This Release may not be modified or amended in any manner, except by an instrument in writing signed by the Company and Employee.

20. **KNOWING AND VOLUNTARY WAIVER AND TIME TO CONSIDER**. Employee agrees that this Release has been written in a manner calculated to be, and which is, understood by Employee. Employee understands that Employee has a period of 45 days from Employee's last day of employment or 45 days from the day Employee receives this Release, whichever is later, within which to consider this Release (Consideration Period). Employee further understands that any offer in this Release will expire and be considered withdrawn unless Employee accepts this Release by delivering a signed copy to Company within the Consideration Period. Employee may choose to sign this Release before the end of this Consideration Period, after carefully considering its terms, except that ***Employee may not sign this Release prior to Employee's last day of employment and prior to receiving Employee's final paycheck***. Employee also understands that Employee may revoke this Release for a period of seven (7) days after the date Employee signs this Release. Company, by this Release, advises Employee in writing to consult with an attorney prior to signing this Release. Employee agrees with Company that changes or negotiations related to this Release, whether material or immaterial, do not restart the running of the Consideration Period. If Employee wishes to accept this Release, Employee must deliver a signed copy of this Release (a) in hard copy **or** (b) by legible scan to .pdf and email to:

CENTENE CORPORATION
HUMAN RESOURCES OPERATIONS ATTN: EMPLOYEE AGREEMENT & RELEASE
7700 FORSYTH BLVD.
ST. LOUIS, MO 63105
Agreements@centene.com

Employees should return any revocation to the same address. If Employee signs the Release, delivers the Release to Company as described above, and does not revoke this Release, it will become effective, binding and enforceable on the eighth day after such signature.

I have read this Release and understand its legal and binding effect. I am acting voluntarily, deliberately, and of my own free will in signing this Release. The Company has provided me with all information needed to make an informed decision to sign this Release, notice of and an opportunity to retain an attorney, and an opportunity to ask questions about this Release.

Jesse Hunter	101654
Employee Name	Employee ID number
/s/Jesse Hunter	November 5, 2021
Employee Signature	Date

STATE SPECIFIC ADDENDUM
TO SEPARATION AGREEMENT AND GENERAL RELEASE

APPLIES TO INDIVIDUALS WHO LIVED OR WORKED IN THE FOLLOWING STATES: CALIFORNIA, ILLINOIS, MASSACHUSETTS, MINNESOTA, MONTANA, NEW JERSEY, NORTH DAKOTA, OREGON, SOUTH DAKOTA, OR WEST VIRGINIA

1. **CALIFORNIA**. If during Employee's employment with Company, Employee lived or worked in California,

the following language is added to the end of Employee's Full and Final Release section of the Release:

I am releasing all rights under Section 1542 of the California Civil Code, which reads as follows:

A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS THAT THE CREDITOR OR RELEASING PARTY DOES NOT KNOW OR SUSPECT TO EXIST IN HIS OR HER FAVOR AT THE TIME OF EXECUTING THE RELEASE, AND THAT, IF KNOWN BY HIM OR HER WOULD HAVE MATERIALLY AFFECTED HIS OR HER SETTLEMENT WITH THE DEBTOR OR RELEASED PARTY.

Employee is also not waiving their right to indemnity for necessary expenditures or losses (e.g., reimbursement of business expenses) incurred on behalf of the Company as provided in Section 2802 of the California Labor Code.

the following is added to the section on protected rights:

Nothing in this Release (including but not limited to the full and final release of claims, promise not to sue, representations, return of company property, confidential information, no disparagement, cooperation, and confidentiality of agreement provisions) waives Employee's right to testify in an administrative, legislative, or judicial proceeding concerning alleged criminal conduct or alleged sexual harassment on the part of the Company, or on the part of the agents or employees of the Company, when I have been required or requested to attend such a proceeding pursuant to a court order, subpoena, or written request from an administrative agency or the legislature.

