CENTENE CORP
Form 10-K
February 22, 2016

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, 2015
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. o
Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of “large accelerated filer”, “accelerated filer” and “small reporting

company" in Rule 12b-2 of the Exchange Act.

x Large accelerated filer o Accelerated filer

o Non-accelerated filer (do not check if a smaller reporting company) o Smaller reporting company

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, 2015, was $9.6 billion.

As of February 17, 2016, the registrant had 121,654,923 shares of common stock issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Proxy Statement for the registrant's 2016 annual meeting of stockholders are incorporated by reference in Part III, Items 10, 11, 12, 13 and 14.

CENTENE CORPORATION
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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 have attempted to identify these statements by terminology including “believe,” “anticipate,” “plan,” “expect,” “estimate,” “intend,” “seek,” “target,” “goal,” “may,” “will,” “would,” “could,” “should,” “can,” “continue” and other similar v expressions in connection with, among other things, any discussion of future operating or financial performance. In particular, these statements include statements about our market opportunity, our growth strategy, competition, expected activities and future acquisitions, including our proposed merger with Health Net, Inc. (Health Net) (Proposed Merger), investments and the adequacy of our available cash resources. These statements may be found in the various sections of this filing, including those entitled “Management's Discussion and Analysis of Financial Condition and Results of Operations,” Part II, Item 1A. “Risk Factors,” and Part II, Item 1 “Legal Proceedings.” 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 and 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. Actual results may differ from projections or estimates due to a variety of important factors applicable to both us and Health Net, 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 projections;
- timing of regulatory contract approval;
- changes in healthcare practices;
- changes in federal or state laws or regulations, including the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act and any regulations enacted thereunder;
- changes in expected contract start dates;
- changes in expected closing dates, estimated purchase price and accretion for acquisitions;
- inflation;
- foreign currency fluctuations;
- provider and state contract changes;
- new technologies;
- advances in medicine;
- reduction in provider payments by governmental payors;
- major epidemics;
- disasters and numerous other factors affecting the delivery and cost of healthcare;
- the expiration, cancellation or suspension of our or Health Net's managed care contracts by federal or state governments (including but not limited to Medicare and Medicaid);
- the outcome of our or Health Net's pending legal proceedings;
- availability of debt and equity financing, on terms that are favorable to us;
- our ability to adequately price products on federally-facilitated and state-based Health Insurance Marketplaces;
- changes in economic, political and market conditions;
- the ultimate closing date of the Proposed Merger;
- the possibility that the expected synergies and value creation from the Proposed Merger will not be realized, or will not be realized within the expected time period;

- the risk that acquired businesses will not be integrated successfully;
- disruption from the Proposed Merger making it more difficult to maintain business and operational relationships;
- the risk that unexpected costs related to the Proposed Merger will be incurred; and
- the possibility that the Proposed Merger does not close, including, but not limited to, due to the failure to satisfy the closing conditions thereto.

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. We disclaim any current intention or obligation to update or revise any forward-looking statements, whether as a result of new information, future events or otherwise. Due to these important factors and risks, we cannot give assurances with respect to our future 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 individuals to more accurately assess the ongoing nature of the Company's operations and measure the Company's performance more consistently. 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.

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PART I
ITEM 1. Business

OVERVIEW

We are a diversified, multi-national healthcare enterprise that provides programs and services to government sponsored 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.

On July 2, 2015, we announced that we had entered into a definitive merger agreement with Health Net, Inc. (Health Net) under which we will acquire all of the issued and outstanding shares of Health Net. Under the terms of the agreement, at the closing of the transaction, Health Net stockholders (with limited exceptions) would receive 0.622 of a validly issued, fully paid, non-assessable share of Centene common stock and $28.25 in cash for each share of Health Net common stock. The transaction is valued at approximately $5.5 billion (based on the Centene closing stock price on February 17, 2016), including the assumption of debt. The Company expects to fund the cash portion of the acquisition through a combination of the debt financing completed in February 2016, borrowings on the Company's revolving credit facility and existing cash on hand. The transaction is expected to close in early 2016 and is subject to approvals by relevant state insurance and healthcare regulators and other customary closing conditions.

We operate in two segments: Managed Care and Specialty Services. Our 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 Care (LTC), Foster Care, dual-eligible individuals (Duals) and the Supplemental Security Income Program, also known as the Aged, Blind or Disabled Program, or collectively ABD. Beginning in 2014, our Managed Care segment also provides health plan coverage to individuals covered through federally-facilitated and state-based Health Insurance Marketplaces (HIM). Our Specialty Services segment consists of our specialty companies offering diversified healthcare services and products to state programs, correctional facilities, healthcare organizations, employer groups and other commercial organizations, as well as to our own subsidiaries. For the year ended December 31, 2015, our Managed Care and Specialty Services segments accounted for 90% and 10%, respectively, of our total external premium and service revenues.

Our managed care membership totaled 5.1 million as of December 31, 2015. For the year ended December 31, 2015, our premium and service revenues and net earnings from continuing operations attributable to Centene were $21.3 billion and $356 million, respectively, and our total cash flow from operations was $658 million.

On February 2, 2015, the Board of Directors declared a two-for-one split of Centene's common stock in the form of a 100% stock dividend distributed February 19, 2015 to stockholders of record on February 12, 2015. All share, per share and stock price information presented in this Form 10-K has been adjusted for the two-for-one stock split.

Our subsidiary, Kentucky Spirit Health Plan (KSHP), ceased serving members in Kentucky as of July 6, 2013. Accordingly, the results of operations for KSHP are classified as discontinued operations for all periods presented in our consolidated financial statements. The following discussion and analysis, with the exception of cash flow

information, is presented in the context of continuing operations unless otherwise identified.

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.”

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INDUSTRY

We provide our services primarily through Medicaid, CHIP, LTC, Foster Care, ABD, Medicare and other state and federal programs for the uninsured. The federal Centers for Medicare and Medicaid Services, or CMS, estimated the total Medicaid and CHIP market was approximately $449 billion in 2013, and estimate the market will grow to $890 billion by 2024. According to the most recent information provided by the Kaiser Commission on Medicaid and the Uninsured, Medicaid spending increased by 13.9% in fiscal 2015 and states appropriated an increase of 6.9% for Medicaid in fiscal 2016 budgets.

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 mandated managed care states.

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 because of their critical health issues.

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. Some states include the parents of these children in their CHIP programs. 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.

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 the Kaiser Commission on Medicaid and the Uninsured, there were approximately 9.6 million dual-eligible enrollees in 2015. These dual-eligible members may receive assistance from Medicaid for Medicaid benefits, such as nursing home care 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, LTC and MMP programs and through Medicare Special Needs Plans.

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, LTC, Foster Care and ABD populations.

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. 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 will pay the entire costs for Medicaid expansion coverage for newly eligible beneficiaries for three years, from 2014 through 2016. In 2017, the federal share declines to 95%; in 2018 it is 94%; in 2019 it is 93%; and it will be 90% in 2020 and subsequent years.

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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 will 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 three levels of coverage that vary 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.

OUR COMPETITIVE STRENGTHS

Our multi-national managed care approach is based on the following key attributes:

- 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 23 states. Our operating performance has been demonstrated by the following:

	2015	2014	% Change 2014 - 2015
Total membership (in millions)	5.1	4.1	26%
Premium and service revenues ($ in billions)	$21.3	$15.7	36%
Net earnings from continuing operations attributable to Centene Corporation	$356	$268	33%
Diluted earnings per share (EPS)	$2.89	$2.23	30%
Diluted EPS (excluding Health Net merger related expenses)	$3.03	$2.23	36%
Adjusted EBITDA[1]	$948	$636	49%

[1]Adjusted EBITDA represents net earnings attributable to Centene Corporation excluding income tax expense, interest expense, depreciation, amortization (excluding senior note premium amortization), stock compensation expense, and Health Net merger related expenses. A reconciliation of this non-GAAP measure follows ($ in millions):

	2015	2014
Net earnings from continuing operations attributable to Centene Corporation	$356	$268
Income tax expense	339	196
Interest expense	43	35
Depreciation and amortization	112	89
Non-cash stock compensation expense	71	48
Health Net merger related expenses	27	—
Adjusted EBITDA	$948	$636

For the year ended December 31, 2015, premium and service revenues of $21.3 billion have produced a five year Compound Annual Growth Rate (CAGR) of 38% and diluted earnings per share of $2.89 has produced a five year CAGR of 26%.

- 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. 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. 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.

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

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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.

- 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, HIM, in-home health services, life and health management, managed vision, pharmacy benefits management, specialty pharmacy and telehealth services. We expect to further broaden our service offerings in 2016 through the acquisition of Health Net, which will add government-sponsored care under its federal contracts with the Department of Defense 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 general and administrative 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, Start Smart For Your Baby, and MemberConnections.

OUR BUSINESS STRATEGY

Our objective is to become the leading multi-national healthcare enterprise focusing on the uninsured and under-insured population through government sponsored healthcare initiatives. We intend to achieve this objective by implementing the following key components of our strategy:

- Increase Penetration of Existing State Markets. We seek to continue to increase our Medicaid 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 2015, we began operating under a contract with the Arizona Department of Health Services/Division of Behavioral Health Services to be the Regional Behavioral Health Authority for the new southern geographic service area.

- 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 revenue. In 2015, we served managed care members in 23 states through over 200 product solutions. We are constantly evaluating new opportunities for expansion both domestically and abroad. For

example, in 2015, we announced that we had entered into a definitive merger agreement with Health Net under which we will acquire all of the issued and outstanding shares of Health Net. In 2014, we acquired U.S. Medical Management, a management services organization and provider of in-home health services for high acuity populations. 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,

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policies and practices, provider compensation and minimizing fraud, waste, and abuse. By helping states structure an appropriate level and range of Medicaid, CHIP and specialty services, 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.

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 focus on states where managed care programs can help address states' financial needs. In 2014, we entered the international market with our investment in Ribera Salud, a Spanish health management group. In 2015, we began managing care for Medicaid members in Oregon and also began managing care for members who are dually eligible for Medicare and Medicaid in Michigan.

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, or IT, investments complement our overall efficiency goals by increasing the automated processing of transactions and growing the base of decision-making analytical tools. 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 state's Medicaid environment, over a long term basis, does not allow us to meet our targeted performance levels. For example, as a result of lower than anticipated financial performance, in July 2013, we terminated our Kentucky Medicaid managed care contract with the Commonwealth of Kentucky.

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We have subsidiaries offering healthcare services in each state we serve. The table below provides summary data for the state markets we currently serve[1]:

State	Primary Local Plan Name	First Year of Operations Under Centene	Managed Care Membership at December 31, 2015
Arizona	Bridgeway Health Solutions	2006	6,900
Arizona	Cenpatico Integrated Care	2005	434,000
Arkansas	Arkansas Health and Wellness Solutions	2014	41,900
California	California Health and Wellness	2013	186,000
Florida	Sunshine State Health Plan	2009	510,400
Georgia	Peach State Health Plan	2006	408,600
Illinois	IlliniCare Health	2011	207,500
Indiana	Managed Health Services	1995	282,100
Kansas	Sunflower Health Plan	2013	141,000
Louisiana	Louisiana Healthcare Connections	2012	381,900
Massachusetts	CeltiCare Health	2009	51,300
Massachusetts	Massachusetts Partnership for Correctional Healthcare	2013	10,200
Michigan	Fidelis SecureCare of Michigan	2015	4,800
Minnesota	Centurion of Minnesota	2014	9,600
Mississippi	Magnolia Health	2011	284,400
Mississippi	Centurion of Mississippi	2015	17,800
Missouri	Home State Health	2012	95,100
New Hampshire	New Hampshire Healthy Families	2013	71,400
Ohio	Buckeye Health Plan	2004	302,700
Oregon	Trillium Community Health Plan	2015	98,700
South Carolina	Absolute Total Care	2007	104,000
Tennessee	Centurion of Tennessee	2013	20,000
Texas	Superior HealthPlan	1999	983,100
Vermont	Centurion of Vermont	2015	1,700
Washington	Coordinated Care	2012	209,400
Wisconsin	MHS Health Wisconsin	1984	77,100
Total at-risk membership			4,941,600
Non-risk membership			166,300
Total			5,107,900

[1]Table includes members served in each our states through our government sponsored programs, Health Insurance Marketplaces, and
correctional healthcare services.

Substantially all of our revenue is derived from operations within the United States and its territories, and all of the Company's 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 medical costs have a seasonality component due to cyclical illness, for example cold and flu season, resulting in higher medical expenses beginning in the fourth quarter and continuing throughout the first quarter of the following year. Our managed care subsidiaries in Texas and Florida had revenues from their respective state governments that each exceeded 10% of our consolidated total revenues in 2015.

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MANAGED CARE

Benefits to States

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

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

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

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

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

- Improved quality and medical outcomes. We have implemented programs developed to improve the quality of healthcare delivered to our members including 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.

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- 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 state to state, our health plans generally provide the following services:

- primary and specialty physician care
- inpatient and outpatient hospital care
- emergency and urgent care
- prenatal care
- laboratory and x-ray services
- home health and durable medical equipment
- behavioral health and substance abuse services
- 24-hour nurse advice line
- transportation assistance

- vision care
- dental care
- immunizations
- prescriptions and limited over-the-counter drugs
- specialty pharmacy
- therapies
- social work services
- care coordination

We also provide the following education and outreach programs to inform, assist and incentivize members in accessing 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 including Case In Point, Hermes Awards, U.S. Environmental Protection Agency and National Health Information Awards.

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

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

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

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

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

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

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

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

- Diabetes Program is an innovative program that is a collaboration with our life and health management subsidiary and our health plans that targets diabetic patients and educates them on their disease state.

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

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

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

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

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

Providers

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

Our health plans facilitate access to healthcare services for our members primarily through contracts with our providers. Our contracts with primary and specialty care physicians and hospitals usually are for one to two-year periods and renew automatically for successive one-year terms, but generally are subject to termination by either party upon 90 to 120 days prior written notice. In the absence of a contract, we typically pay providers at state Medicaid

reimbursement levels. We pay hospitals under a variety of methods, including fee-for-service, capitation arrangements, per diems, diagnostic related grouping and case rates. We pay physicians under a fee-for-service, capitation arrangement, or risk-sharing performance-based arrangement. In addition, we are governed by state prompt payment policies.

- Under our fee-for-service contracts with physicians, particularly specialty care physicians, we pay a negotiated fee for covered services. This model is characterized as having no financial risk for the physician. In addition, this model requires management oversight because our total cost may increase as the units of services increase or as more expensive services replace less expensive services. We have prior authorization procedures in place that are intended to make sure that certain high cost diagnostic and other services are medically appropriate.

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- Under our capitated contracts, primary care physicians are paid a monthly fee for each of our members assigned to his or her practice for all ambulatory care. In return for this payment, these physicians provide all primary care and preventive services, including primary care office visits and EPSDT services, and are at risk for all costs associated with such services. If these physicians also provide non-capitated services to their assigned members, they may receive payment under fee-for-service arrangements at standard Medicaid rates.

- Under risk-sharing performance-based arrangements, physicians are paid under a capitated or fee-for-service arrangement. The arrangement, however, contains provisions for additional bonus to the physicians or reimbursement from the physicians based upon cost and quality measures.

