CENTENE CORP
Form 10-K
February 20, 2018

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549
Form 10-K
(Mark One)
x ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the fiscal year ended December 31, 2017
or
o TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the transition period from to
Commission file number: 001-31826
Centene Corporation
(Exact name of registrant as specified in its charter)

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

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

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

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

Large accelerated filer x	Accelerated filer o
Non-accelerated filer o (do not check if a smaller reporting company)	o

Smaller reporting company	
Emerging growth company	o

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

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

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant, based upon the last reported sale price of the common stock on the New York Stock Exchange on June 30, 2017, was $13.8 billion.

As of February 16, 2018, the registrant had 173,495,595 shares of common stock issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Proxy Statement for the registrant's 2018 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. We intend such forward-looking statements to be covered by the safe-harbor provisions for forward-looking statements contained in the Private Securities Litigation Reform Act of 1995, and we are including this statement for purposes of complying with these safe-harbor provisions. We have attempted to identify these statements by terminology including “believe,” “anticipate,” “plan,” “expect,” “estimate,” “intend,” “seek,” “target,” “goal,” “m “would,” “could,” “should,” “can,” “continue” and other similar words or expressions (and the negative thereof) in connection with, among other things, any discussion of future operating or financial performance. In particular, these statements include without limitation statements about our market opportunity, growth strategy, competition, expected activities and future acquisitions, including our proposed acquisition of New York State Catholic Health Plan, Inc., d/b/a Fidelis Care New York (Fidelis Care) (Proposed Fidelis Acquisition or Fidelis Care Transaction), investments and the adequacy of our available cash resources. These statements may be found in the various sections of this filing, such as Part II, Item 7. “Management's Discussion and Analysis of Financial Condition and Results of Operations,” Part I, Item 3. “Legal Proceedings,” and Part I, Item 1A. “Risk Factors.” Readers are cautioned that matters subject to forward-looking statements involve known and unknown risks and uncertainties, including economic, regulatory, competitive and other factors that may cause our or our industry’s actual results, levels of activity, performance or achievements to be materially different from any future results, levels of activity, performance or achievements expressed or implied by these forward-looking statements. These statements are not guarantees of future performance and are subject to risks, uncertainties and assumptions.

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

- our ability to accurately predict and effectively manage health benefits and other operating expenses and reserves;
- competition;
- membership and revenue declines or unexpected trends;
- changes in healthcare practices, new technologies, and advances in medicine;
- increased healthcare costs;
- changes in economic, political or market conditions;
- changes in federal or state laws or regulations, including changes with respect to government healthcare programs as well as changes with respect to the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act and any regulations enacted thereunder that may result from changing political conditions;
- rate cuts or other payment reductions or delays by governmental payors and other risks and uncertainties affecting our government businesses;
- our ability to adequately price products on federally facilitated and state based Health Insurance Marketplaces;
- tax matters;
- disasters or major epidemics;
- the outcome of legal and regulatory proceedings;
- changes in expected contract start dates;
- provider, state, federal and other contract changes and timing of regulatory approval of contracts;
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- the expiration, suspension, or termination of our or Fidelis Care's contracts with federal or state governments (including but not limited to Medicaid, Medicare, and TRICARE);
- the difficulty of predicting the timing or outcome of pending or future litigation or government investigations;
- challenges to our or Fidelis Care's contract awards;
- cyber-attacks or other privacy or data security incidents;
- the possibility that the expected synergies and value creation from acquired businesses, including, without limitation, the acquisition (Health Net Acquisition) of Health Net, Inc. (Health Net), and the Proposed Fidelis Acquisition, will not be realized, or will not be realized within the expected time period, including, but not limited to, as a result of any failure to obtain any regulatory, governmental or third party consents or approvals in connection with the Proposed Fidelis Acquisition (including any such approvals under the New York Non-For-Profit Corporation Law) or any conditions, terms, obligations or restrictions imposed in connection with the receipt of such consents or approvals;
- the exertion of management’s time and our resources, and other expenses incurred and business changes required in connection with complying with the undertakings in connection with any regulatory, governmental or third party consents or approvals for the Health Net Acquisition;