ILLINOIS. If during Employee's employment with Company, Employee lived or worked in Illinois, the following is added to the section on protected rights:

Nothing in this Release (including but not limited to the full and final release of claims, promise not to sue, representations, return of company property, confidential information, no disparagement, cooperation, and confidentiality of agreement provisions) precludes Employee from testifying in an administrative, legislative, or judicial proceeding concerning alleged criminal conduct or alleged unlawful employment practices regarding the Company, its agents, or employees, when Employee has been required or requested to do so pursuant to a court order, subpoena, or written request from an administrative agency or the legislature.

MASSACHUSETTS. If during Employee's employment with Company, Employee lived or worked in Massachusetts, the following statutes are added to the list of statutes in the release and waiver language set forth in the Employee's Full and Final Release section of the Release: the Massachusetts Fair Employment Practices Act, the Massachusetts Payment of Wages Law, the Massachusetts Overtime Law, the Massachusetts Civil Rights Act, the Massachusetts Equal Pay Act, the Massachusetts Privacy Statute, and the Massachusetts Equal Rights Act, the Massachusetts Labor and Industries Act, the Massachusetts Independent Contractor Act, the Massachusetts Earned Sick Time Law.

MINNESOTA. If during Employee's employment with Company, Employee lived or worked in Minnesota, Employee has 15 days to revoke the Release instead of the 7 days stated in the time to consider paragraph. In addition, the Release shall not become effective until the 15-day revocation period expires, provided Employee does not revoke.

MONTANA. If during Employee's employment with Company, Employee lived or worked in Montana, the following language is added to the end of the Employee's Full and Final Release section of the Release:

I am releasing all rights under Montana Code Annotated Section 28-1-1602, which provides:

> A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS THAT THE CREDITOR DOES NOT KNOW OR SUSPECT TO EXIST IN THE CREDITOR'S FAVOR AT THE TIME OF EXECUTING THE RELEASE, WHICH, IF KNOWN BY THE CREDITOR, MUST HAVE MATERIALLY AFFECTED THEE CREDITOR'S SETTLEMENT WITH THE DEBTOR.

I understand that I am referred to in this statute as the "creditor" and the Company is referred to as the "debtor."

NEW JERSEY. If during Employee's employment with Company, Employee lived or worked in New Jersey, the following statutes are added to the list of statutes in the Employee's Full and Final Release section of the Release: the New Jersey Conscientious Employee Protection Act, the New Jersey Law Against Discrimination, the Family Leave Act, and the Diane B. Allen Equal Pay Act.

In addition, the following is added to the section on protected rights:

> **Nothing in this Release (including but not limited to the full and final release of claims, promise not to sue, representations, return of company property, confidential information, no disparagement, cooperation, and confidentiality of agreement provisions) shall have the purpose or effect of requiring me to conceal the details relating to any claim of discrimination, harassment, or retaliation, provided that I do not reveal proprietary information consisting of non-public trade secrets, business plans, and customer information.**

NORTH DAKOTA. If during Employee's employment with Company, Employee lived or worked in North Dakota, the following language is added to the Employee's Full and Final Release section of the Release:

> I expressly waive any and all rights that I may have under any state or local statute, executive order, regulation, common law and/or public policy relating to unknown claims, including but not limited to North Dakota Century Code § 9-13-02.

OREGON. If during Employee's employment with Company, Employee lived or worked in Oregon, the following is added to the section on protected rights:

> **Nothing in this Release (including but not limited to the full and final release of claims, promise not to sue, representations, return of company property, confidential information, no disparagement, cooperation, and confidentiality of agreement provisions) shall has the purpose or effect of preventing me from disclosing factual information or discussing conduct that constitutes unlawful discrimination; harassment; sexual harassment, abuse, assault, or other criminal conduct; or retaliation**

SOUTH DAKOTA. If during Employee's employment with Company, Employee lived or worked in South Dakota, the following language is added to the Employee's Full and Final Release section of the Release:

> I expressly waive any and all rights that I may have under any state or local statute, executive order, regulation, common law and/or public policy relating to unknown claims, including but not limited to South Dakota Codified Laws Section 20-7-11.