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

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

- Customized Utilization Reports provide certain of our contracted physicians with information that enables them to run their practices more efficiently and focuses them on specific patient needs. For example, quarterly detail reports update physicians on their status within their risk pools. Equivalency reports provide physicians with financial comparisons of capitated versus fee-for-service arrangements.

- Case Management Support helps the physician coordinate specialty care and ancillary services for patients with complex conditions and direct members to appropriate community resources to address both their health and socio-economic needs.

- Web-based Claims and Eligibility Resources have been implemented to provide physicians with on-line access to perform claims and eligibility inquiries.

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

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

Quality Management

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

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

- appropriate leveling of care for neonatal intensive care unit hospital admissions, other inpatient hospital admissions, and observation admissions, in accordance with Interqual criteria

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- tightening of our pre-authorization list and more stringent review of durable medical equipment and injectibles

- Emergency room program designed to collaboratively work with hospitals to steer non-emergency care away from the costly emergency room setting (through patient education, on-site alternative urgent care settings, etc.)

- increase emphasis on case management and clinical rounding where case managers are nurses or social workers who are employed by the health plan to assist selected members with the coordination of healthcare services in order to meet a member's specific healthcare needs

- incorporation of disease management, which is a comprehensive, multidisciplinary, collaborative approach to chronic illnesses such as asthma and diabetes

- Start Smart For Your Baby, a prenatal case management program aimed at helping women with high-risk pregnancies deliver full-term, healthy infants

- Pharmacy treatment compliance programs are driven by clinical policy and focus 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, or HEDIS, reporting constitutes the core of the information base that drives our clinical quality performance efforts. This reporting is monitored by Plan Quality Improvement Committees and our corporate medical management team.

In an effort to ensure the quality of our provider networks, we undertake to verify the credentials and background of our providers using standards that are supported by the National Committee for Quality Assurance, or NCQA.

It is our objective to provide access to the highest quality of care for our members. As a validation of that objective, we often pursue accreditation by independent organizations that have been established to promote healthcare quality. The NCQA Health Plan Accreditation and URAC Health Plan Accreditation programs provide unbiased, third party reviews to verify and publicly report results on specific quality care metrics. While we have achieved or are pursuing accreditation for all of our plans, accreditation is only one measure of our ability to provide access to quality care for our members. We currently have 17 of 19 eligible health plans with NCQA accreditation.

SPECIALTY SERVICES

Our specialty services are a key component of our healthcare strategy and complement our core Managed Care business. Specialty services diversify our revenue stream, provide higher quality health outcomes to our membership and others, and assist in controlling costs. Our specialty services are provided primarily through the following businesses:

- Pharmacy Solutions. US Script is rebranding and will be transitioning to Envolve Pharmacy Solutions. Envolve Pharmacy Solutions will utilize innovative, flexible solutions and customized care management. Under the new brand, we will continue to offer traditional pharmacy benefits management as well as comprehensive specialized pharmacy benefit services through our specialty pharmacy, AcariaHealth. Our traditional pharmacy benefits management program offers progressive pharmacy benefits management services that are specifically designed to improve quality of care while containing costs. This is achieved through a low cost strategy that helps optimize clients' pharmacy benefits. Services include claims

processing, pharmacy network management, benefit design consultation, drug utilization review, formulary and rebate management, online drug management tools, mail order pharmacy services, home delivery services, analytics and clinical consulting and patient and physician intervention. AcariaHealth offers specialized care management services for complex diseases and enhances the patient care offering through collaboration with providers and the capture of relevant data to measure patient outcomes.

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Health, Triage, Wellness, and Disease Management Services companies are rebranding and will transition to Envolve PeopleCare. Envolve PeopleCare will bring together our behavioral health, nurse advice, telehealth, and health, wellness and disease guidance programs, allowing for a focus on individual health management through education and empowerment. Our networks feature a full range of services and levels of care to help people with mental illness reach their recovery and wellness goals. Our life and health management programs specialize in encouraging healthy behaviors, promote healthier workplaces, improve workforce and societal productivity and reduce healthcare costs.

- Health risk appraisals, biometric screenings, interactive wellness programs, disease management and work-life/employee assistance services are areas of focus. We utilize telephonic health and work/life balance coaching, in-home and online interaction and informatics processes to deliver effective clinical outcomes, enhanced patient-provider satisfaction and lower overall healthcare cost. We offer telehealth services where members reach bilingual customer service representatives and nursing staff who provide health education, 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 Services. Opticare Managed Vision is rebranding and will transition to Envolve Vision. Under the new name, we will continue to coordinate benefits beyond traditional medical benefits to offer fully integrated vision health services. Our vision benefit administers routine and medical surgical eye care benefits via a contracted national network of eye care providers.

- Dental Services. Dental Health & Wellness is rebranding and will transition to Envolve Dental. We will continue to coordinate benefits beyond traditional medical benefits to offer fully integrated dental health services. Through the dental benefit, we are dedicated to improving oral health through a contracted network of dental healthcare providers.

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

- Correctional Healthcare Services. Centurion, our joint venture subsidiary with MHM Services Inc., provides comprehensive healthcare services to individuals incarcerated in Massachusetts, Minnesota, Mississippi, Tennessee and Vermont state correctional facilities. In 2016, we expect to begin providing healthcare services to individuals incarcerated in Florida.

- In-Home Health Services. U.S. Medical Management, our majority owned subsidiary acquired in January 2014, provides in-home health services for high acuity populations.

- Integrated Long-Term Care. LifeShare provides home and community-based support for people with developmental disabilities, children in the child welfare system and people of all ages and abilities, with a focus on those that are often marginalized by society. In addition, LifeShare operates school-based programs that focus on students with special needs.

The NCQA and URAC also provide accreditation and certification for our specialty companies. We currently have four specialty companies with NCQA accreditation or certification and five specialty companies with URAC accreditation.

CORPORATE COMPLIANCE

Our Corporate Ethics and Compliance Program provides controls by which we assure that our values are reflected in everything we do, further enhancing operations, improving access to quality care and safeguarding against fraud,

waste and abuse.

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

- written standards of conduct
- designation of a corporate compliance officer and compliance committee
- effective training and education

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- effective lines for reporting and communication
- enforcement of standards through well publicized disciplinary guidelines and actions
- internal monitoring and auditing
- prompt response to detected offenses and development of corrective action plans

The goal of the program is to build a culture of ethics and compliance, which is assessed periodically using a diagnostic survey to measure the integrity of the organization. Our internal Corporate Compliance intranet site, accessible to all employees, contains our Business Ethics and Conduct Policy (Code of Conduct), Compliance Program description and resources for employees to report concerns or ask questions. If needed, employees have access to the contact information for the members of our Board of Directors' Audit Committee 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, the Board of Directors reviews an ethics and compliance report on a quarterly basis.

COMPETITION

We continue to face varying and increasing levels of competition as we expand in our existing service areas or enter new markets. Federal regulations require at least two competitors in each service area. Healthcare reform may cause a number of commercial managed care organizations to decide to enter or exit the various managed care markets.

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

- Medicaid Managed Care Organizations focus on providing healthcare services to Medicaid recipients. These organizations consist of national and regional organizations, as well as not-for-profits and smaller organizations that operate in one city or state and are owned by providers, primarily hospitals.

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

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

- Accountable Care Organizations are groups of doctors, hospitals, and other health care providers, who come together to give coordinated high quality care to their patients.

We compete with other managed care organizations and specialty companies for state contracts. In order to grant a contract, state governments consider many factors. These factors include quality of care, financial requirements, an ability to deliver services and establish provider networks and infrastructure. In addition, our specialty companies also 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 also compete with other managed care organizations to enter into contracts with physicians, physician groups and other providers. We believe the factors that providers consider in deciding whether to contract with us include existing and potential member volume, reimbursement rates, medical management programs, speed of reimbursement and administrative service capabilities. See “Risk Factors - Competition may limit our ability to increase penetration of the markets that we serve.”

REGULATION

Our operations are regulated at both 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. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws and rules also may occur periodically.

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Our regulated subsidiaries are licensed to operate as health maintenance organizations (HMOs), 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 health care providers, and departments of health that oversee the activities of managed care organizations providing or arranging to provide services to Medicaid, Medicare and Health Insurance Marketplace commercial enrollees.

The process for obtaining authorization to operate as a managed care organization and provider organizations 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, complaint procedures, provider network and procedures for covering emergency medical conditions. 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 health care provider must meet criteria to secure the approval of state regulatory authorities before implementing operational changes, including the development of new product offerings 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
- stringent prompt payment laws
- disclosure requirements regarding provider fee schedules and coding procedures
- 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 acts 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.

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.

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Our health care 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 both the state and 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.

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 must operate under a contract with the state's Medicaid agency. States generally use either a formal proposal process, reviewing a number of bidders, or award individual contracts to qualified applicants that apply for entry to the program. 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. We also contract with states to provide healthcare services to correctional facilities.

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

- eligibility, enrollment and dis-enrollment processes
- covered services
- eligible providers
- subcontractors
- record-keeping and record retention
- periodic financial and informational reporting
- quality assurance
- accreditation

- health education and wellness and prevention programs
- timeliness of claims payment
- financial standards
- safeguarding of member information
- fraud, waste and abuse detection and reporting
- grievance procedures
- organization and administrative systems

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

The table below sets forth the terms of our contracts and provides details regarding related renewal or extension and termination provisions. The contracts are subject to termination for cause, an event of default or lack of funding.

Contract	Expiration Date	Renewal or Extension

Arizona - Behavioral Health	September 30, 2018	Renewable for two additional two-year terms.
Arizona - LTC	September 30, 2016	Renewable for one additional one-year term.
Arizona - Special Needs Plan (Medicare)	December 31, 2016	Renewable annually for successive 12-month periods.
Arkansas - Medicaid Expansion	December 31, 2016	Renewable annually for successive 12-month periods.
California - Medicaid & ABD	October 31, 2018	Renewable up to three additional one-year terms.
Florida - Medicaid, ABD, LTC & Foster Care	December 31, 2018	Renewable through the state's recertification process.
Florida - CHIP	September 30, 2017	May be extended for two additional one-year terms.

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Florida - Special Needs Plan (Medicare)	December 31, 2016	Renewable annually for successive 12-month periods.
Florida - Special Needs Plan (Medicaid)	December 31, 2017	Renewable through the state's recertification process.
Georgia - Medicaid & CHIP	June 30, 2016	RFP awarded for an initial one-year term to begin July 1, 2016 and renewable for five additional one-year terms. The expiration date of the current contract may be extended for up to two six-month periods, subject to CMS approval.
Georgia - Special Needs Plan (Medicare)	December 31, 2016	Renewable annually for successive 12-month periods.
Illinois - ABD & LTC	April 30, 2016	May be extended for up to five additional years.
Illinois - Duals	December 31, 2016	Renewable for one additional one-year term.
Illinois - Medicaid	June 30, 2019	May be extended for up to five additional years.
Indiana - ABD	March 31, 2019	May be extended for two additional one-year terms.
Indiana - Medicaid, CHIP & Hybrid (Healthy Indiana Plan)	December 31, 2016	Renewable for one additional one-year term.
Kansas - Medicaid, ABD, CHIP, LTC & Foster Care	December 31, 2017	Renewable through the state's reprocurement process.
Louisiana - Medicaid, CHIP, ABD, Foster Care & Behavioral Health	January 31, 2018	May be extended for up to two additional one-year terms.
Massachusetts - Correctional Healthcare Services	June 30, 2018	Renewable for two additional two-year terms.
Massachusetts - Medicaid	September 30, 2016	May be extended for five additional one-year terms.
Michigan - Duals	December 31, 2017	Renewable through the state's reprocurement process.
Minnesota - Correctional Healthcare Services	June 30, 2018	Renewable through the state's reprocurement process.
Mississippi - Medicaid, ABD & Foster Care	June 30, 2017	May be extended for up to two additional one-year terms.
Mississippi - CHIP	June 30, 2017	May be extended for up to two additional one-year terms.
Mississippi - Correctional Healthcare Services	June 30, 2016	Renewable through the state's reprocurement process.
Missouri - Medicaid, CHIP & Foster Care	June 30, 2016	Renewable for two additional one-year terms.
New Hampshire - Medicaid, CHIP, Foster Care & ABD	June 30, 2016	Renewable for one additional two-year term.
New Hampshire - Medicaid Expansion	December 31, 2016	Program is expected to end on December 31, 2016. The majority of members converted to Health Insurance Marketplace effective January 1, 2016.
Ohio - Duals	December 31, 2016	Renewable for one additional one-year term.

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Ohio - Medicaid, CHIP & ABD	June 30, 2016	Renewable annually for successive 12-month periods.
Ohio - Special Needs Plan (Medicare)	December 31, 2016	Renewable annually for successive 12-month periods.
Oregon - Medicaid, Medicaid Expansion, ABD, CHIP & Foster Care	December 31, 2018	Renewable through the state's reprocurement process.
Oregon - Medicare Advantage HMO (Includes Special Needs Plan)	December 31, 2016	Renewable annually for successive 12-month periods.
Oregon - Medicare Advantage PPO	December 31, 2016	Renewable annually for successive 12-month periods.
South Carolina - Medicaid & ABD	June 30, 2016	Renewable through the state's recertification process.
South Carolina - Duals	December 31, 2016	Renewable for one additional one-year term.
Tennessee - Correctional Healthcare Services	August 31, 2016	Renewable through the state's reprocurement process.
Texas - ABD Dallas Expansion	August 31, 2018	Renewable through the state's reprocurement process.
Texas - ABD MRSA	August 31, 2017	May be extended for up to five additional years.
Texas - CHIP Rural Service Area	August 31, 2018	Renewable through the state's reprocurement process.
Texas - Foster Care	August 31, 2018	May be extended for up to five additional years.
Texas - Medicaid, CHIP & ABD	August 31, 2018	May be extended for up to one and a half additional years.
Texas - Duals	December 31, 2016	Renewable for two additional one-year terms.
Texas - Special Needs Plan (Medicare)	December 31, 2016	Renewable annually for successive 12-month periods.
Vermont - Correctional Healthcare Services	January 31, 2018	May be extended for up to two additional one-year terms.
Washington - Medicaid, CHIP, Foster Care & ABD	December 31, 2016	Renewable through the state's recertification process.
Wisconsin - Medicaid, CHIP & ABD	December 31, 2017	Renewable through the state's recertification process every two years.
Wisconsin - Network Health Plan Subcontract	December 31, 2017	Renews automatically for successive three-year terms.
Wisconsin - Special Needs Plan (Medicare)	December 31, 2016	Renewable annually for successive 12-month periods.

Marketplace Contracts

We operate under federally facilitated and state-based Marketplace contracts in 12 states with CMS that expire annually. In 2016, we began operating in a federally facilitated Marketplace in New Hampshire.

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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 the "private option"). This contract expires December 31, 2016 and may be extended for subsequent and consecutive one-year terms. In 2016, we started operating under a contract with the New Hampshire Department of Health and Human Services to participate in the Medicaid expansion model that New Hampshire has adopted (referred to as the “premium assistance program”). This contract expires December 31, 2016 and may be extended for subsequent and consecutive one-year terms.