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- disruption caused by significant completed and pending acquisitions, including the Health Net Acquisition and the Proposed Fidelis Acquisition, making it more difficult to maintain business and operational relationships;
- the risk that unexpected costs will be incurred in connection with the completion and/or integration of acquisition transactions, including among others, the Health Net Acquisition and the Proposed Fidelis Acquisition;
- changes in expected closing dates, estimated purchase price and accretion for acquisitions;
- the risk that acquired businesses, including Health Net and Fidelis Care, will not be integrated successfully;
- the risk that the conditions to the completion of the Proposed Fidelis Acquisition may not be satisfied or completed on a timely basis, or at all;
- failure to obtain or receive any required regulatory approvals, consents or clearances for the Proposed Fidelis Acquisition, and the risk that, even if so obtained or received, regulatory authorities impose conditions on the completion of the transaction that could require the exertion of management's time and our resources or otherwise have an adverse effect on Centene;
- business uncertainties and contractual restrictions while the Proposed Fidelis Acquisition is pending, which could adversely affect our business and operations;
- change of control provisions or other provisions in certain agreements to which Fidelis Care is a party, which may be triggered by the completion of the Proposed Fidelis Acquisition;
- loss of management personnel and other key employees due to uncertainties associated with the Proposed Fidelis Acquisition;
- the risk that, following completion of the Proposed Fidelis Acquisition, the combined company may not be able to effectively manage its expanded operations;
- restrictions and limitations that may stem from the financing arrangements that the combined company will enter into in connection with the Proposed Fidelis Acquisition;
- our ability to achieve improvement in the Centers for Medicare and Medicaid Services (CMS) Star ratings and maintain or achieve improvement in other quality scores in each case that can impact revenue and future growth;
- availability of debt and equity financing, on terms that are favorable to us;
- inflation; and
- foreign currency fluctuations.

This list of important factors is not intended to be exhaustive. We discuss certain of these matters more fully, as well as certain other risk factors that may affect our business operations, financial condition and results of operations, in our filings with the Securities and Exchange Commission, including our annual reports on Form 10-K, 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 costs.

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Non-GAAP Financial Presentation

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

Specifically, the Company believes the presentation of non-GAAP financial information that excludes amortization of acquired intangible assets, acquisition related expenses, as well as other items, allows investors to develop a more meaningful understanding of the Company's performance over time. The tables below provide reconciliations of non-GAAP items (in millions, except per share data in dollars):

	Year Ended December 31,		
	2017	2016	2015
GAAP net earnings from continuing operations	$828	$559	$356
Amortization of acquired intangible assets	156	147	24
Acquisition related expenses	20	234	27
Penn Treaty assessment expense	56	—	—
Cost sharing reductions	22	—	—
Income Tax Reform	(125)	—	—
Charitable contribution [1]	40	50	—
California minimum medical loss ratio change	—	(195)	—
Debt extinguishment	—	11	—
Income tax effects of adjustments [2]	(108)	(79)	(20)
Adjusted net earnings from continuing operations	$889	$727	$387
GAAP diluted earnings per share (EPS) from continuing operations	$4.69	$3.41	$2.89
Amortization of acquired intangible assets [3]	0.56	0.57	0.11
Acquisition related expenses [4]	0.07	0.98	0.14
Penn Treaty assessment expense [5]	0.20	—	—
Cost sharing reductions [6]	0.08	—	—
Income Tax Reform	(0.71)	—	—
Charitable contribution [7]	0.14	0.19	—
California minimum medical loss ratio change [8]	—	(0.76)	—
Debt extinguishment [9]	—	0.04	—
Adjusted Diluted EPS from continuing operations	$5.03	$4.43	$3.14

(1) In connection with the favorable impact of the Tax Cuts and Jobs Act (Income Tax Reform) passed in late 2017 and the additional revenue associated with the California minimum medical loss ratio (MLR) change in 2016, the Company made charitable commitments to its foundation in 2017 and 2016, respectively.

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

(3) Amortization of acquired intangible assets per diluted share is net of an income tax benefit of $0.32, $0.33, and $0.08 for the years ended December 31, 2017, 2016 and 2015, respectively.

(4) Acquisition related expenses per diluted share are net of an income tax benefit of $0.04, $0.45 and $0.08 for the years ended December 31, 2017, 2016 and 2015, respectively.

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(5) The Penn Treaty assessment expense per diluted share is net of an income tax benefit of $0.12 for the year ended December 31, 2017.

(6) The cost sharing reduction (CSR) expense per diluted share is net of an income tax benefit of $0.04 for the year ended December 31, 2017.

(7) The charitable contributions per diluted share are net of an income tax benefit of $0.09 and $0.11 for the years ended December 31, 2017 and 2016, respectively.

(8) The impact associated with the retroactive contract amendment received in the fourth quarter of 2016 that changed the minimum MLR calculation per diluted share is net of the income tax expense of $(0.43) for the year ended December 31, 2016.