. **WEST VIRGINIA**. If during Employee's employment with Company, Employee lived or worked in West Virginia, the following language is added to the Releases in the indicated places:

- "The West Virginia Human Rights Act" is added to the list of statutes released in the Employee's Full and Final Release section of the Release
- A reference to "The toll free number for the West Virginia Bar Association is 1-866-989-8227" is added to the knowing and voluntary waiver and time to consider section.
- "This confidentiality obligation does not apply to communications between Employee and (a) the Human Rights Commission and (b) similarly situated employees" is added to the confidentiality of agreement section.

"the method and/or factors used or considered in arriving at the amount of consideration offered" is included in Involuntary Reduction Program section after "time limits:"

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 #26, Inc., a Delaware corporation
AcariaHealth Pharmacy, Inc., a California corporation
AcariaHealth Solutions, Inc., a Delaware corporation
AcariaHealth, Inc., a Delaware corporation
Access Medical Acquisition, LLC, a Delaware LLC
Access Medical Group of Florida City, LLC, a Florida LLC
Access Medical Group of Hialeah, LLC, a Florida LLC
Access Medical Group of Lakeland, LLC, a Florida LLC
Access Medical Group of Miami, LLC, a Florida LLC
Access Medical Group of North Miami Beach, LLC, a Florida LLC
Access Medical Group of Opa-Locka, LLC, a Florida LLC
Access Medical Group of Perrine, LLC, a Florida LLC
Access Medical Group of Tampa, LLC, a Florida LLC
Access Medical Group of Tampa II, LLC, a Florida LLC
Access Medical Group of Tampa III, LLC, a Florida LLC
Access Medical Group of Westchester, LLC, a Florida LLC
Accountable Care Coalition Direct Contracting, LLC, a Florida LLC
Accountable Care Coalition of Chesapeake, LLC, a Maryland LLC
Accountable Care Coalition of Community Health Centers, LLC, a Texas LLC
Accountable Care Coalition of Community Health Centers II, LLC, a Texas LLC
Accountable Care Coalition of Elite Providers II, LLC, a Delaware LLC
Accountable Care Coalition of Elite Providers, III, LLC, a Delaware LLC
Accountable Care Coalition of Elite Providers IV, LLC, a Delaware LLC
Accountable Care Coalition of Elite Providers LLC, a Hawaii LLC
Accountable Care Coalition of Elite Providers V, LLC, a Delaware LLC
Accountable Care Coalition of Elite Providers VII, LLC, an Arizona LLC
Accountable Care Coalition of Florida Partners, LLC, a Florida LLC
Accountable Care Coalition of Georgia, LLC, a Georgia LLC
Accountable Care Coalition of Maryland, LLC, a Maryland LLC
Accountable Care Coalition of Maryland Primary Care, LLC, a Maryland LLC
Accountable Care Coalition of New Jersey, Inc., a New Jersey corporation
Accountable Care Coalition of North Texas, LLC, a Texas LLC
Accountable Care Coalition of Northeast Georgia, LLC, a Georgia LLC
Accountable Care Coalition of Northeast Partners, LLC, a Pennsylvania LLC
Accountable Care Coalition of Northwest Florida, LLC, a Florida LLC
Accountable Care Coalition of Prime Health, LLC, an Oregon LLC
Accountable Care Coalition of Quality Health, LLC, an Oregon LLC
Accountable Care Coalition of Quality Health II, LLC, a Delaware LLC
Accountable Care Coalition of Quality Health III, LLC, a Delaware LLC
Accountable Care Coalition of Southeast Partners, LLC, a Georgia LLC