The Health Insurance Portability and Accountability Act (HIPAA)

In 1996, Congress enacted the Health Insurance Portability and Accountability Act, or HIPAA. We are subject to various federal and state laws and rules regarding the use and disclosure of confidential information, including HIPAA and the Gramm-Leach-Bliley Act. HIPAA is designed to improve the portability and continuity of health insurance coverage, simplify the administration of health insurance through standard transactions and ensure the privacy and security of individual health information. Among the requirements of HIPAA are the Administrative Simplification provisions which include: standards for processing health insurance claims and related transactions (Transactions Standards); requirements for protecting the privacy and limiting the use and disclosure of medical records and other personal health information (Privacy Rule); and standards and specifications for safeguarding personal health information which is maintained, stored or transmitted in electronic format (Security Rule). The Health Information Technology for Economic and Clinical Health (HITECH) Act amended certain provisions of HIPAA and enhanced data security obligations for covered entities and their business associates. HITECH also mandated individual notifications in instances of a data breach, provided enhanced penalties for HIPAA violations, and granted enforcement authority to states' Attorneys Generals in addition to the HHS Office for Civil Rights. The HIPAA Omnibus Rule further enhanced the changes under the HITECH Acts and the Genetic Information Nondiscrimination Act of 2008 (GINA) which clarified that genetic information is protected under HIPAA and prohibits most health plans from using or disclosing genetic information for underwriting purposes. This Omnibus rule enhances the privacy protections and strengthens the government's ability to enforce the law. The preemption provisions of HIPAA provide that the federal standards will not preempt state laws that are more stringent than the related federal requirements.

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

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

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

We have implemented processes, policies and procedures to comply with HIPAA, HITECH and the Omnibus Rule, including administrative, technical and physical safeguards to prevent against an electronic data breach. We provide education and training for employees specifically designed to help prevent any unauthorized use or access to health information and enhance the reporting of suspected breaches. In addition, our corporate privacy officer and subsidiary privacy officials handle complaints and serve as resources to employees to address questions or concerns they may have. We periodically review our privacy and security procedures and conduct risk assessments to ensure we promptly identify and address gaps in our processes.

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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 participants in public government healthcare programs such as Medicare and Medicaid. The fraud, waste and abuse laws include the federal False Claims Act, which prohibits the known filing of a false claim or the known use of false statements to obtain payment from the federal government. Many states have false claim act statutes that closely resemble the federal False Claims Act. The laws and regulations relating to fraud, waste and abuse and the requirements applicable to health plans and providers participating in these programs are complex and change regularly. Compliance with these laws may require substantial resources. We are constantly looking for ways to improve our waste, fraud and abuse detection methods. While we have both prospective and retrospective processes to identify abusive patterns and fraudulent billing, we continue to increase our capabilities to proactively detect inappropriate billing prior to payment.

EMPLOYEES

As of December 31, 2015, we had approximately 18,200 employees. None of our employees are represented by a union. We believe our relationships with our employees are positive.

EXECUTIVE OFFICERS OF THE REGISTRANT

The following table sets forth information regarding our executive officers, including their ages, at February 17, 2016:

Name	Age	Position
Michael F. Neidorff	73	Chairman, President and Chief Executive Officer
K. Rone Baldwin	57	Executive Vice President, Markets
Cynthia J. Brinkley	56	Executive Vice President, Global Corporate Development
Carol E. Goldman	58	Executive Vice President and Chief Administrative Officer
Jesse N. Hunter	40	Executive Vice President, Products
William N. Scheffel	62	Executive Vice President, Chief Financial Officer and Treasurer
Jeffrey A. Schwaneke	40	Senior Vice President, Corporate Controller and Chief Accounting Officer
Keith H. Williamson	63	Executive Vice President, General Counsel and Secretary

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

K. Rone Baldwin. Mr. Baldwin has served as our Executive Vice President, Markets since January 2016. From December 2012 to January 2016, he served as our Executive Vice President, Insurance Group Business Unit. Prior to joining Centene, he served as Executive Vice President and Business Leader of Group Insurance Business, which included both group health and ancillary product lines, for Guardian Life Insurance Company, which he joined in 2006.

Cynthia J. Brinkley. Ms. Brinkley has served as our Executive Vice President, Global Corporate Development since January 2016. From November 2014 to January 2016, she served as Executive Vice President, International Operations and Business Integration. Prior to joining Centene, she served as Vice President of Global Human Resources at General Motors from 2011 to 2014. She previously held various positions of increasing responsibility at AT&T including Senior Vice President of Talent Development/Chief Diversity Officer and President of AT&T's

operations in both Missouri and Arkansas.

Carol E. Goldman. Ms. Goldman is our Executive Vice President and Chief Administrative Officer and has served in that capacity since June 2007.

Jesse N. Hunter. Mr. Hunter has served as our Executive Vice President, Products since January 2016. From December 2012 to January 2016, he serviced as Executive Vice President, Chief Business Development Officer. From February 2012 to December 2012, he served as our Executive Vice President, Operations. He previously served as our Executive Vice President, Corporate Development from April 2008 to February 2012.

William N. Scheffel. Mr. Scheffel is our Executive Vice President, Chief Financial Officer and Treasurer and has served in that capacity since May 2009. Mr. Scheffel is expected to retire in early 2016.

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Jeffrey A. Schwaneke. Mr. Schwaneke is our Senior Vice President, Corporate Controller and has served in that capacity since July 2008 and has been our Chief Accounting Officer since September 2008. Mr. Schwaneke will assume the role of Executive Vice President, Chief Financial Officer and Treasurer upon Mr. Scheffel's retirement in early 2016.

Keith H. Williamson. Mr. Williamson has served as our Executive Vice President, General Counsel and Secretary since November 2012. He served as Senior Vice President and General Counsel from November 2006 to November 2012.

Available Information

We are subject to the reporting and information requirements of the Securities Exchange Act of 1934, as amended (Exchange Act) and, as a result, we file periodic reports and other information with the Securities and Exchange Commission, or SEC. We make these filings available on our website free of charge, the URL of which is http://www.centene.com, as soon as reasonably practicable after we electronically file such material with, or furnish it to, the SEC. The SEC maintains a website (http://www.sec.gov) that contains our annual, quarterly and current reports and other information we file electronically with the SEC. You can read and copy any materials we file with the SEC at the SEC's Public Reference Room at 100 F Street, N.E., Room 1850, Washington, D.C. 20549. You may obtain information on the operation of the Public Reference Room by calling the SEC at 1-800-SEC-0330. Information on our website does not constitute part of this Annual Report on Form 10-K.

ITEM 1A. Risk Factors

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

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

Reductions in funding or changes to eligibility requirements for government sponsored healthcare programs in which we participate could substantially affect our financial position, results of operations and cash flows.

The majority of our revenues come from government subsidized healthcare programs including Medicaid, Medicare, CHIP, LTC, ABD, Foster Care and Health Insurance Marketplace premiums. 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, with the federal share currently averaging around 57%.

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, CHIP, LTC, ABD and Foster Care. Adverse economic conditions may continue to put pressures on state budgets as tax and other state revenues decrease while the population that is eligible to participate in these programs increases, creating more need for funding. We anticipate this will require government agencies to find funding alternatives, which may result in reductions in funding for programs, contraction of covered benefits, and limited or no premium rate increases or premium rate decreases. A

reduction (or less than expected increase), a protracted delay, or a change in allocation methodology in government funding for these programs, as well as termination of the contract for the convenience of the government, may materially and adversely affect our results of operations, financial position and cash flows.

Additionally, changes in these programs could reduce the number of persons enrolled in or eligible for these programs or increase our administrative or healthcare costs under these programs. Recent legislation generally requires that eligibility levels be maintained, but this 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.

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Lastly, if a federal government shutdown were to occur for a prolonged period of time, federal government payment obligations, including its obligations under Medicaid, Medicare, CHIP, LTC, ABD, Foster Care and the new 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.

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

Our profitability, to a significant degree, depends on our ability to estimate and effectively manage expenses related to health benefits through our ability to contract favorably with hospitals, physicians and other healthcare providers. For example, our Medicaid revenue is often based on bids submitted before the start of the initial contract year. If our actual medical expense exceeds our estimates, our health benefits ratio, or our expenses related to medical services as a percentage of premium revenue, would increase and our profits would decline. Because of the narrow margins of our health plan business, relatively small changes in our health benefits ratio can create significant changes in our financial results. Changes in healthcare regulations and practices, the level of utilization of healthcare services, hospital and pharmaceutical costs, major epidemics or pandemics, new medical technologies, pharmaceutical compounds and other external factors, including general economic conditions such as inflation and unemployment levels, are beyond our control and could reduce our ability to accurately predict and effectively control the costs of providing health benefits.

Our medical expense includes claims reported but not paid, estimates for claims incurred but not reported, and estimates for the costs necessary to process unpaid claims at the end of each period. Our development of the medical claims liability estimate is a continuous process which we monitor and refine on a monthly basis as claims receipts and payment information as well as inpatient acuity information becomes available. As more complete information becomes available, we adjust the amount of the estimate, and include the changes in estimates in medical expense in the period in which the changes are identified. However, we still cannot be sure that our medical claims liability estimate is adequate or that adjustments to the estimate will not unfavorably impact our results of operations.

Additionally, when we commence operations in a new state, region or product, we have limited information with which to estimate our medical claims liability. For a period of time after the inception of the new business, we base our estimates on state-provided historical actuarial data and limited actual incurred and received claims and inpatient acuity information. The addition of new categories of individuals who are eligible under new legislation may pose the same difficulty in estimating our medical claims liability. Similarly, we may face difficulty in estimating our medical claims liability in 2016 for the relatively new and evolving Health Insurance Marketplaces.

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

The implementation of the Health Reform Legislation and other reforms could materially and adversely affect our results of operations, financial position and cash flows.

In March 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 generally upheld by the Supreme Court in 2012, the Court determined 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 each states' election. The federal government will pay the entire costs for Medicaid coverage for newly eligible beneficiaries for three years (2014 through 2016). Beginning in 2017, the federal share begins to decline, ending at 90% for 2020 and subsequent years. As of December 31, 2015, 31 states and the District of Columbia have expanded Medicaid eligibility, and additional states continue to discuss expansion. The ACA also maintained CHIP eligibility standards through September 2019.

The ACA required the establishment of Health Insurance Marketplaces for individuals and small employers to purchase health insurance coverage commencing in January 2014. The ACA required insurers participating on the Health Insurance Marketplaces to offer a minimum level of benefits and included guidelines on setting premium rates and coverage limitations.

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Our ability to adequately price products offered in the Health Insurance Marketplaces may have a negative impact on our results of operations, financial position and cash flow. We may be adversely selected by individuals who will have a higher acuity level than the anticipated pool of participants. In addition, the risk corridor, reinsurance and risk adjustment ("three Rs") provisions of the ACA established to reduce risk for insurers may not be effective in appropriately mitigating the financial risks related to the Marketplace product. Further, the reinsurance and risk corridor components may not be adequately funded. Any variation from our expectations regarding acuity, enrollment levels, adverse selection, the three Rs, or other assumptions utilized in setting adequate premium rates could have a material adverse effect on our results of operations, financial position and cash flows.

The U.S. Department of Health and Human Services (HHS) has stated that it will consider a limited number of premium assistance demonstration proposals from States that want to privatize Medicaid expansion. States must provide a choice between at least two qualified health plans and offer very similar benefits as those available in the newly created Health Insurance Marketplaces. Arkansas became the first state to obtain federal approval to use Medicaid funding to purchase private insurance for low-income residents and we began operations under the program beginning January 1, 2014.

The ACA imposes an annual insurance industry assessment of $8.0 billion starting in 2014, and $11.3 billion in each of 2015 and 2016, with increasing annual amounts thereafter. Such assessments are not deductible for federal and most state income tax purposes. The fee will be allocated based on health insurers' premium revenues in the previous year. Each health insurer's fee is calculated by multiplying its market share by the annual fee. Market share is based on commercial, Medicare, and Medicaid premium revenue. Not-for-profit insurers may have a competitive advantage since they are exempt from paying the fee if they receive at least 80% of their premium revenue from Medicare, Medicaid, and CHIP, and other not-for-profit insurers are allowed to exclude 50% of their premium revenue from the fee calculation. If we are not reimbursed by the states for the cost of the federal premium assessment (including the associated tax impact), or if we are unable to otherwise adjust our business model to address this new assessment, our results of operations, financial position and cash flows may be materially adversely affected.

There are numerous steps required to implement the legislation, including the promulgation of a substantial number of new and potentially more onerous federal regulations. Further, various health insurance reform proposals are also emerging at the state level. Because of the unsettled nature of these reforms and numerous steps required to implement them, we cannot predict what additional health insurance requirements will be implemented at the federal or state level, or the effect that any future legislation or regulation will have on our business or our growth opportunities. Although we believe the legislation may provide us with significant opportunities to grow our business, the enacted reforms, as well as future regulations and legislative changes, may in fact have a material adverse effect on our results of operations, financial position or liquidity. If we fail to effectively implement 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.

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

requirements.

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

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

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Our contracts with states may require us to maintain a minimum health benefits ratio (HBR) or may require us to share profits in excess of certain levels. In certain circumstances, our plans may be required to return premium back to the state in the event profits exceed established levels or HBR does not meet the minimum requirement. Other states may require us to meet certain performance and quality metrics in order to maintain our contract or receive additional or full contractual revenue.

The governmental healthcare programs in which we participate are subject to the satisfaction of certain regulations and performance standards. For example, under Health Reform Legislation, Congress authorized CMS and the states to implement managed care demonstration programs to serve dually eligible beneficiaries to improve the coordination of their care. Participation in these demonstration programs is subject to CMS approval and the satisfaction of conditions to participation, including meeting certain performance requirements. Our inability to improve or maintain adequate quality scores and star ratings to meet government performance requirements or to match the performance of our competitors could result in limitations to our participation in or exclusion from these or other government programs. Specifically, several of our Medicaid contracts require us to maintain a Medicare health plan. Although we strive to comply with all existing regulations and to meet performance standards applicable to our business, failure to meet these requirements could result in financial fines and penalties. Also, states may not allow us to continue to participate in their government programs, or we may fail to win procurements to participate in such programs which could materially and adversely affect our results of operations, financial position and cash flows.

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

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

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

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

our results of operations, financial position and cash flows.

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If any of our government contracts are terminated or are not renewed or we receive an adverse review, audit or investigation, our business will suffer.

We provide managed care programs and selected services to individuals receiving benefits under governmental assistance programs. We provide those healthcare services under contracts with regulatory entities in the areas in which we operate. Our government contracts are generally intended to run for three years and may be extended for additional years if the contracting entity or its agent elects to do so. When our contracts expire, they may be opened for bidding by competing healthcare providers, and there is no guarantee that our contracts will be renewed or extended. Competitors may buy their way into the market by submitting bids with lower pricing. Even if our responsive bids are successful, the bids may be based upon assumptions or other factors which could result in the contracts being less profitable than we had anticipated. Further, our government contracts contain certain provisions regarding eligibility, enrollment and dis-enrollment processes for covered services, eligible providers, periodic financial and informational reporting, quality assurance, timeliness of claims payment and agreement to maintain a Medicare plan in the state and financial standards 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 and applicable laws and regulations. Any adverse review, audit or investigation could result in: 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; or loss of one or more of our licenses.

If any of our government contracts are terminated, not renewed, renewed on less favorable terms, or not renewed on a timely basis, or we have an adverse review, audit or investigation, our business will suffer, our goodwill could be impaired and our financial position, results of operations or cash flows may be materially affected.