(9) The debt extinguishment cost per diluted share is net of the income tax benefit of $0.03 for the year ended December 31, 2016.

	Year Ended December 31,		
	2017	2016	2015
GAAP selling, general and administrative expenses	$4,446	$3,676	$1,802
Acquisition related expenses	20	234	27
Penn Treaty assessment expense	56	—	—
Charitable contribution	40	50	—
Adjusted selling, general and administrative expenses	$4,330	$3,392	$1,775

	Year Ended December 31,	
	2017	2016
Net earnings from continuing operations attributable to Centene Corporation	$828	$559
Income tax expense	326	599
Interest expense	255	217
Depreciation and amortization	362	281
Non-cash stock compensation expense	135	148
Adjusted EBITDA [(1)]	$1,906	$1,804

(1) Adjusted EBITDA represents net earnings attributable to Centene Corporation excluding income tax expense, interest expense, depreciation, amortization (excluding senior note premium amortization) and non-cash compensation expense.

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PART I
ITEM 1. Business

OVERVIEW

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

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

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 including Medicaid, the State Children's Health Insurance Program (CHIP), Long-Term Services and Supports (LTSS), Medicare, Foster Care, Supplemental Security Income Program, also known as the Aged, Blind or Disabled, or collectively ABD, and Medicare-Medicaid Plans (MMP), which cover beneficiaries who are dually eligible for Medicare and Medicaid. In addition, our commercial operations, which include our members through the Health Insurance Marketplace, are included within the Managed Care segment. Our Specialty Services segment consists of our specialty companies offering diversified healthcare services and products to state programs, correctional facilities, healthcare organizations, employer groups, military service members and their families, and other commercial organizations, as well as to our own subsidiaries. For the year ended December 31, 2017, our Managed Care and Specialty Services segments accounted for 95% and 5%, respectively, of our total external revenues.

Our membership totaled 12.2 million as of December 31, 2017. For the year ended December 31, 2017, our total revenues and net earnings from continuing operations attributable to Centene were $48.4 billion and $828 million, respectively, and our total cash flow from operations was $1.5 billion.

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 corporate office is located at 7700 Forsyth Boulevard, St. Louis, Missouri 63105, and our telephone number is (314) 725-4477. Our stock is publicly traded on the New York Stock Exchange under the ticker symbol "CNC."

INDUSTRY

We provide a full spectrum of managed healthcare products and services, primarily through Medicaid (which includes CHIP, LTSS, Foster Care, ABD and MMP), 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 at the federal level. Each state establishes its own eligibility standards, benefit packages, payment rates and program administration within federal standards. As a result, there are 56 Medicaid programs - one for each U.S. state, each U.S. territory and the District of Columbia. Eligibility is based on a combination of household income and assets, often determined by an income level relative to the federal poverty level. Historically, children have represented the largest eligibility group. Many states have selected Medicaid managed care as a means of delivering quality healthcare and controlling costs. We refer to these states as mandatory managed care states.

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

The Balanced Budget Act of 1997 created 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.

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 group receiving LTSS, by spending, are older individuals and individuals with physical disabilities ($98 billion in 2015), followed by individuals with intellectual and developmental disabilities ($44 billion in 2015), those with serious mental illness and/or serious emotional disturbance ($9 billion in 2015) and other populations ($7 billion in 2015). States are increasingly turning to managed care as a solution to provide coordinated, holistic care to their LTSS beneficiaries. According to the National Association of States United for Aging and Disabilities, 20 states utilize some form of LTSS up from eight in 2004.

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

CMS estimated the total Medicaid market was approximately $566 billion in 2016, and estimated the market will grow to $929 billion by 2025. Medicaid spending increased by 3.9% in 2016 and is projected to increase at an average annual rate of 5.7% between 2017 and 2025.

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 rooms, which tends to be more expensive. As a result, many states have found that the costs of providing Medicaid benefits have increased while the medical outcomes for the recipients remained unsatisfactory.

We believe recognition of the value of managed care as a means of delivering improved health outcomes for Medicaid beneficiaries and effectively controlling costs will continue to strengthen. A growing number of states have mandated that their Medicaid recipients enroll in managed care plans. Other states are considering moving to a mandated managed care approach. 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, CHIP, LTSS, Foster Care and ABD 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. 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.

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

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

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

CMS estimated the total Medicare market was approximately $679 billion in 2016, and estimate the market will grow to approximately $1.3 trillion by 2025. Medicare spending increased 5.1% in fiscal 2016 and is projected to increase at an average annual rate of 7.3% between 2017 and 2025.