Accountable Care Coalition of Southeast Physician Partners, LLC, a South Carolina LLC
Accountable Care Coalition of Southeast Texas, Inc., a Texas corporation
Accountable Care Coalition of Southeast Wisconsin, LLC, a Wisconsin LLC
Accountable Care Coalition of Tennessee, LLC, a Tennessee LLC
Accountable Care Coalition of Texas, Inc., a Texas 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
America's 1st Choice California Holdings, LLC, a Florida corporation
American Progressive Life and Health Insurance Company of New York, a New York corporation
Apixio, Inc, a Delaware 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
AT Learning Ltd., an English and Welsh private company
AT Medics Holdings LLP, an English and Welsh LLP
AT Medics Ltd., an English and Welsh private company
AT Technology (Private) Ltd., a Pakistan private company
AT Technology Services Ltd., an English and Welsh private company
AWC of Syracuse, Inc., a New York corporation
B2B Gestion Integra S.L.U., a Spanish S.L.U.
B2B Salud S.L.U., a Spanish S.L.U.
Bankers Reserve Life Insurance Company of Wisconsin, a Wisconsin corporation
Bishopswood SPV Ltd., an English and Welsh private company
BMI Healthcare Ltd., an English and Welsh private company
BMI Hospital Decontamination Ltd., an English and Welsh private company
BMI Imaging Clinic Ltd., an English and Welsh private company
BMI Southend Private Hospital Ltd., an English and Welsh private company
BMI Syon Clinic Ltd., an English and Welsh private company
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
California Health and Wellness Plan, a California corporation
Cantina Laredo Clayton, LP, a Delaware limited partnership
Care1st Health Plan Administrative Services, Inc., an Arizona corporation
Care 1st Health Plan of Arizona, Inc., an Arizona corporation
Carolina Complete Health Holding Company Partnership, a Delaware partnership
Carolina Complete Health, Inc., a North Carolina corporation
CCTX Holdings, LLC, a Texas LLC
CEF Holding Company Limited, a limited liability Malta company
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, LLC, a California LLC
Centene Center, LLC, a Delaware LLC

Centene Center I, LLC, a Delaware LLC
Centene Center II, LLC, a Delaware 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 Institute for Advanced Health Education, LLC, a Delaware LLC
Centene International Financing Company Limited, a limited liability Malta company
Centene International Ventures, LLC, a Delaware LLC
Centene Management Company, LLC, a Wisconsin LLC
Centene Technology Europe, S.L.U., a Spanish S.L.U.
Centene Technology UK Ltd., an English and Welsh private company
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
Centene Venture Insurance Company Texas, Inc., a Texas corporation
Centro Inmunologocia De La Comunidad Valenciana, S.L., a Spanish S.L.
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 Indiana, LLC, an Indiana 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
Chrysalis Medical Services, LLC, a New Jersey LLC
Circle Birmingham Ltd., an English and Welsh private company
Circle Clinical Services Ltd., an English and Welsh private company
Circle Harmony Health Ltd., a Hong Kong private company
Circle Health 1 Ltd., an English and Welsh private company
Circle Health 2 Ltd., an English and Welsh private company
Circle Health 3 Ltd., an English and Welsh private company
Circle Health 4 Ltd., an English and Welsh private company
Circle Health Holdings Ltd., an English and Welsh private company
Circle Health Ltd., an English and Welsh private company
Circle Holdings Ltd., a Jersey private company
Circle Hospital (Reading) Ltd., an English and Welsh private company
Circle International, an English and Welsh PLC

Circle Nottingham Ltd., an English and Welsh private company
Circle Rehabilitation Services Ltd., an English and Welsh private company
Clinica Santo Domingo De Lugo, S.L., a Spanish S.L.
CMC Real Estate Company, LLC, a Delaware LLC
Collaborative Health Systems, LLC, a New York LLC
Collaborative Health Systems IPA, LLC, a Florida LLC
Collaborative Health Systems of Maryland, LLC, a Maryland LLC
Collaborative Health Systems of Virginia, LLC, a Virginia LLC
Community Medical Holdings Corporation, a Delaware corporation
Comprehensive Health Management, Inc., a Florida corporation
Coordinated Care Corporation, an Indiana corporation
Coordinated Care of Washington, Inc., a Washington corporation
CT Poprad, s.r.o., a Slovakia S.R.O.
CT Presov s.r.o., a Slovakia S.R.O.
DELMARVA Collaborative Care, LLC, a Delaware LLC
Discare CZ, a.s., a Czech Republic A.S.
District Community Care, Inc., a Washington D.C. corporation
Dr Magnet s.r.o., a Slovakia S.R.O.
Elche-Crevillente Salud, a Spanish S.A.
Envolve Benefits Options, Inc., a Delaware 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 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
Essential Care Partners, LLC, a Texas LLC
Forensic Health Services, LLC, a Delaware LLC
Foundation Care, LLC, a Missouri LLC
General Healthcare Group Ltd., an English and Welsh private company
General Healthcare Holdings 2 Ltd., an English and Welsh private company
General Healthcare Holdings 3 Ltd., an English and Welsh private company
Generale de Sante International Ltd., an English and Welsh private company
GHG (DB) Pension Trustees Ltd., an English and Welsh private company
GHG Healthcare Holdings Ltd., an English and Welsh private company
GHG Intermediate Holdings Ltd., an English and Welsh private company
GHG Leasing Ltd., an English and Welsh private company
GHG Mount Alvernia Hospital Ltd., an English and Welsh private company
Golden Triangle Physician Alliance, a Texas not-for-profit corporation