Ineffectiveness of state-operated systems and subcontractors could adversely affect our business.

Our health plans rely on other state-operated systems or subcontractors to qualify, solicit, educate and assign eligible members into managed care plans. The effectiveness of these state operations and subcontractors can have a material effect on a health plan’s enrollment in a particular month or over an extended period. When a state implements new programs to determine eligibility, new processes to assign or enroll eligible members into health plans, or chooses new subcontractors, there is an increased potential for an unanticipated impact on the overall number of members assigned to managed care plans.

Our investment portfolio may suffer losses which could materially and adversely affect our results of operations or liquidity.

We maintain a significant investment portfolio of cash equivalents and short term and long term investments in a variety of securities, which are subject to general credit, liquidity, market and interest rate risks and will decline in value if interest rates increase or one of the issuers’ credit ratings is reduced. As a result, we may experience a reduction in value or loss of our investments, which may have a negative adverse effect on our results of operations, liquidity and financial condition.

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

Our growth strategy includes the acquisition 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.

Although we review the records of companies or businesses we plan to acquire, it is possible that we could assume unanticipated liabilities or adverse operating conditions, or an acquisition may not perform as well as expected or may not achieve timely profitability. We also face the risk that we will not be able to effectively integrate acquisitions into our existing operations effectively without substantial expense, delay or other operational or financial problems and we may need to divert more management resources to integration than we planned.

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

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

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

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

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

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

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

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

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

We derive a majority of our premium revenues from operations in a limited number of states, and our financial position, results of operations or cash flows would be materially affected by a decrease in premium revenues or profitability in any one of those states.

Operations in a limited number of states have accounted for most of our premium revenues to date. If we were unable to continue to operate in any of our current 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 revenue 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 bid out their Medicaid program 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. In addition, the impact of healthcare reform legislation and potential growth in our segment may attract new competitors.

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Some of the health plans with which we compete have greater financial and other resources and offer a broader scope of products than we do. In addition, significant merger and acquisition activity has occurred in the managed care industry, as well as complementary industries, such as the hospital, physician, pharmaceutical, medical device and health information systems businesses. To the extent that competition intensifies in any market that we serve, as a result of industry consolidation or otherwise, our ability to retain or increase members and providers, or maintain or increase our revenue growth, pricing flexibility and control over medical cost trends may be adversely affected.

If we are unable to maintain relationships with our provider networks, our profitability may be harmed.

Our profitability depends, in large part, upon our ability to contract at competitive prices with hospitals, physicians and other healthcare providers. Our provider arrangements with our primary care physicians, specialists and hospitals generally may be canceled by either party without cause upon 90 to 120 days prior written notice. We cannot provide any assurance that we will be able to continue to renew our existing contracts or enter into new contracts on a timely basis or under favorable terms enabling us to service our members profitably. Healthcare providers with whom we contract may not properly manage the costs of services, maintain financial solvency or avoid disputes with other providers. Any of these events could have a material adverse effect on the provision of services to our members and our operations.

In any particular market, physicians and other healthcare providers could refuse to contract, demand higher payments, or take other actions that could result in higher medical costs or difficulty in meeting regulatory or accreditation requirements. 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. In addition, we are aware that other managed care organizations have been subject to class action lawsuits by healthcare providers with respect to claim payment procedures, and we may be subject to similar lawsuits. Regardless of whether any 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, we may incur significant expenses and may be unable to operate our business effectively. 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.

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

We are highly dependent on our ability to attract and retain qualified personnel to operate and expand our business. We would be adversely impacted if we are unable to adequately plan for the succession of our executives and senior management. While we have succession plans in place for members of our executive and senior management team, these plans do not guarantee that the services of our executive and senior management team will continue to be

available to us. Our ability to replace any departed members of our executive and senior management or other key employees may be difficult and may take an extended period of time because of the limited number of individuals in the managed care and specialty services industry with the breadth of skills and experience required to operate and successfully expand a business such as ours. Competition to hire from this limited pool is intense, and we may be unable to hire, train, retain or motivate these personnel. If we are unable to attract, retain and effectively manage the succession plans for key personnel, executives and senior management, our business and financial position, results of operations or cash flows could be harmed.

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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 are unable to properly maintain or expand our information systems, we could suffer, among other things, operational disruptions, loss of existing members and difficulty in attracting new members, regulatory problems and increases in administrative expenses. In addition, our ability to integrate and manage our information systems may be impaired as the result of events outside our control, including acts of nature, such as earthquakes or fires, or acts of terrorists.

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

We are a defendant from time to time in lawsuits and regulatory actions relating to our business, including, without limitation, medical malpractice claims. Due to the inherent uncertainties of litigation and regulatory proceedings, we cannot accurately predict the ultimate outcome of any such proceedings. An unfavorable outcome could have a material adverse impact on our business and financial position, results of operations or cash flows. In addition, regardless of the outcome of any litigation or regulatory proceedings, such proceedings are costly and time consuming and require significant attention from our management, and could therefore harm our business and financial position, results of operations or cash flows.

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

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

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

As part of our normal operations, we collect, process and retain confidential member information. We are subject to various federal and state laws and rules regarding the use and disclosure of confidential member information, including the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act and the Gramm-Leach-Bliley Act, which require us to protect the privacy of medical records and safeguard personal health information we maintain and use. Certain of our businesses are also subject to the Payment Card Industry Data Security Standard, which is a multifaceted security standard that is designed to protect credit card account data as mandated by payment card industry entities. Despite our best attempts

to maintain adherence to information privacy and security best practices as well as compliance with applicable laws and rules, 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, misplaced or lost data including paper or electronic media, programming and/or human errors or other similar events. In the past, we have had data breaches resulting in disclosure of confidential or protected health information that have not resulted in any material financial loss or penalty to date. However, future data breaches could require us to expend significant resources to remediate any damage, interrupt our operations and damage our reputation, subject us to state or federal agency review and could also result in enforcement actions, material fines and penalties, litigation or other actions which could have a material adverse effect on our business, reputation and results of operations, financial position and cash flows.

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In addition, HIPAA broadened the scope of fraud and abuse laws applicable to healthcare companies. HIPAA created civil penalties for, among other things, billing for medically unnecessary goods or services. HIPAA established new enforcement mechanisms to combat fraud and abuse, including civil and, in some instances, criminal penalties for failure to comply with specific standards relating to the privacy, security and electronic transmission of protected health information. The HITECH Act expanded the scope of these provisions by mandating individual notification in instances of breaches of protected health information, providing enhanced penalties for HIPAA violations, and granting enforcement authority to states' Attorneys General in addition to the HHS Office for Civil Rights. It is possible that Congress may enact additional legislation in the future to increase penalties and to create a private right of action under HIPAA, which could entitle patients to seek monetary damages for violations of the privacy rules. In addition, HHS has announced that it will continue its audit program to assess HIPAA compliance efforts by covered entities with a focus on security risk assessments. Although we are not aware of HHS plans to audit any of our covered entities, an audit resulting in findings or allegations of noncompliance could have a material adverse effect on our results of operations, financial position and cash flows.

Under HIPAA, health plans 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 to version 5010 prior to the implementation of the ICD-10 coding system. While we transitioned to the ICD-10 coding system in October 2015, if unforeseen circumstances arise, it is possible that we could be exposed to investigations and allegations of noncompliance. In addition, if some providers continue to use ICD-9 codes on claims after October 1, 2015, we may have to reject such claims, which may lead to claim resubmissions, increased call volume and provider and customer dissatisfaction. Further, providers may use ICD-10 codes differently than they used ICD-9 codes in the past, which could result in higher costs and reimbursement levels, or lost revenues under risk adjustment. As a result, the changes and complications associated with the transition to ICD-10 may have a material adverse effect on our results of operations, financial position and cash flows.

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

Companies involved in public health care programs are often the subject of fraud 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 and abuse laws applicable to us could result in civil monetary penalties, criminal fines and imprisonment, and/or exclusion from participation in Medicaid, Medicare, other federal health care programs and federally funded state health programs. Fraud and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical services, improper marketing and violations of patient privacy rights. These fraud and abuse laws include the federal False Claims Act, which prohibits the known filing of a false claim or the known use of false statements to obtain payment from the federal government. Many states have false claim act statutes that closely resemble the federal False Claims Act. In addition, the Deficit Reduction Act of 2005 encourages states to enact state-versions of the federal False Claims Act that establish liability to the state for false and fraudulent Medicaid claims and that provide for, among other things, claims to be filed by qui tam relators. Federal and state governments have made investigating and prosecuting health care fraud and abuse a priority. In the event we fail to comply with the extensive federal and state fraud and abuse laws, our business, reputation, results of operations, financial position and cash flows could be materially and adversely affected.

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

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

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Security breaches may arise from external or internal threats. External breaches include hacking personal information for financial gain, attempting to cause harm to our operations, or intending to obtain competitive information. We experience attempted external hacking or malicious attacks on a regular basis. We maintain a rigorous system of preventive and detective controls through our security programs; however, our prevention and detection controls may not prevent or identify all such attacks. 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.

Consummation of the merger with Health Net is subject to receipt of regulatory approvals and certain other conditions and we cannot predict when or if such conditions will be satisfied or waived or if, in connection with the receipt of necessary approvals, regulators will impose conditions on us that have an adverse effect on our business.

Consummation of the merger with Health Net is subject to receipt of certain remaining regulatory approvals and certain other conditions, including, among others:

- certain filings or consents required for the consummation of the Merger and the other transactions under applicable state and foreign insurance and health care regulatory laws having been made or obtained; and
- certain other customary conditions.

We cannot provide any assurance that the merger will be completed, that there will not be a delay in the completion of the merger or that all or any of the anticipated benefits of the merger will be realized. Any delay could also, among other things, result in additional transaction costs, loss of revenue or other negative effects associated with uncertainty about completion of the merger. In the event the merger agreement is terminated or the transaction is materially delayed for any reason, the price of our common stock may be impacted. Regulatory authorities reviewing the merger may refuse to permit the merger or may impose restrictions or conditions on the merger that may adversely affect the Company if the merger is completed.

We may be unable to successfully integrate our business with Health Net and realize the anticipated benefits of the merger.

The success of the merger will depend, in part, on our ability to successfully combine the businesses of the Company and Health Net, which currently operate as independent public companies, and realize the anticipated benefits, including synergies, cost savings, innovation and operational efficiencies, from the combination. If we are unable to achieve these objectives within the anticipated time frame, or at all, the anticipated benefits may not be realized fully or at all, or may take longer to realize than expected and the value of our common stock may be harmed.

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

- the diversion of management's attention from ongoing business concerns and performance shortfalls at one or both of the companies as a result of the devotion of management's attention to the merger;
- managing a larger combined company;
- maintaining employee morale and retaining key management and other employees;
- the possibility of faulty assumptions underlying expectations regarding the integration process;
- retaining existing business and operational relationships and attracting new business and operational relationships;
- consolidating corporate and administrative infrastructures and eliminating duplicative operations;
- coordinating geographically separate organizations;
- unanticipated issues in integrating information technology, communications and other systems;
- unanticipated changes in federal or state laws or regulations, including the ACA and the Health Care Education Affordability Reconciliation Act and any regulations enacted thereunder; and

- unforeseen expenses or delays associated with the merger.

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.

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We and Health Net are currently permitted to conduct only limited planning for the integration of the two companies following the merger and have not yet fully determined the exact nature of how the businesses and operations of the two companies will be combined after the merger. The actual integration may result in additional and unforeseen expenses, and the anticipated benefits of the integration plan may not be realized.

Our financial results after the merger will depend on our ability to maintain our and Health Net's business and operational relationships.

A substantial portion of each of our and Health Net's revenues are received under contracts with states. Our success following the merger will depend in part on our ability to maintain these state contracts and other business and operational relationships, including those of Health Net. Health Net's state contracts and other business and operational relationships may have termination or other rights that may be triggered by the merger, or the states or other business and operational relationships may decide not to renew their existing relationships with Health Net or, after the merger, with us. If Health Net (prior to the completion of the merger) and we (after the completion of the merger) are unable to maintain these contracts and other business and operational relationships, our financial position, results of operations or cash flows could be materially affected.

We are expected to incur substantial expenses related to the completion of the merger and the integration of Health Net.

We are expected to incur substantial expenses in connection with the completion of the merger and the integration of Health Net. There are a large number of processes, policies, procedures, operations, technologies and systems that must be integrated, including purchasing, accounting and finance, sales, payroll, pricing, revenue management, marketing and benefits. In addition, the businesses of Centene and Health Net will continue to maintain a presence in St. Louis, Missouri and Woodland Hills, California, respectively. The substantial majority of these costs will be non-recurring expenses related to the merger (including financing of the merger), facilities and systems consolidation costs. We may incur additional costs to maintain employee morale and to retain key employees. We will also incur transaction fees and costs related to formulating integration plans for the combined business, and the execution of these plans may lead to additional unanticipated costs. Additionally, as a result of the merger, rating agencies may take negative actions with regard to our credit ratings. This may increase our costs in connection with the financing of the merger. These incremental transaction and merger-related costs may exceed the savings the combined company expects to achieve from the elimination of duplicative costs and the realization of other efficiencies related to the integration of the businesses, particularly in the near term and in the event there are material unanticipated costs.

Failure to complete the merger could impact our stock price and our future business and financial position, results of operations and cash flows.

If the merger is not completed or our financing for the transaction becomes unavailable, our ongoing business and financial position, results of operations and cash flows may be materially affected and we will be subject to a number of risks, including the following:

- depending on the reasons leading to such termination we could be liable to Health Net for termination fees in connection with the termination of the merger agreement;
- we could be responsible for the transaction costs relating to the merger, whether or not the merger is completed;
- while the merger agreement is in force, we are subject to certain restrictions on the conduct of our business, which may adversely affect our ability to execute certain of our business strategies;
- the market price of our common stock could decline to the extent that the current market price reflects, and is positively affected by, a market assumption that the transactions contemplated by the merger will be completed; and
- matters relating to the merger (including integration planning) may require substantial commitments of time and resources by our management, whether or not the merger is completed, which could otherwise have been devoted to other opportunities that may have been beneficial to us.

In addition, if the merger is not completed, we may experience negative reactions from the financial markets and from our providers, members and employees. We may also be subject to litigation related to any failure to complete the merger or to enforcement proceedings commenced against us to perform our obligations under the merger agreement. If the merger is not completed, these risks may materialize and may materially affect our financial position, results of

operations and cash flows, as well as the price of our common stock.

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The market price of our common stock may decline as a result of the merger with Health Net.

The market price of the common stock of our company may decline as a result of the merger if, among other things, we are unable to achieve the expected growth in earnings, or if the operational cost savings estimates in connection with the integration of Health Net's business with ours are not realized, or if the transaction costs related to the merger are greater than expected, or if the financing related to the transaction is on unfavorable terms. The market price also may decline if we do not achieve the perceived benefits of the merger as rapidly or to the extent anticipated by financial or industry analysts or if the effect of the merger on our financial position, results of operations or cash flows is not consistent with the expectations of financial or industry analysts.

The merger will substantially reduce the percentage ownership interests of our current stockholders; it may not be accretive and may cause dilution to our earnings per share, which may negatively affect the market price of our common stock.