Commercial

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

In 2010, the Patient Protection and Affordable Care Act and the accompanying Health Care and Education Affordability Reconciliation Act, collectively referred to as the Affordable Care Act (ACA), were enacted. While the constitutionality of the ACA was subsequently challenged in a number of legal actions, in June 2012, the Supreme Court upheld the constitutionality of the ACA, with one limited exception relating to the Medicaid expansion provision (Medicaid Expansion). The Supreme Court held that states could not be required to expand Medicaid and risk losing all federal money for their existing Medicaid programs. Under the ACA, Medicaid coverage was expanded

to all individuals under age 65 with incomes up to 138% of the federal poverty level beginning January 1, 2014, subject to the states' elections. The federal government paid the entire costs for Medicaid Expansion coverage for newly eligible beneficiaries from 2014 through 2016, and 95% of the costs in 2017. Assuming that the current program remains in effect unchanged, in 2018 the federal share is scheduled to decline to 94%; in 2019 it would be 93%; and it would be 90% in 2020 and subsequent years.

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

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International

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

OUR COMPETITIVE STRENGTHS

Our approach is based on the following key competitive strengths:

- Expertise in Government Sponsored Programs. For more than 30 years, we have developed a specialized government services expertise that has helped us establish and maintain relationships with members, providers and state governments. We have implemented programs developed to achieve savings for state governments and improve medical outcomes for members by reducing inappropriate emergency room use, inpatient days and high cost interventions, as well as by managing care of chronic illnesses. We work with state agencies in order to maximize the effectiveness of their programs. Our approach is to accomplish this while maintaining adequate levels of provider compensation and protecting our profitability.

- Strong Historic Operating Performance. We have increased revenues as we have grown in existing markets, expanded into new markets and broadened our product offerings. We entered the Wisconsin market in 1984 as a single health plan and have grown to serve 29 states. Our operating performance has been demonstrated by the following:

	2017	2016	% Change 2016 - 2017
Total membership (in millions)	12.2	11.4	7%
Total revenues ($ in billions)	$48.4	$40.6	19%
Net earnings from continuing operations attributable to Centene Corporation ($ in millions)	$828	$559	48%
Diluted earnings per share (EPS)	$4.69	$3.41	38%
Adjusted Diluted EPS	$5.03	$4.43	14%
Adjusted EBITDA	$1,906	$1,804	6%

For the year ended December 31, 2017, total revenues of $48.4 billion produced a five year Compound Annual Growth Rate (CAGR) of 43%.

- Financial Strength and Scale. Our size and scale allow us to grow, diversify and invest in our businesses through strategic acquisitions and investments in technology and other resources that support our business and help us navigate the changing healthcare landscape.

- Innovative Technology and Scalable Systems. The ability to access data and translate it into meaningful information is essential to operating across a multi-state service area in a cost-effective manner. Our centralized information systems support our core processing functions under a set of integrated databases and are designed to be both replicable and scalable to accommodate organic growth and growth from acquisitions. We continue to enhance our systems in order to leverage the platform we have developed for our existing states for configuration into new states or health plan acquisitions. We believe our predictive modeling technology enables our medical management

operations to proactively case and disease manage specific high risk members. It can recommend medical care opportunities using a mix of company defined algorithms and evidence based medical guidelines. Interventions are determined by the clinical indicators, the ability to improve health outcomes, and the risk profile of members. We believe our integrated approach helps to assure that consistent sources of claim and member information are provided across all of our health plans. Our membership and claims processing system is capable of expanding to support additional members in an efficient manner.

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Diversified Business Lines. We continue to broaden our service offerings to address areas that we believe have been traditionally under-served by Medicaid managed care organizations. In addition to our Medicaid and Medicaid-related managed care services, our service offerings include behavioral health management, care management software, correctional healthcare services, dental benefits management, commercial programs, home-based primary care services, life and health management, vision benefits management, pharmacy benefits management, specialty pharmacy and telehealth services. With the acquisition of Health Net, we further broadened our service offerings in 2016, which added government-sponsored care under its federal contracts with the Department of Defense (DoD) and the U.S. Department of Veterans Affairs (VA), as well as Medicare Advantage. Through the utilization of a multi-business line approach, we are able to improve the quality of care, improve outcomes, diversify our revenues and help control our medical costs.

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

Quality and Innovation. Our innovative medical management programs focus on improving quality of care in areas that have the greatest impact on our members. We concentrate on serving the whole person to impact outcomes and costs. We recognize the importance of member-focused delivery of quality managed care services and have developed award winning education and outreach programs including the CentAccount program, On.Demand Diabetes, Start Smart For Your Baby, and MemberConnections.