Granite State Health Plan, Inc., a New Hampshire corporation
Hallmark Life Insurance Company, an Arizona corporation
Harmony Health Management, Inc., a New Jersey corporation
Harmony Health Plan, Inc., an Illinois corporation
Harmony Health Systems Inc., a New Jersey 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 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, Inc., an Arizona corporation
Health Net of California, Inc., a California corporation
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 Health Systems, Inc., a Texas corporation
Heritage Health Systems of Texas, Inc., a Texas corporation
Heritage Physician Networks, a Texas not-for-profit corporation
HHS Texas Management, Inc., a Texas corporation
HHS Texas Management, LP, a Texas limited partnership
HLM Strategic Investment Fund, L.P., a Delaware limited partnership
Home State Health Plan, Inc., a Missouri corporation
HomeScripts.com, LLC, a Michigan LLC
Hospinet, S.L.,a Spanish S.L.
Hospital Polusa, S.A., a Spanish S.A.
Hospital Povisa, S.A., a Spanish S.A.
Illinois Health Practice Alliance, LLC, a Delaware corporation
Infraestructuras y Servicios de Alzira S. L., a Spanish S.L.
Integrated Mental Health Services, a Texas 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
LifeShare Management Group, LLC, a New Hampshire LLC
Louisiana Healthcare Connections, Inc., a Louisiana 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
Marina Salud, S.A., a Spanish S.A.
Maryland Collaborative Care, LLC, a Maryland LLC
Maryland Collaborative Care Transformation Organization, Inc., a Delaware corporation
Mauli Ola Health and Wellness, Inc., a Hawaii corporation
Medicina NZ, spol s.r.o., a Slovakia S.R.O.
Meriden Hospital Advanced Imaging Centre Ltd., an English and Welsh private company
Meridian Health Plan of Illinois, Inc., an Illinois corporation
Meridian Health Plan of Michigan, Inc., a Michigan corporation
Meridian Management Company, LLC (a/k/a Meridian Administration Company, LLC), a Michigan LLC
Meridian Network Services, LLC, a Michigan LLC
MeridianRx, LLC, a Michigan LLC
MeridianRx IPA, LLC, a New York LLC
MeridianRx of Indiana, LLC, a Michigan LLC
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 Services of California, LLC, a California LLC
MHM Solutions, LLC, a Delaware LLC
MHM Health Professionals, LLC, a Delaware LLC
MHN Government Services LLC, a Delaware LLC
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
Mid-Atlantic Collaborative Care, LLC, a Maryland LLC
Mount Alvernia PET CT Ltd., an English and Welsh private company
MR Centrum Melnick, s.r.o., a Czech Republic S.R.O.
MR Poprad, s.r.o., a Slovakia S.R.O.
MR Zilina, s.r.o., a Slovakia S.R.O.
Nations Healthcare Ltd., an English and Welsh private company
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
Northern Maryland Collaborative Care, LLC, a Maryland LLC
North West Cancer Clinic Ltd., an English and Welsh private company
Novasys Health, Inc., a Delaware corporation
OB Care, a Czech Republic S.R.O.
OB Klinika a.s., a Czech Republic A.S.
Ohana Health Plan, Inc., a Hawaii corporation
Oklahoma Complete Health Holding Company, LLC, a Delaware LLC
Oklahoma Complete Health Inc., an Oklahoma corporation
One Care by Care 1st Health Plans of Arizona, Inc, an Arizona corporation
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
Pantherx Access Services, LLC, a Pennsylvania LLC
Pantherx Specialty, LLC, a Pennsylvania LLC
Panther Pass Co, LLC, a Pennsylvania LLC
Panther Specialty Holding Co, LLC, a Pennsylvania LLC
Parker LP, LLC, a Nevada LLC
Peach State Health Plan, Inc., a Georgia corporation
Penn Marketing America, LLC, a Delaware LLC
Pennsylvania Health and Wellness, Inc., a Pennsylvania corporation
Preamed s.r.o., a Slovakia S.R.O.
Premier Marketing Group, LLC, a Delaware LLC
Primary Care Partners Ltd., an English and Welsh private company
PRIMEROSALUD, S.L.U., a Spanish S.L.U.
Pro Diagnostic Group, A.S., a Slovakia A.S.
Pro Magnet, s.r.o, a Slovakia S.R.O.
Pro Magnet CZ, s.r.o., a Czech Republic S.R.O.
Pro Nuclear, a.s., a Slovakia A.S.
Pro RTG, s.r.o, a Slovakia S.R.O.
Progress Medical A.S., a Czech Republic A.S.
Prowl Holdings, LLC, a Delaware LLC
QCA Healthplan, Inc., an Arkansas corporation
Qualchoice Life and Health Insurance Company, and Arkansas company
Quincy Coverage Corporation, a New York corporation
Rhythm Health Tennessee, Inc., a Tennessee corporation
Ribera Diagnóstics, S.L.U., a Spanish S.L.U.
Ribera Healthcare,S.L.U., a Spanish S.L.U.
Ribera Lab, S.L.U., a Spanish S.L.U.
Ribera Management, S.L.U., a Spanish S.L.U.
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
Runnymeade SPV Ltd., an English and Welsh private company
Salus Administrative Services, Inc., a New York corporation
Salus IPA, LLC, a New York LLC
Secure Capital Solutions 2000, S.L.U., a Spanish S.L.U.
SelectCare Health Plans, Inc., a Texas corporation
SelectCare of Texas, Inc., a Texas corporation
Servicios De Mantenimiento Prevencor, S.L.U., a Spanish S.L.U.
Shanghai Circle Harmony Hospital Management Limited, a Chinese private company
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
Superior Health Management Advisors, LLC
Terapias Medicas Domiciliarias, S.L., a Spanish S.L.
The Pavilion Clinic Ltd., an English and Welsh private company
The Practice Properties Limited, an English and Welsh private company
The WellCare Management Group, Inc., a New York corporation
Three Shires Hospital LP, an English and Welsh limited partnership
TKH Holding Ltd., 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
Transplant Health Solutions IPA, Inc., a New York corporation
Trillium Community Health Plan, Inc., an Oregon corporation
UAM Agent Services Corp., an Iowa corporation
Universal American Corp., a Delaware corporation
Universal American Holdings, LLC, a Delaware LLC
Universal American Financial Services, Inc., a Delaware corporation
Vivamed s.r.o., a Slovakia S.R.O.
WCG Health Management, Inc., a Delaware corporation
Windsor Health Group, Inc., a Tennessee corporation
WellCare Health Insurance Company of America, an Arkansas corporation
WellCare Health Insurance Company of Kentucky, Inc., a Kentucky corporation
WellCare Health Insurance Company of Louisiana, Inc., a Louisiana corporation
WellCare Health Insurance Company of Nevada, Inc., a Nevada corporation
WellCare Health Insurance Company of Oklahoma, Inc., an Oklahoma corporation
WellCare Health Insurance Company of Washington, Inc., a Washington corporation
WellCare Health Insurance Company of New Hampshire, Inc., a New Hampshire corporation
WellCare Health Insurance Company of New Jersey, Inc., a New Jersey corporation
WellCare Health Insurance of Arizona, Inc., an Arizona corporation
WellCare Health Insurance of Connecticut, Inc., a Connecticut corporation
WellCare Health Insurance of Hawaii, Inc., a Hawaii corporation
WellCare Health Insurance of New York, Inc., a New York corporation
WellCare Health Insurance of North Carolina, Inc., a North Carolina corporation
WellCare Health Insurance of Southwest, Inc., an Arizona corporation
WellCare Health Insurance of Tennessee, Inc., a Tennessee corporation
WellCare Health Plans, Inc., a Delaware corporation
WellCare Health Plans of Arizona, Inc., an Arizona corporation
WellCare Health Plans of Kentucky, Inc., a Kentucky corporation
WellCare Health Plans of Massachusetts, Inc., a Massachusetts corporation
WellCare Health Plans of Missouri, Inc., a Missouri corporation
WellCare Health Plans of New Jersey, Inc., a New Jersey corporation
WellCare Health Plans of Rhode Island, Inc., a Rhode Island corporation
WellCare Health Plans of Vermont, Inc., a Vermont corporation
WellCare National Health Insurance Company, a Texas corporation
WellCare of Alabama, Inc., an Alabama corporation