Our stockholders have the right to vote in the election of our Board of Directors and on certain other matters affecting the Company. If the merger is completed we will pay approximately $5.5 billion and Health Net's stockholders are expected to hold approximately 29% of the common stock of the Company after the merger. As a result, if the merger is completed, our pre-merger stockholders will own a smaller proportion of our outstanding common stock than the proportion of our outstanding common stock they owned before the merger and, as a result, they will have less influence on our management and policies following the merger than they now have on our management and policies. We currently anticipate that the merger will be accretive to our earnings per share. This expectation is based on preliminary estimates which may materially change. We could also encounter additional transaction and integration-related costs or other factors such as the failure to realize all of the benefits anticipated in the merger, or unforeseen liabilities or other issues existing or arising with the business of Health Net or otherwise resulting from the merger. All of these factors could cause dilution to our earnings per share or decrease or delay the expected accretive effect of the merger and cause a decrease in the price of our common stock.

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

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

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

Following the completion of the merger, the size of the combined company's business will be significantly larger than the current size of either Centene's or Health Net's respective businesses. The combined company's ability to successfully manage this expanded business will depend, in part, upon management's ability to design and implement strategic initiatives that address not only the integration of two discrete companies, but also the increased scale and scope of the combined business with its associated increased costs and complexity. There can be no assurances that the combined company will be successful or that it will realize the expected operating efficiencies, cost savings and other benefits currently anticipated from the merger.

The combined company will be significantly more leveraged than Centene is currently.

Upon completion of the merger, the combined company expects to incur approximately $2,382 million in additional indebtedness. The combined company will have consolidated indebtedness of approximately $4,136 million, which is greater than the current indebtedness of Centene prior to the merger. The increased indebtedness and higher debt-to-equity ratio of the combined company in comparison to that of Centene on a historical basis will have the effect, among other things, of reducing the flexibility of Centene to respond to changing business and economic conditions and increasing borrowing costs.

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Item 1B. Unresolved Staff Comments

None.

Item 2. Properties

We own our corporate office headquarters buildings and land located in St. Louis, Missouri. 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 are adequate to meet our operational needs for the foreseeable future.

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Item 3. Legal Proceedings

On July 5, 2013, the Company's subsidiary, Kentucky Spirit Health Plan, Inc. (Kentucky Spirit), terminated its contract with the Commonwealth of Kentucky (the Commonwealth). Kentucky Spirit believes it had a contractual right to terminate the contract and filed a lawsuit in Franklin Circuit Court seeking a declaration of this right. The Commonwealth has alleged that Kentucky Spirit's exit constitutes a material breach of contract. The Commonwealth seeks to recover substantial damages and to enforce its rights under Kentucky Spirit's $25 million performance bond. The Commonwealth's attorneys have asserted that the Commonwealth's expenditures due to Kentucky Spirit's departure range from $28 million to $40 million plus interest, and that the associated CMS expenditures range from $92 million to $134 million. Kentucky Spirit disputes the Commonwealth's alleged damages, and filed a lawsuit in April 2013, amended in October 2014, in Franklin Circuit Court seeking damages against the Commonwealth for losses sustained due to the Commonwealth's alleged breaches.

On February 6, 2015, the Kentucky Court of Appeals affirmed a Franklin Circuit Court ruling that Kentucky Spirit does not have a contractual right to terminate the contract early. The Court of Appeals also found that the contract’s liquidated damages provision “is applicable in the event of a premature termination of the Contract term.” On September 8, 2015, Kentucky Spirit filed a motion for discretionary review seeking Kentucky Supreme Court review of the finding that Kentucky Spirit's departure constituted a breach of contract. On October 9, 2015, the Commonwealth filed a response opposing discretionary review.

On May 26, 2015, the Commonwealth issued a demand for indemnification to its actuarial firm for "all defense costs, and any resultant monetary awards in favor of Kentucky Spirit, arising from or related to Kentucky Spirit's claims which are predicated upon the alleged omissions and errors in the Data Book and the certified actuarially sound rates." On August 19, 2015, the actuarial firm moved to intervene in the litigation. The Franklin Circuit Court granted the actuarial firm's motion on September 8, 2015 and ordered a forty-five day stay of all pretrial proceedings in order for the firm to review the record. Also, on August 19, 2015, the actuarial firm filed a petition seeking a declaratory judgment that it is not liable to the Commonwealth for indemnification related to the claims asserted by Kentucky Spirit against the Commonwealth. On October 5, 2015, the Commonwealth filed an answer to the actuarial firm's petition and asserted counterclaims/cross-claims against the firm.

On March 9, 2015, the Secretary of the Kentucky Cabinet for Health and Family Services (CHFS) issued a determination letter finding that Kentucky Spirit owed the Commonwealth $40 million in actual damages plus prejudgment interest at 8 percent. On March 18, 2015, in a letter to the Kentucky Finance and Administration Cabinet (FAC), Kentucky Spirit contested CHFS' jurisdiction to make such a determination. The FAC did not issue a decision within the required 120 days. On August 13, 2015, Kentucky Spirit filed a declaratory judgment action against the Commonwealth in Franklin Circuit Court seeking a declaration that the Commonwealth may not purport to issue a decision against Kentucky Spirit awarding damages to itself when the matter is already before the Kentucky courts, and that the Commonwealth has waived its claims against Kentucky Spirit for damages arising out of the contract. The Commonwealth filed counterclaims seeking a Declaration of Rights and Entry of Judgment on its determination letter. On December 1, 2015, the Franklin Circuit Court consolidated this declaratory judgment action with Kentucky Spirit's other litigation claims against the Commonwealth. On December 15, 2015, the Franklin Circuit Court denied Kentucky Spirit's motion to dismiss the Commonwealth's counterclaim for Declaration of Rights and Entry of Judgment. Discovery is proceeding in the consolidated litigation matters.

The resolution of the Kentucky litigation matters may result in a range of possible outcomes. If Kentucky Spirit prevails on its claims, it would be entitled to damages. If the Commonwealth prevails, a liability to the Commonwealth could be recorded. The Company is unable to estimate the ultimate outcome resulting from the Kentucky litigation. As a result, the Company has not recorded any receivable or any liability for potential damages

under the contract as of December 31, 2015. While uncertain, the ultimate resolution of the pending litigation could have a material effect on the financial position, cash flow or results of operations of the Company in the period it is resolved or becomes known.

Excluding the Kentucky matters discussed above, the Company is also routinely subjected to legal proceedings in the normal course of business. While the ultimate resolution of such matters in the normal course of business is uncertain, the Company does not expect the results of any of these matters individually, or in the aggregate, to have a material effect on its financial position, results of operations or cash flows.

Item 4. Mine Safety Disclosures

Not applicable.

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PART II

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

Market for Common Stock; Dividends

Our common stock has been traded and quoted on the New York Stock Exchange under the symbol “CNC” since October 16, 2003. On February 2, 2015, the Board of Directors declared a two-for-one split of Centene's common stock in the form of a 100% stock dividend distributed February 19, 2015 to stockholders of record on February 12, 2015. All share, per share and stock price information presented in this Form 10-K has been adjusted for the two-for-one stock split. The high and low prices, as reported by the NYSE, are set forth below for the periods indicated.

	2016 Stock Price (through February 17, 2016)		2015 Stock Price		2014 Stock Price	
	High	Low	High	Low	High	Low
First Quarter	$68.42	$47.36	$71.66	$51.73	$33.18	$28.44
Second Quarter			82.18	61.85	38.84	27.56
Third Quarter			83.00	50.93	41.99	35.49
Fourth Quarter			67.53	51.75	54.24	37.53

As of February 17, 2016, there were 322 holders of record of our common stock.

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

Issuer Purchases of Equity Securities

In 2009, the Company's Board of Directors extended the Company's stock repurchase program. The program authorizes the repurchase of up to 8,000,000 shares of the Company's common stock from time to time on the open market or through privately negotiated transactions. We have 3,335,448 available shares remaining under the program for repurchases as of December 31, 2015. 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, 2015, we did not repurchase any shares through this publicly announced program.

Issuer Purchases of Equity Securities
Fourth Quarter 2015

Period	Total Number of Shares Purchased[1]	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number of Shares that May Yet Be Purchased Under the Plans or Programs[2]
October 1 – October 31, 2015	8,959	$57.77	—	3,335,448
November 1 – November 30, 2015	10,759	59.95	—	3,335,448
December 1 – December 31, 2015	754,235	57.46	—	3,335,448
Total	773,953	$57.50	—	3,335,448

(1) Shares acquired represent shares relinquished to the Company by certain employees for payment of taxes or option cost upon vesting of restricted stock units or option exercise.
(2) Our Board of Directors adopted a stock repurchase program which allows for repurchases of up to a remaining amount of 3,335,448 shares. No duration has been placed on the repurchase program.

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Stock Performance Graph

The graph below compares the cumulative total stockholder return on our common stock for the period from December 31, 2010 to December 31, 2015 with the cumulative total return of the New York Stock Exchange Composite Index and the Standard & Poor's Supercomposite Managed Healthcare Index over the same period. The graph assumes an investment of $100 on December 31, 2010 in our common stock (at the last reported sale price on such day), the New York Stock Exchange Composite Index and the Standard & Poor's Supercomposite Managed Healthcare Index and assumes the reinvestment of any dividends.

	December 31,					
	2010	2011	2012	2013	2014	2015
Centene Corporation	$100.00	$156.27	$161.80	$232.68	$409.87	$519.42
New York Stock Exchange Composite Index	100.00	93.89	106.02	130.59	136.10	127.37
S&P Supercomposite Managed Healthcare Index	100.00	133.96	140.46	203.83	271.09	325.43
Centene Corporation closing stock price	$12.67	$19.80	$20.50	$29.48	$51.93	$65.81
Centene Corporation annual shareholder return	19.6 %	56.3 %	3.5 %	43.8 %	76.2 %	26.7 %

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.

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Item 6. Selected Financial Data

The following selected consolidated financial data should be read in conjunction with the consolidated financial statements and related notes and “Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations” included in our Annual Report on Form 10-K. The assets, liabilities and results of operations of Kentucky Spirit Health Plan have been classified as discontinued operations for all periods presented.

	Year Ended December 31,				
	2015	2014	2013	2012	2011
	(In millions, except share data)				
Revenues:					
Premium	$19,389	$14,198	$10,153	$7,569	$4,948
Service	1,876	1,469	373	113	104
Premium and service revenues	21,265	15,667	10,526	7,682	5,052
Premium tax and health insurer fee	1,495	893	337	428	159
Total revenues	22,760	16,560	10,863	8,110	5,211
Expenses:					
Medical costs	17,242	12,678	8,995	6,781	4,191
Cost of services	1,621	1,280	327	88	78
General and administrative expenses	1,826	1,314	931	705	578
Premium tax expense	1,151	698	333	428	161
Health insurer fee expense	215	126	—	—	—
Total operating expenses	22,055	16,096	10,586	8,002	5,008
Earnings from operations	705	464	277	108	203
Other income (expense):					
Investment and other income	35	28	19	35	13
Debt extinguishment costs	—	—	—	—	(8)
Interest expense	(43)	(35)	(27)	(20)	(20)
Earnings from continuing operations, before income tax expense	697	457	269	123	188
Income tax expense	339	196	107	47	71
Earnings from continuing operations, net of income tax expense	358	261	162	76	117
Discontinued operations, net of income tax expense (benefit) of $(1), $1, $2, $(48), and ($4), respectively	(1)	3	4	(87)	(9)
Net earnings (loss)	357	264	166	(11)	108
(Earnings) loss attributable to noncontrolling interests	(2)	7	(1)	13	3
Net earnings attributable to Centene Corporation	$355	$271	$165	$2	$111
Amounts attributable to Centene Corporation common shareholders:					
Earnings from continuing operations, net of income tax expense	$356	$268	$161	$89	$120
Discontinued operations, net of income tax expense (benefit)	(1)	3	4	(87)	(9)
Net earnings	$355	$271	$165	$2	$111
Net earnings (loss) per common share attributable to Centene Corporation:					
Basic:					

Continuing operations	$2.99	$2.30	$ 1.49	$0.86	$ 1.20
Discontinued operations	(0.01)	0.03	0.03	(0.84)	(0.09)
Basic earnings per common share	$2.98	$2.33	$ 1.52	$0.02	$ 1.11
Diluted:					
Continuing operations	$2.89	$2.23	$ 1.43	$0.83	$ 1.15
Discontinued operations	(0.01)	0.02	0.04	(0.81)	(0.09)
Diluted earnings per common share	$2.88	$2.25	$ 1.47	$0.02	$ 1.06
Weighted average number of common shares outstanding:					
Basic	119,100,744	116,345,764	108,253,090	103,018,732	100,397,908
Diluted	123,066,370	120,360,212	112,494,346	107,428,750	104,948,476

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	December 31,				
	2015	2014	2013	2012	2011
	(In millions)				
Consolidated Balance Sheet Data:					
Cash and cash equivalents [1]	$1,760	$1,610	$974	$746	$494
Investments and restricted deposits [1]	2,218	1,557	941	727	653
Total assets	7,339	5,824	3,519	2,764	2,182
Medical claims liability [1]	2,298	1,723	1,112	815	519
Long term debt [1]	1,216	874	655	526	341
Total stockholders' equity	2,168	1,743	1,243	954	936

[1] From continuing operations.

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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.

OVERVIEW

In 2013, we classified the operations for Kentucky Spirit Health Plan (KSHP) as discontinued operations for all periods presented in our consolidated financial statements. The following discussion and analysis, with the exception of cash flow information, is presented in the context of continuing operations unless otherwise identified.

On February 2, 2015, the Board of Directors declared a two-for-one split of Centene's common stock in the form of a 100% stock dividend distributed February 19, 2015 to stockholders of record on February 12, 2015. All share, per share and stock price information presented in this Form 10-K has been adjusted for the two-for-one stock split.

Our financial performance for 2015 is summarized as follows:

- Year-end managed care membership of 5.1 million, an increase of over 1.0 million members, or 26% over 2014.
- Premium and service revenues of $21.3 billion, representing 36% growth year over year.
- Health Benefits Ratio of 88.9%, compared to 89.3% in 2014.
- General and Administrative expense ratio of 8.6%, compared to 8.4% in 2014.
- Total operating cash flows of $658 million, or 1.8 times net earnings.
- Diluted net earnings per share of $2.89, or $3.03 excluding $0.14 of diluted EPS of Health Net merger related expenses, compared to $2.23 in 2014.

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

- Arizona. In October 2015, our subsidiary, Cenpatico Integrated Care, in partnership with University of Arizona Health Plan, began operating under a contract with the Arizona Department of Health Services/Division of Behavioral Health Services to be the Regional Behavioral Health Authority for the new southern geographic service area.

- California. In January 2014, California Health and Wellness (CHW), began serving members under the state's Medicaid expansion program. In December 2014, the ABD membership of CHW increased as a result of the mandatory transition of the ABD population to managed care. The enrollment of this population to managed care was previously voluntary.

- Centurion. In January 2014, Centurion began operating under a new agreement with the Minnesota Department of Corrections to provide healthcare services to offenders in the state's correctional facilities. In February 2015, Centurion also began operating under a new contract with the State of Vermont Department of Corrections. In July 2015, Centurion began operating under a new contract with the Mississippi Department of Corrections.