OUR BUSINESS STRATEGY

Key components of our current business strategy include:

Increase Penetration of Existing State Markets. We seek to continue to increase our Medicaid, Medicare and Health Insurance Marketplace membership in states in which we currently operate through alliances with key providers, outreach efforts, development and implementation of community-specific products and acquisitions. For example, in 2017, we began providing managed care services to MO HealthNet Managed Care beneficiaries under an expanded statewide contract. Also, in 2017, we expanded our Medicare Advantage footprint into four of our existing states. In 2018, we expanded Medicare Advantage further into nine of our existing states.

Diversify Business Lines. We seek to broaden our business lines into areas that complement our existing business to enable us to grow and diversify our revenues. In 2017, we served managed care members in 27 states through approximately 300 product solutions. We are constantly evaluating new opportunities for expansion both domestically and abroad. For example, in 2016, we acquired Health Net, which broadened our service offerings and added government-sponsored care. We employ a disciplined acquisition strategy that is based on defined criteria including internal rate of return, accretion to earnings per share, market leadership and compatibility with our information systems. We engage our executives in the relevant operational units or functional areas to ensure consistency between the diligence and integration process.

- Address Emerging State Needs. We work to assist the states in which we operate in addressing the operating challenges they face. We seek to assist the states in balancing premium rates, benefit levels, member eligibility, policies and practices, provider compensation and minimizing fraud, waste, and abuse. By helping states structure appropriate programs to cover a wide range of populations including Medicaid, CHIP, LTSS, ABD, Intellectual or Developmental Disabilities (IDD), behavioral health and specialty services, among others. We seek to ensure that we are able to continue to provide those services on terms that achieve targeted gross margins, provide an acceptable return and grow our business.

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- Develop and Acquire Additional Markets. We continue to leverage our experience to identify and develop new domestic and international markets by seeking both to acquire existing business and to build our own operations. Domestically, we focus expansion in states where Medicaid recipients are mandated to enroll in managed care organizations because we believe member enrollment levels are more predictable in these states. In addition, we provide solutions to states looking to deliver the highest quality of care within their budgetary constraints. In 2016, we increased our ownership interest to 75% in The Practice (Group) Limited (TPG), one of the largest provider networks for NHS England. In 2017, we expanded into Maryland, Nebraska and Nevada. Also in 2017, we signed a definitive agreement under which Fidelis Care will become our health plan in New York State.

- Leverage Established Infrastructure to Enhance Operating Efficiencies. We intend to continue to invest in infrastructure to further drive efficiencies in operations and to add functionality to improve the service provided to members and other organizations at a low cost. Information technology (IT) investments complement our overall efficiency goals by increasing the automated processing of transactions and growing the base of decision-making analytical tools. We believe that our centralized functions and common systems enable us to add members and markets quickly and economically.

- Maintain Operational Discipline. We seek to operate in markets that allow us to meet our internal metrics including membership growth, plan size, market leadership and operating efficiency. We use multiple techniques to monitor and reduce our medical costs, including on-site hospital review by staff nurses and involvement of medical management in significant cases. Our executive dashboard is utilized to quickly identify cost drivers and medical trends. Our management team regularly evaluates the financial impact of proposed changes in provider relationships, contracts, changes in membership and mix of members, potential state rate changes and cost reduction initiatives. We may divest contracts or health plans in markets where the environment, over a long-term basis, does not allow us to meet our targeted performance levels. For example, due to under performance, we exited the Arizona individual PPO business, effective January 1, 2017. In addition, in 2016, we took various rate and product design actions for 2017 to address issues and improve profitability in connection with certain lines of business acquired with the Health Net Acquisition.

Substantially all of our revenues are derived from operations within the United States and its territories, and all of our long-lived assets are based in the United States and its territories. We generally receive a fixed premium per member per month pursuant to our state contracts. Our managed care subsidiaries in California and Texas had revenues from their respective state governments that each exceeded 10% of our consolidated total revenues in 2017. In addition, the federal government is a significant customer to our Specialty Services segment due to our Federal Services business.

MANAGED CARE

Benefits to Customers

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

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

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

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

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

- Improved quality and medical outcomes. We have implemented programs to enhance the ability of providers to improve the quality of healthcare delivered to our members including On.Demand Diabetes, Start Smart for your Baby, Living Well With Sickle Cell and The CentAccount Program.

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

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

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

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

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

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

Member Programs and Services

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