WellCare of Arkansas, Inc., an Arkansas corporation
WellCare of California, Inc., a California corporation
WellCare of Connecticut, Inc., a Connecticut corporation
WellCare of Georgia, Inc., a Georgia corporation
WellCare of Illinois, Inc., an Illinois corporation
WellCare of Indiana, Inc., an Indiana corporation
WellCare of Maine, Inc., a Maine corporation
WellCare of Michigan Holding Company, a Michigan corporation
WellCare of Missouri Health Insurance Company, Inc., a Missouri corporation
WellCare of Mississippi, Inc., a Mississippi corporation
WellCare of New Hampshire, Inc., a New Hampshire corporation
WellCare of New York, Inc., a New York corporation
WellCare of North Carolina, Inc., a North Carolina corporation
WellCare of Ohio, Inc., an Ohio corporation
WellCare of Oklahoma, Inc., an Oklahoma corporation
WellCare of Pennsylvania, Inc., a Pennsylvania corporation
WellCare of South Carolina, Inc., a South Carolina corporation
WellCare of Texas, Inc., a Texas corporation
WellCare of Virginia, Inc., a Virginia corporation
WellCare of Washington, Inc., a Washington corporation
WellCare Prescription Insurance, Inc., an Arizona corporation
Western Sky Community Care, Inc., a New Mexico corporation
Winning Security, S.L., a Spanish S.L.
Worlco Management Services, Inc., a New York corporation