- Florida. In March 2014, our Florida subsidiary, Sunshine Health, completed the implementation of 10 regions under the state's new Medicaid managed care Long Term Care program. In May 2014, Sunshine Health began operating under a new contract in 9 of 11 regions of the Managed Medical Assistance (MMA) program. The MMA program includes TANF recipients as well as ABD and dual-eligible members. In addition, we began operating as the sole provider under a new statewide contract for the Child Welfare Specialty Plan (Foster Care). Enrollment for both the MMA program and Foster Care began in May 2014 and was implemented by region through August 2014.

In October 2015, Sunshine Health began operating under a two-year, statewide contract with the Florida Healthy Kids Corporation to manage healthcare services for children ages five through 18 in all 11 regions of Florida.

- Health Insurance Marketplaces (HIM). In January 2014, we began serving members enrolled in Health Insurance Marketplaces in certain regions of nine states. In 2015, we expanded our participation in Health Insurance Marketplaces to include members in certain regions of 3 additional states.

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- Illinois. In March 2014, our Illinois subsidiary, IlliniCare Health, began operating under a new contract as part of the Illinois Medicare-Medicaid Alignment Initiative serving dual-eligible members in Cook, DuPage, Lake, Kane, Kankakee and Will counties (Greater Chicago region).

In July 2014, IlliniCare Health began operating under a new contract with the Cook County Health and Hospitals System to perform third party administrative services to members enrolled in the CountyCare program, as well as care coordination, behavioral health, vision care and pharmacy benefit management services.

In September 2014, IlliniCare Health began serving additional Medicaid members under the state's Medicaid and Medicaid expansion programs.

- Indiana. In February 2015, our Indiana subsidiary, Managed Health Services, began operating under an expanded contract with the Indiana Family & Social Services Administration to provide Medicaid services under the state's Healthy Indiana Plan 2.0 (HIP 2.0) program.

In April 2015, Managed Health Services began operating under an expanded contract with the Indiana Family & Social Services Administration to provide services to its ABD Medicaid enrollees who qualify for the new Hoosier Care Connect Program.

- Louisiana. In July 2014, we completed the transaction whereby Community Health Solutions of America, Inc. assigned its contract with the Louisiana Department of Health and Hospitals under the Bayou Health Shared Savings Program to our subsidiary, Louisiana Healthcare Connections (LHC).

In February 2015, LHC began operating under a new contract with the Louisiana Department of Health and Hospitals to serve Bayou Health (Medicaid) beneficiaries. Members previously served under the shared savings program were transitioned to the at-risk program on February 1, 2015.

In December 2015, Louisiana Healthcare Connections began operating under an expanded contract to include behavioral health benefits.

- Massachusetts. In January 2014, our CeltiCare Health subsidiary began operating under a new contract with the Massachusetts Executive Office of Health and Human Services to participate in the Medicaid expansion MassHealth CarePlus program in all five regions.

- Michigan. In May 2015, we completed the acquisition of Fidelis SecureCare of Michigan, Inc. (Fidelis). Fidelis began operating under a new contract with the Michigan Department of Community Health and the Centers for Medicare and Medicaid Services to provide integrated healthcare services to members who are dually eligible for Medicare and Medicaid in Macomb and Wayne counties in May 2015. Passive enrollment began in July 2015.

- Mississippi. In July 2014, our Mississippi subsidiary, Magnolia Health, began operating as one of two contractors under a new statewide managed care contract serving members enrolled in the Mississippi Coordinated Access Network program. Program expansion began in December 2014 and continued through July 2015.

In January 2015, Magnolia Health began operating under a new temporary six-month contract with the State of Mississippi to provide services under the Children's Health Insurance Program (CHIP). In July 2015, Magnolia Health began operating under a two-year CHIP contract with the State of Mississippi. In December 2015, Magnolia Health began operating under an expanded contract to include the inpatient benefit for Medicaid and ABD members.

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New Hampshire. In September 2014, our New Hampshire subsidiary, New Hampshire Healthy Families, began serving members under the state's Medicaid expansion program.

Ohio. In January 2014, our Ohio Subsidiary, Buckeye Health Plan (Buckeye), began serving members under the state's Medicaid expansion program. In May 2014, Buckeye began operating under a new contract with the Ohio Department of Medicaid and the Centers for Medicare and Medicaid Services to serve Medicaid members in a dual-eligible demonstration program in three of seven regions: Northeast (Cleveland), Northwest (Toledo) and West Central (Dayton). This three-year program, which is part of the Integrated Care Delivery System expansion, serves those who have both Medicare and Medicaid eligibility. Passive enrollment for Medicaid began in May 2014 and implementation was completed in July 2014. Passive enrollment for Medicare began in January 2015.

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- Oregon. In September 2015, we completed the acquisition of Agate Resources, Inc., a diversified holding company that offers primarily Medicaid and other healthcare products and services to Oregon residents through Trillium Community Health Plan.

- South Carolina. In February 2015, our South Carolina subsidiary, Absolute Total Care, began operating under a new contract with the South Carolina Department of Health and Human Services and the Centers for Medicare and Medicaid Services to serve dual-eligible members as part of the state's dual demonstration program.

- Texas. In September 2014, we began operating under a new contract with the Texas Health and Human Services Commission (HHSC) to expand our operations and serve STAR+PLUS members in two Medicaid Rural Service Areas. We also began providing expanded coverage in September 2014 under our STAR+PLUS contracts to provide acute care services for intellectually and developmentally disabled members. In March 2015, we began operating under an expanded STAR+PLUS contract with the Texas HHSC to include nursing facility benefits.

In March 2015, we also began operating under a new contract with the Texas HHSC and the Centers for Medicare and Medicaid Services to serve dual-eligible members in three counties as part of the state's dual demonstration program.

- U.S. Medical Management. In January 2014, we acquired a majority interest in U.S. Medical Management, LLC, a management services organization and provider of in-home health services for high acuity populations.

- Washington. In January 2014, our subsidiary, Coordinated Care, began serving additional Medicaid members under the state's Medicaid expansion program.

In addition, in July 2014, we completed an investment accounted for under the equity method for the purchase of a noncontrolling interest in Ribera Salud S.A. (Ribera Salud), a Spanish health management group. Centene is a joint shareholder with Ribera Salud's remaining investor, Banco Sabadell S.A.

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

- We expect to realize the full year benefit in 2016 of business commenced during 2015 in Arizona, Florida, Illinois, Indiana, Louisiana, Michigan, Mississippi, Oregon, South Carolina, Texas and Vermont as discussed above.

- In February 2016, our Nebraska subsidiary, Nebraska Total Care, was recommended by the Nebraska Department of Health and Human Services' Division of Medicaid and Long-Term Care as one of three managed care organizations to administer its new Heritage Health program for Medicaid and CHIP enrollees. The contract is expected to commence in the first quarter of 2017, pending regulatory approvals.

- In February 2016, Centurion of Florida, LLC reached a formal agreement to provide correctional healthcare services for the Florida Department of Corrections in Regions 1, 2 and 3. The contract is expected to commence in the second quarter of 2016.

- In January 2016, the governor of Louisiana signed an executive order to expand Medicaid coverage under the Affordable Care Act (ACA) by July 1, 2016.

- In October 2015, our subsidiary, Superior HealthPlan, Inc., was awarded a contract by the Texas HHSC to serve seven delivery areas for STAR Kids Medicaid recipients. The new contract is expected to commence in the second half of 2016.

- In September 2015, our subsidiary, Peach State Health Plan, was one of the Care Management Organizations selected to serve Medicaid recipients enrolled in the Georgia Families, PeachCare for Kids and Planning for Healthy Babies programs. The contract renewal is expected to commence in July 2016, pending regulatory approval. However, the expiration date of the current contract may be extended for up to two six-month periods.

- In August 2015, our subsidiary, Coordinated Care of Washington, was selected by the Washington State Health Care Authority as the sole provider for the Apple Health Foster Care contract. The new contract is expected to commence in April of 2016, pending regulatory approvals.

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- In July 2015, we entered into a definitive merger agreement with Health Net, Inc. (Health Net) under which we will acquire all of the issued and outstanding shares of Health Net. The transaction is valued at approximately $5.5 billion (based on Centene's closing stock price on February 17, 2016), including the assumption of debt. The transaction is expected to close in early 2016.

MEMBERSHIP

From December 31, 2013 to December 31, 2015, we increased our managed care membership by 2.2 million, or 77%. The following table sets forth our membership by state:

	December 31,		
	2015	2014	2013
Arizona	440,900	204,000	163,700
Arkansas	41,900	38,400	—
California	186,000	163,900	97,200
Florida	510,400	425,700	222,000
Georgia	408,600	389,100	318,700
Illinois	207,500	87,800	22,300
Indiana	282,100	197,700	195,500
Kansas	141,000	143,300	139,900
Louisiana	381,900	152,900	152,300
Massachusetts	61,500	48,400	22,600
Michigan	4,800	—	—
Minnesota	9,600	9,500	—
Mississippi	302,200	108,700	78,300
Missouri	95,100	71,000	59,200
New Hampshire	71,400	62,700	33,600
Ohio	302,700	280,100	173,200
Oregon	98,700	—	—
South Carolina	104,000	109,700	91,900
Tennessee	20,000	21,000	20,700
Texas	983,100	971,000	935,100
Vermont	1,700	—	—
Washington	209,400	194,400	82,100
Wisconsin	77,100	83,200	71,500
Total at-risk membership	4,941,600	3,762,500	2,879,800
Non-risk membership	166,300	298,400	—
Total	5,107,900	4,060,900	2,879,800

At December 31, 2015, we served 449,000 members in Medicaid expansion programs in eight states compared to 201,300 members at December 31, 2014 in six states, included in the table above.

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

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	December 31,		
	2015	2014	2013
Medicaid	3,497,500	2,754,900	2,054,700
CHIP & Foster Care	260,900	222,700	275,100
ABD, Medicare & Duals	446,000	392,700	305,300
Health Insurance Marketplaces	146,100	74,500	—
Hybrid Programs	—	18,900	19,000
LTC	75,000	60,800	37,800
Behavioral Health	456,800	197,000	156,600
Correctional Healthcare Services	59,300	41,000	31,300
Total at-risk membership	4,941,600	3,762,500	2,879,800
Non-risk membership	166,300	298,400	—
Total	5,107,900	4,060,900	2,879,800

The following table identifies the Company's dual-eligible membership by line of business. The membership tables above include these members.

	December 31,		
	2015	2014	2013
ABD	112,300	118,300	71,700
LTC	55,100	35,900	28,800
Medicare	11,100	7,200	6,500
Medicaid / Medicare Duals	26,300	3,200	—
Total	204,800	164,600	107,000

The reduction in ABD is the result of members transitioning to Medicaid / Medicare Duals.

From December 31, 2014 to December 31, 2015, our membership increased as a result of:

- product and geographic expansions in Arizona, Florida, Louisiana, Mississippi, South Carolina, and Texas;
- the acquisition of Agate Resources, Inc., our Oregon subsidiary;
- the commencement of HIP 2.0 program in Indiana;
- the commencement of Health Insurance Marketplaces in certain regions of Illinois, Oregon and Wisconsin;
- organic growth in Illinois; and
- the commencement of correctional healthcare service contracts in Mississippi and Vermont.

From December 31, 2013 to December 31, 2014, our membership increased as a result of:

- product and geographic expansions in Florida and Illinois;
- the assignment of members in Louisiana under the CHS transaction;
- the commencement of Medicaid expansion programs in California, Illinois, Massachusetts, New Hampshire, Ohio, and Washington;
- the commencement of Health Insurance Marketplaces in certain regions of nine states: Arkansas, Florida, Georgia, Indiana, Massachusetts, Mississippi, Ohio, Texas and Washington;
- product expansions in Mississippi and Texas;
- organic growth in South Carolina; and
- the commencement of a correctional healthcare service contract in Minnesota.

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RESULTS OF OPERATIONS

The following discussion and analysis is based on our consolidated statements of operations, which reflect our results of operations for each of the three years ended December 31, 2015, prepared in accordance with generally accepted accounting principles in the United States ($ in millions, except per share data):

	2015	2014	2013	% Change 2014-2015	% Change 2013-2014
Premium	$19,389	$14,198	$10,153	37 %	40 %
Service	1,876	1,469	373	28 %	294 %
Premium and service revenues	21,265	15,667	10,526	36 %	49 %
Premium tax and health insurer fee	1,495	893	337	67 %	165 %
Total revenues	22,760	16,560	10,863	37 %	52 %
Medical costs	17,242	12,678	8,995	36 %	41 %
Cost of services	1,621	1,280	327	27 %	291 %
General and administrative expenses	1,826	1,314	931	39 %	41 %
Premium tax expense	1,151	698	333	65 %	110 %
Health insurer fee expense	215	126	—	71 %	n.a.
Earnings from operations	705	464	277	52 %	68 %
Investment and other income, net	(8)	(7)	(8)	(14)%	13 %
Earnings from continuing operations, before income tax expense	697	457	269	53 %	70 %
Income tax expense	339	196	107	73 %	83 %
Earnings from continuing operations, net of income tax	358	261	162	37 %	61 %
Discontinued operations, net of income tax expense (benefit) of $(1), $1, and $2, respectively	(1)	3	4	(133)%	(25)%
Net earnings	357	264	166	35 %	59 %
(Earnings) loss attributable to noncontrolling interests	(2)	7	(1)	129 %	n.m.
Net earnings attributable to Centene Corporation	$355	$271	$165	31 %	64 %
Amounts attributable to Centene Corporation common shareholders:					
Earnings from continuing operations, net of income tax expense	$356	$268	$161	33 %	66 %
Discontinued operations, net of income tax expense (benefit)	(1)	3	4	(133)%	(25)%
Net earnings	$355	$271	$165	31 %	64 %
Diluted earnings (loss) per common share attributable to Centene Corporation:					
Continuing operations	$2.89	$2.23	$1.43	30 %	56 %
Discontinued operations	(0.01)	0.02	0.04	(150)%	(50)%
Total diluted earnings per common share	$2.88	$2.25	$1.47	28 %	53 %

n.a.: not applicable
n.m.: not meaningful

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Revenues and Revenue Recognition

Our health plans generate revenues primarily from premiums we receive from the states in which we operate. We generally receive a fixed premium per member per month pursuant to our state contracts. We generally receive premium payments and recognize premium revenue during the month in which we are obligated to provide services to our members. 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 analyzing submissions of processed claims data to determine the acuity of our membership relative to the entire state's membership. Some contracts allow for additional premiums associated with certain supplemental services provided such as maternity deliveries.

Our contracts with states may require us to maintain a minimum health benefits ratio or may require us to share profits in excess of certain levels. In certain circumstances, our plans may be required to return premium to the state in the event profits exceed established levels. We recognize reductions in revenue in the current period for these programs. 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, which is adjusted on a monthly basis by the states for retroactive additions or deletions to membership data. These eligibility adjustments are estimated monthly and subsequently adjusted 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 specialty services generate revenues under contracts with state 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.

Premium and service revenues collected in advance are recorded as unearned revenue. Premium and service revenues due to us are recorded as premium and related receivables and are recorded net of an allowance based on historical trends and our management's judgment of the collectibility of these accounts. As we generally receive 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 our financial condition or results of operations.

Some states enact premium taxes, similar assessments and provider and hospital pass-through payments, collectively, premium taxes, and these taxes are recorded as a component of revenues as well as operating expenses. Additionally, our insurance subsidiaries are subject to the Affordable Care Act annual Health Insurer Fee (HIF). The Company recognizes revenue associated with the HIF on a straight line basis when we have binding agreements for the reimbursement of the fee, including the “gross-up” to reflect the HIFs non-tax deductible nature. We exclude the HIF and premium taxes from our key ratios as we believe they are a pass-through of costs and not indicative of our operating performance. Collectively, this revenue is recorded as Premium Tax and HIF revenue in the consolidated statement of operations.

The Centers for Medicare and Medicaid Services (CMS) deploys a risk adjustment model that retroactively apportions Medicare premiums paid according to health severity and certain demographic factors. The model pays more for members whose medical history indicates they have certain medical conditions. 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 estimates the amount of risk adjustment based upon the diagnosis and pharmacy data submitted and expected to be submitted to CMS and records revenues on a risk adjusted basis.

Operating Expenses

Medical Costs

Medical costs include payments to physicians, hospitals, and other providers for healthcare and specialty services claims. Medical costs also include estimates of medical expenses incurred but not yet reported, or IBNR, and estimates of the cost to process unpaid claims. We use our judgment to determine the assumptions to be used in the calculation of the required IBNR estimate. The assumptions we consider 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 Medicaid fee schedules, and the incidence of high dollar or catastrophic claims.

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Our development of the IBNR estimate is a continuous process which we monitor and refine on a monthly basis as claims receipts and payment information becomes available. As more complete information becomes available, we adjust the amount of the estimate, and include the changes in estimates in medical expense in the period in which the changes are identified.

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 medical costs.

While we believe our IBNR estimate is appropriate, it is possible future events could require us to make significant adjustments for revisions to these estimates. Accordingly, we cannot assure you that medical costs will not materially differ from our estimates.

Results of operations depend on our ability to manage expenses associated with health benefits and to accurately estimate costs incurred. The Health Benefits Ratio, or HBR, represents medical costs as a percentage of premium revenues (excluding Premium Tax and Health Insurer Fee revenues) and reflects the direct relationship between the premium received and the medical services provided.

Cost of Services

Cost of services expense includes the pharmaceutical costs associated with our pharmacy benefit manager and specialty pharmacy's external revenues and certain direct costs to support the functions responsible for generation of our service revenues. These expenses consist of the salaries and wages of the professionals who provide the services and associated expenses.

General and Administrative Expenses

General and administrative expenses, or G&A, primarily reflect wages and benefits, including stock compensation expense, and other administrative costs associated with our health plans, specialty companies and centralized functions that support all of our business units. Our major centralized functions are finance, information systems and claims processing. G&A expenses also include business expansion costs, such as wages and benefits for administrative personnel, contracting costs, and information technology buildouts, incurred prior to the commencement of a new contract or health plan.

The G&A expense ratio represents G&A expenses as a percentage of premium and service revenues, and reflects the relationship between revenues earned and the costs necessary to earn those revenues.

Health Insurer Fee

The Health Insurer Fee reflects the annual fee mandated by the ACA to health insurers. The fee is determined based on our premium revenues in the previous year. Each health insurer's fee is calculated by multiplying its market share by the annual fee. Market share is based on commercial, Medicare, and Medicaid premium revenue.

Other Income (Expense)

Other income (expense) consists principally of investment income from cash and investments, earnings in equity method investments, and interest expense on debt.

Discontinued Operations

Our subsidiary, Kentucky Spirit Health Plan (KSHP), ceased serving Medicaid members in Kentucky as of July 6, 2013. Accordingly, the results of operations for KSHP are classified as discontinued operations for all periods presented in our consolidated financial statements. The following discussion and analysis is presented primarily in the context of continuing operations unless otherwise identified.

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Year Ended December 31, 2015 Compared to Year Ended December 31, 2014

Premium and Service Revenues

Premium and service revenues increased 36% in the year ended December 31, 2015 over the corresponding period in 2014 primarily as a result of the impact from expansions or new programs in many of our states, particularly, Florida, Illinois, Indiana, Louisiana, Mississippi, Ohio and Texas. During the year ended December 31, 2015, we received premium rate adjustments which yielded a net 1% composite change across all of our markets.

Operating Expenses

Medical Costs

Results of operations depend on our ability to manage expenses associated with health benefits and to accurately estimate costs incurred. The Health Benefits Ratio, or HBR, represents medical costs as a percentage of premium revenues (excluding Premium Tax and Health Insurer Fee revenues) and reflects the direct relationship between the premium received and the medical services provided. The table below depicts the HBR for our membership by member category for the year ended December 31,:

	2015		2014	
Medicaid, CHIP, Foster Care & HIM	86.0	%	86.3	%
ABD, LTC and Medicare	92.9		93.5	
Specialty Services	85.8		85.5	
Total	88.9		89.3	

The consolidated HBR for the year ended December 31, 2015 of 88.9% was a decrease of 40 basis points over the comparable period in 2014. The decrease compared to last year is primarily attributable to improvement in medical expense in the high acuity populations (LTC/MMP) and membership growth in Medicaid expansion programs and Health Insurance Marketplace, which operate at a lower HBR than traditional Medicaid businesses.

Cost of Services

Cost of services increased by $341 million in the year ended December 31, 2015, compared to the corresponding period in 2014. This was primarily due to growth in the AcariaHealth business. The cost of service ratio for the year ended December 31, 2015, was 86.4% compared to 87.1% in 2014.

General and Administrative Expenses

General and administrative expenses, or G&A, increased by $512 million in the year ended December 31, 2015, compared to the corresponding period in 2014. This was primarily due to expenses for additional staff and facilities to support our membership growth. During the year ended December 31, 2015, we recorded approximately $27 million of Health Net merger related expenses, which reduced our diluted earnings per share by $0.14.

During the first quarter of 2015, we recorded a gain of $10 million on the settlement of contingent consideration related to the CHS transaction. We also recorded expense of $10 million for a contribution to our charitable foundation during the first quarter of 2015.

Also during 2015, we experienced higher than anticipated opt-out rates and member attrition in the new Michigan dual demonstration program, resulting in lower than expected membership and lower blended premium rates. As a

result, the fair value of estimated contingent consideration was reduced from $50 million to $16 million, and we recorded a gain of $34 million in general and administrative expenses. In connection with the lower membership and revenue outlook, we conducted an impairment analysis of the identifiable intangible assets and goodwill, resulting in a reduction of goodwill and intangible assets of $38 million which was recorded in general and administrative expenses. The Company's initial allocation of fair value resulted in goodwill and intangible assets of $52 million. At December 31, 2015, the Company had goodwill of $11 million and other identifiable intangible assets of $1 million, net of $2 million of amortization, remaining on the balance sheet.

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The consolidated G&A expense ratio for the years ended December 31, 2015 and 2014 was 8.6% and 8.4%, respectively. The G&A ratio for the year ended December 31, 2015 was 8.5% excluding the impact of the Health Net merger related expenses. The increase over prior year is primarily related to the expansion of our Health Insurance Marketplace business which operates at a higher G&A ratio and incurred higher open enrollment costs in the fourth quarter of the current year.

Health Insurer Fee

During the year ended December 31, 2015, we recorded $215 million of non-deductible expense for the Affordable Care Act (ACA) annual health insurer fee, compared to $126 million for the year ended December 31, 2014. As of December 31, 2015, we recorded $344 million in Premium Tax and Health Insurer Fee revenue associated with the accrual for the reimbursement of the fee, compared to $195 million in 2014.

Other Income (Expense)

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

	2015	2014
Investment income	$27	$22
Earnings from equity method investments	8	6
Interest expense	(43)	(35)
Other income (expense), net	$(8)	$(7)

The increase in investment income in 2015 reflects an increase in investment balances over 2014 and improved performance of certain equity investments. Interest expense increased during the year ended December 31, 2015 by $8 million primarily reflecting the issuance of $300 million of Senior Notes in April 2014 and the issuance of an additional $200 million in Senior Notes in January 2015.

Income Tax Expense

Our effective tax rate for the year ended December 31, 2015 was 48.6% compared to 42.9% in 2014. The effective tax rate is higher than the applicable statutory rate primarily as a result of the non-deductibility of the health insurer fee expense.

Segment Results

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

	2015	2014	% Change 2014-2015
Premium and Service Revenues			
Managed Care	$19,154	$13,946	37%
Specialty Services	7,075	4,800	47%
Eliminations	(4,964)	(3,079)	(61)%
Consolidated Total	$21,265	$15,667	36%
Earnings from Operations			
Managed Care	$513	$353	45%
Specialty Services	192	111	73%
Consolidated Total	$705	$464	52%

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Managed Care

Premium and service revenues increased 37% in the year ended December 31, 2015, primarily as a result of expansions or new programs in many of our states, particularly Florida, Illinois, Indiana, Louisiana, Mississippi, Ohio and Texas. Earnings from operations increased $160 million between years primarily reflecting growth in the business.

Specialty Services

Premium and service revenues increased 47% in the year ended December 31, 2015, resulting primarily from increased service associated with membership growth in the Managed Care segment and growth in our pharmacy businesses. Earnings from operations increased $81 million in the year ended December 31, 2015, primarily reflecting growth in the specialty services provided to our increased Managed Care membership.

Year Ended December 31, 2014 Compared to Year Ended December 31, 2013

Premium and Service Revenues

Premium and service revenues increased 49% in the year ended December 31, 2014 over the corresponding period in 2013 as a result of expansions in Florida, Ohio, Washington, Texas and Illinois, growth in the AcariaHealth business, the addition of the California and New Hampshire operations and our participation in the Health Insurance Marketplaces. During the year ended December 31, 2014 we received premium rate adjustments which yielded an approximate net 1% composite increase across all of our markets.

Operating Expenses

Medical Costs

The table below depicts the HBR for our membership by member category for the year ended December 31,:

	2014		2013	
Medicaid, CHIP, Foster Care & HIM	86.3	%	87.5	%
ABD, LTC and Medicare	93.5		90.4	
Specialty Services	85.5		85.4	
Total	89.3		88.6	

The consolidated HBR for the year ended December 31, 2014, of 89.3% was an increase of 70 basis points over the comparable period in 2013. The increase compared to last year is primarily attributable to an increase in complex care membership over the prior year.

Cost of Services

Cost of services increased by $953 million in the year ended December 31, 2014, compared to the corresponding period in 2013. This was primarily due to the acquisition of and growth in our AcariaHealth business as well as the acquisition of U.S. Medical Management. The cost of service ratio for the year ended December 31, 2014, was 87.1% compared to 87.7% in 2013.

General and Administrative Expenses

General and administrative expenses, or G&A, increased by $383 million in the year ended December 31, 2014, compared to the corresponding period in 2013. This was primarily due to expenses for additional staff and facilities to support our membership growth.

The consolidated G&A expense ratio for the years ended December 31, 2014 and 2013 was 8.4% and 8.8%, respectively. The year over year decrease in the G&A ratio reflects the leveraging of expenses over higher revenues in 2014, offset by the acquisition of U.S. Medical Management and start up of Health Insurance Marketplaces which operate at higher G&A ratios.

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Health Insurer Fee

During the year ended December 31, 2014, we recorded $126 million of non-deductible expense for the Affordable Care Act (ACA) annual health insurer fee. As of December 31, 2014, we had received signed agreements representing virtually all of the total revenue associated with the reimbursement of the ACA insurer fee including the related gross-up for the associated income tax effects. As a result, we recorded $195 million in Premium Tax and Health Insurer Fee revenue associated with the reimbursement of the fee.

Other Income (Expense)

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

	2014	2013
Investment income	$22	$18
Earnings from equity method investments	6	1
Interest expense	(35)	(27)
Other income (expense), net	$(7)	$(8)

The increase in investment income in 2014 reflects an increase in investment balances over 2013 and improved performance of certain equity investments. Interest expense increased during the year ended December 31, 2014 by $8 million reflecting the issuance of an additional $300 million in Senior Notes in April 2014 and a higher level of borrowings under our revolving credit agreement.

Income Tax Expense

Our effective tax rate for the year ended December 31, 2014 was 42.9% compared to 39.8% in 2013. The increase is due to the non-deductibility of the health insurer fee which increased our effective tax rate. This was partially offset by a reduction of tax expense associated with the compensation deduction limitation. During 2014, the IRS issued final regulations related to the compensation deduction limitation applicable to certain health insurance providers. Accordingly, we reversed previously recorded tax expense of $14 million for prior years resulting in a decrease in the effective tax rate which offset the health insurer fee impact. As a result, we no longer believe the deduction limitation applies.

Segment Results

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

	2014	2013	% Change 2013-2014
Premium and Service Revenues			
Managed Care	$13,946	$9,782	43%
Specialty Services	4,800	2,932	64%
Eliminations	(3,079)	(2,188)	(41)%
Consolidated Total	$15,667	$10,526	49%
Earnings from Operations			
Managed Care	$353	$198	78%
Specialty Services	111	79	41%
Consolidated Total	$464	$277	68%

Managed Care

Premium and service revenues increased 43% in the year ended December 31, 2014, primarily as a result of expansions in Florida, Ohio, Washington, Mississippi, Texas and Illinois, the addition of the California and New Hampshire operations and our participation in the Health Insurance Marketplaces. Earnings from operations increased $155 million in the year ended December 31, 2014, primarily reflecting growth in the business.

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Specialty Services

Premium and service revenues increased 64% in the year ended December 31, 2014, resulting from growth in our AcariaHealth business, increased services associated with membership growth in the Managed Care segment, the addition of three Centurion contracts and the acquisition of U.S. Medical Management. Earnings from operations increased $32 million in the year ended December 31, 2014, primarily reflecting growth in the AcariaHealth business as well as favorable performance in our legacy individual health business.

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LIQUIDITY AND CAPITAL RESOURCES

Shown below is a condensed schedule of cash flows for the years ended December 31, 2015, 2014 and 2013, used in the discussion of liquidity and capital resources ($ in millions).

	Year Ended December 31,		
	2015	2014	2013
Net cash provided by operating activities	$658	$1,223	$382
Net cash used in investing activities	(813)	(848)	(342)
Net cash provided by financing activities	305	198	154
Effect of exchange rate changes on cash and cash equivalents	—	(1)	—
Net increase in cash and cash equivalents	$150	$572	$194

Cash Flows Provided by Operating Activities

Normal operations are funded primarily through operating cash flows and borrowings under our revolving credit facility. Cash flows from operating activities for 2015 were $658 million, 1.8 times net earnings, compared to $1,223 million in 2014. The cash provided by operations in 2015 and 2014 was primarily related to net earnings and an increase in medical claims liabilities resulting from growth in the business, partially offset by increases in premium and related receivables.

Cash flows from operating activities for 2014 increased to $1,223 million, compared to $382 million in 2013. Operating cash flows in 2014 significantly benefited from the 49% premium and service revenue growth, which resulted in increased medical claims liabilities. In addition, 2014 uniquely benefited from an increase in payables associated with various programs requiring a return of premium to state customers. Cash flows from operating activities benefited in 2013 due to an increase in net earnings and growth in our business.