Exhibit 23

Consent of Independent Registered Public Accounting Firm

We consent to the incorporation by reference in the registration statements Nos. 333-261993, 333-255735, 333-238597, 333-236036, 333-217634, 333-210376, 333-197737, 333-180976, 333-108467, and 333-90976 on Form S-8 and in the registration statements Nos. 333-238050 and 333-209252 on Form S-3 of our reports dated February 22, 2022, with respect to the consolidated financial statements of Centene Corporation and the effectiveness of internal control over financial reporting.

/s/ KPMG LLP

St. Louis, Missouri
February 22, 2022

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 22, 2022

/s/ MICHAEL F. NEIDORFF

Chairman and Chief Executive Officer
(principal executive officer)

EXHIBIT 31.2

CERTIFICATION

I, Andrew L. Asher, 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 22, 2022

/s/ ANDREW L. ASHER

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

EXHIBIT 32.1

CERTIFICATION PURSUANT TO 18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Annual Report on Form 10-K of Centene Corporation (the Company) for the period ended December 31, 2021, 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 22, 2022

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

EXHIBIT 32.2

CERTIFICATION PURSUANT TO 18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Annual Report on Form 10-K of Centene Corporation (the Company) for the period ended December 31, 2021, as filed with the Securities and Exchange Commission on the date hereof (the Report), the undersigned, Andrew L. Asher, 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 22, 2022

/s/ ANDREW L. ASHER
Executive Vice President and Chief Financial Officer
(principal financial officer)