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

The reimbursement of the HIF from our state customers may be settled as a separate payment or monthly in combination with our other premium payments. The vast majority of our state customers are settling the reimbursement through a separate payment after verification of each state's portion of our HIF, resulting in an increase in Premium and Related Receivables at December 31, 2015. During 2015, we paid the 2015 annual HIF totaling $220 million. This negatively impacted our cash flows as we have not been reimbursed from the majority of our state customers. Similarly, during 2014, we paid the 2014 annual HIF invoice totaling $126 million. The table below details the impact to cash flows from operations from the timing of payments from our states ($ in millions).

	Year Ended December 31,		
	2015	2014	2013
(Increase) in premium and related receivables	$(360)	$(463)	$(143)
Increase (decrease) in unearned revenue	(27)	129	3
Net (decrease) in operating cash flow	$(387)	$(334)	$(140)

Cash Flows Used in Investing Activities

Investing activities used cash of $813 million for the year ended December 31, 2015, and $848 million in the comparable period in 2014. Cash flows used in investing activities in 2015 primarily consisted of additions to the investment portfolio of our regulated subsidiaries, including transfers from cash and cash equivalents to long term investments and capital expenditures.

In January 2015, we sold a 25% ownership interest in Celtic Insurance Company. No gain or loss was recognized on the sale of the ownership interest. Celtic Insurance Company is included in the Managed Care segment. Under the terms of the agreement, we entered into a put agreement with the noncontrolling interest holder to purchase the noncontrolling interest at a later date.

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Cash flows used in investing activities in 2014 primarily consisted of additions to the investment portfolio of our regulated subsidiaries, including transfers from cash and cash equivalents to long term investments, the acquisition of U.S. Medical Management and CHS, an equity investment in Ribera Salud and capital expenditures. We completed the acquisition of U.S. Medical Management for $213 million in total consideration. The transaction was financed through a combination of Centene common stock as well as $80 million of cash. We also completed a transaction with CHS for initial cash consideration of $56 million as well as common stock. Additionally, we purchased a noncontrolling interest in Ribera Salud, S.A. (Ribera Salud), a Spanish health management group for $17 million. During 2013, our investing activities primarily related to additions to the investment portfolio of our regulated subsidiaries, including transfers from cash and cash equivalents to long term investments, the acquisition of AcariaHealth and capital expenditures. We completed the acquisition of AcariaHealth for $142 million in total consideration. The transaction was financed through a combination of Centene common stock as well as $67 million of cash.

Our investment policies are designed to provide liquidity, preserve capital and maximize total return on invested assets within our guidelines. Net cash provided by and used in investing activities will fluctuate from year to year due to the timing of investment purchases, sales and maturities. As of December 31, 2015, our investment portfolio consisted primarily of fixed-income securities with an average duration of 2.9 years. These securities generally are actively traded in secondary markets and the reported fair market value is determined based on recent trading activity, recent trading activity in similar securities and other observable inputs. Our investment guidelines comply with the regulatory restrictions enacted in each state. We had unregulated cash and investments of $78 million at December 31, 2015, compared to $85 million at December 31, 2014.

We spent $150 million, $103 million and $68 million in 2015, 2014 and 2013, respectively, on capital expenditures for system enhancements and market expansions.

Cash Flows Provided by Financing Activities

Our financing activities provided cash of $305 million, $198 million and $154 million in 2015, 2014 and 2013, respectively. Financing activities in 2015, 2014 and 2013 are discussed below.

2015

During 2015, our financing activities primarily related to the proceeds from the issuance of Senior Debt and an additional $150 million of borrowings on our revolving credit facility. In January 2015, we issued an additional $200 million of 4.75% Senior Notes due May 15, 2022 at par (Add on Notes). In connection with the January 2015 issuance, we entered into interest rate swap agreements for a notional amount of $200 million (2015 Swap Agreements) that are scheduled to expire on May 15, 2022. Under the 2015 Swap Agreements, we receive a fixed rate of 4.75% and pay a variable rate of LIBOR plus a spread adjusted quarterly, which allows us to adjust the $200 million Notes to a floating rate. We do not hold or issue any derivative instrument for trading or speculative purposes.

2014

In April 2014, pursuant to a shelf registration statement, we issued $300 million 4.75% Senior Notes due May 15, 2022 at par. Interest is paid semi-annually in May and November. In connection with the issuance, we entered into $300 million notional amount of interest rate swap agreements (2014 Swap Agreements) that are scheduled to expire May 15, 2022. Under the 2014 Swap Agreements, we receive a fixed rate of 4.75% and pay a variable rate of LIBOR plus a spread adjusted quarterly, which allows us to adjust the $300 million Notes to a floating rate. We do not hold or issue any derivative instrument for trading or speculative purposes.

2013

During 2013, our financing activities primarily related to borrowings under our revolving credit facility, the sale of $15 million of common stock to fund the escrow account for the acquisition of AcariaHealth and the repayment of a mortgage note.

In May 2013, we entered into a new unsecured $500 million revolving credit facility and terminated our previous $350 million revolving credit facility. Borrowings under the agreement bear interest based upon LIBOR rates, the Federal Funds Rate or the Prime Rate. The agreement has a maturity date of June 1, 2018, provided it will mature 90 days prior to the maturity date of the 5.75% Senior Notes due 2017 if such notes are not refinanced (or extended) or certain financial conditions are not met, including carrying $100 million of unrestricted cash on deposit.

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Liquidity Metrics

The $500 million revolving credit agreement contains non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios, maximum debt-to-EBITDA ratios and minimum tangible net worth. We are required not to exceed a maximum debt-to-EBITDA ratio of 3.0 to 1.0. As of December 31, 2015, we had $225 million in borrowings outstanding under our revolving credit facility, and we were in compliance with all covenants. As of December 31, 2015, there were no limitations on the availability under the revolving credit agreement as a result of the debt-to-EBITDA ratio.

We had outstanding letters of credit of $47 million as of December 31, 2015, which were not part of our revolving credit facility. We also had letters of credit for $50 million (valued at the December 31, 2015 conversion rate), or €46 million, representing our proportional share of the letters of credit issued to support Ribera Salud's outstanding debt which are a part of the revolving credit facility. Collectively, the letters of credit bore interest at 1.55% as of December 31, 2015. In addition, we had outstanding surety bonds of $305 million as of December 31, 2015.

The indenture governing our Senior Notes contains non-financial and financial covenants, including requirements of a minimum fixed charge coverage ratio.

At December 31, 2015, we had working capital, defined as current assets less current liabilities, of negative $24 million, compared to $51 million at December 31, 2014. 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, 2015, our debt to capital ratio, defined as total debt divided by the sum of total debt and total equity, was 36.0%, compared to 33.5% at December 31, 2014. Excluding the $67 million non-recourse mortgage note, our debt to capital ratio was 34.7% as of December 31, 2015, compared to 31.7% at December 31, 2014. We utilize the debt to capital ratio as a measure, among others, of our leverage and financial flexibility.

We have a stock repurchase program authorizing us to repurchase up to 8 million shares of common stock from time to time on the open market or through privately negotiated transactions. We have 3 million available shares remaining under the program for repurchases as of December 31, 2015. No duration has been placed on the repurchase program. We reserve the right to discontinue the repurchase program at any time. We did not make any repurchases under this plan during 2015, 2014 or 2013.

During the year ended December 31, 2015, 2014 and 2013, we received dividends of $11 million, $50 million, and $18 million, respectively, from our regulated subsidiaries.

2016 Expectations

In early 2016, we expect to complete the merger with Health Net, a publicly traded managed care organization that delivers health care services through health plans and government-sponsored managed care plans, for approximately $5.5 billion. In connection with the upcoming closing of the merger, in February 2016, our wholly owned unrestricted subsidiary (Escrow Issuers) issued approximately $1.4 billion 5.625% Senior Notes due 2021 at par and $1.0 billion 6.125% Senior Notes due 2024 at par. The transaction will be financed through a combination of borrowings on our revolving credit facility, existing cash on hand, the $2.4 billion February debt issuance, and approximately $2.8 billion in shares of Centene common stock. The proceeds of the debt issuance will be held in escrow until the closing of the Health Net merger. If the Health Net merger is not consummated, the Escrow Issuer will be required to redeem each series of Notes at a redemption price equal to 100% of the principal amount of such series of Notes, plus accrued and

unpaid interest to the redemption date.

Upon execution of the merger agreement, the Company negotiated the terms of a new unsecured $1,000 million revolving credit facility with its banking syndicate. The new $1,000 million revolving credit facility is effective upon the closing of the merger and the existing $500 million unsecured revolving credit facility will be terminated simultaneously.

Including the effects of potential contributions and expenditures related to Health Net, we expect to make net capital contributions to our insurance subsidiaries of approximately $250 million during 2016 associated with our growth and spend approximately $330 million in additional capital expenditures primarily associated with system enhancements, integration, and market expansions. These capital contributions are expected to be funded by unregulated cash flow generation in 2016 and borrowings on our revolving credit facility.

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In January 2016, the Company announced an ongoing comprehensive internal search for six hard drives that were unaccounted for in its inventory of approximately 26,000 information technology (IT) devices. This incident resulted from an employee not following established procedures on storing IT hardware. In the process of completing its investigation, in February 2016, the Company received an admission from an employee to placing the six hard drives in a locked receptacle for secure destruction. As a result, the Company satisfied itself and concluded its investigation.

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

CONTRACTUAL OBLIGATIONS

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

	Payments Due by Period				
	Total	Less Than 1 Year	1-3 Years	3-5 Years	More Than 5 Years
Medical claims liability	$2,298	$2,298	$—	$—	$—
Debt and interest	1,454	56	722	61	615
Redeemable Noncontrolling Interest	156	—	156	—	—
Operating lease obligations	315	58	109	78	70
Purchase obligations	79	31	43	5	—
Other long term liabilities [1]	—	—	—	—	—
Total	$4,302	$2,443	$1,030	$144	$685

[1] Our Consolidated Balance Sheet as of December 31, 2015, includes $170 million of other long term liabilities. This consists primarily of long term deferred income taxes, liabilities under our deferred compensation plan, and reserves for uncertain tax positions. These liabilities have been excluded from the table above as the timing and/or amount of any cash payment is uncertain.

REGULATORY CAPITAL AND DIVIDEND RESTRICTIONS

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

Our subsidiaries are required to maintain minimum capital requirements prescribed by various regulatory authorities in each of the states in which we operate. As of December 31, 2015, our subsidiaries had aggregate statutory capital and surplus of $2,284 million, compared with the required minimum aggregate statutory capital and surplus requirements of $1,195 million. During the year ended December 31, 2015, we contributed $643 million of statutory capital to our subsidiaries. We estimate our Risk Based Capital, or RBC, percentage (including KSHP) to be in excess of 350% of the Authorized Control Level.

The National Association of Insurance Commissioners 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, 2015, each of our health plans was in compliance with the risk-based capital requirements enacted in those states.

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.

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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 medical claims liability and intangible assets 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.

Medical Claims Liability

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

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

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

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

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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, 2015 data:

Completion Factors: [1]		Cost Trend Factors: [2]	
(Decrease) Increase in Factors	Increase (Decrease) in Medical Claims Liabilities (in millions)	(Decrease) Increase in Factors	Increase (Decrease) in Medical Claims Liabilities (in millions)
(2.0)%	$264	(2.0)%	$(72)
(1.5)	197	(1.5)	(54)
(1.0)	131	(1.0)	(36)
(0.5)	65	(0.5)	(18)
0.5	(64)	0.5	18
1.0	(128)	1.0	36
1.5	(191)	1.5	55
2.0	(253)	2.0	73

(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 $14 million for the year ended December 31, 2015, excluding the effect of any return of premium, risk corridor, or minimum medical loss ratio 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,		
	2015	2014	2013
Balance, January 1,	$1,723	$1,112	$815
Acquisitions	79	—	—
Incurred related to:			
Current year	17,471	12,820	9,073
Prior years	(229)	(142)	(78)
Total incurred	17,242	12,678	8,995
Paid related to:			
Current year	15,279	11,122	7,975
Prior years	1,467	945	723
Total paid	16,746	12,067	8,698
Balance, December 31,	$2,298	$1,723	$1,112
Days in claims payable [1]	44.3	44.2	42.4

[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.

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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, 2015 will be known by the end of 2016.

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 $47 million, $26 million and $0 million of the “Incurred related to: Prior period” was recorded as a reduction to premium revenues in 2015, 2014 and 2013, respectively. Further, claims processing initiatives yielded increased claim payment recoveries and coordination of benefits related to prior year dates of service. Changes in medical utilization and cost trends and the effect of medical management initiatives may also contribute to changes in medical claim liability estimates. While we have evidence that medical management initiatives are effective on a case by case basis, medical management initiatives primarily focus on events and behaviors prior to the incurrence of the medical event and generation of a claim. Accordingly, any change in behavior, leveling of care, or coordination of treatment occurs prior to claim generation and as a result, the costs prior to the medical management initiative are not known by us. Additionally, certain medical management initiatives are focused on member and provider education with the intent of influencing behavior to appropriately align the medical services provided with the member's acuity. In these cases, determining whether the medical management initiative changed the behavior cannot be determined. Because of the complexity of our business, the number of states in which we operate, and the volume of claims that we process, we are unable to practically quantify the impact of these initiatives on our changes in estimates of IBNR.

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

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

Goodwill and Intangible Assets

We have made several acquisitions that have resulted in our recording of intangible assets. These intangible assets primarily consist of customer relationships, purchased contract rights, provider contracts, trade names and goodwill. At December 31, 2015, we had $842 million of goodwill and $155 million of other intangible assets.

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

Intangible Asset	Amortization Period
Purchased contract rights	5 - 15 years

Provider contracts	4 - 15 years
Customer relationships	3 - 15 years
Trade names	7 - 20 years
Developed technology	5 years

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

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

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We first assess qualitative factors to determine whether it is necessary to perform the two-step quantitative goodwill impairment test. We generally do not calculate the fair value of a reporting unit unless we determine, based on a qualitative assessment, that it is more likely than not that its fair value is less than its carrying amount. However, in certain circumstances, such as recent acquisitions, we may elect to perform a quantitative assessment without first assessing qualitative factors. The fair value of all reporting units with material amounts of goodwill was substantially in excess of the carrying value as of our annual impairment testing date, with the exception of reporting units that were recently acquired without excess fair value on the acquisition date.

ITEM 7A. Quantitative and Qualitative Disclosures About Market Risk

INVESTMENTS AND DEBT

As of December 31, 2015, we had short term investments of $176 million and long term investments of $2,042 million, including restricted deposits of $115 million. The short term investments generally consist of highly liquid securities with maturities between three and 12 months. The long term investments consist of municipal, corporate and U.S. Treasury securities, government sponsored obligations, life insurance contracts, asset backed securities and equity securities and have maturities greater than one year. Restricted deposits consist of investments required by various state statutes to be deposited or pledged to state agencies. Due to the nature of the states' requirements, these investments are classified as long term regardless of the contractual maturity date. Substantially all of our investments are subject to interest rate risk and will decrease in value if market rates increase. Assuming a hypothetical and immediate 1% increase in market interest rates at December 31, 2015, the fair value of our fixed income investments would decrease by approximately $55 million. Declines in interest rates over time will reduce our investment income.

We have interest rate swap agreements for a notional amount of $750 million with creditworthy financial institutions to manage the impact of market interest rates on interest expense. Our swap agreements convert a portion of our interest expense from fixed to variable rates to better match the impact of changes in market rates on our variable rate cash equivalent investments. As a result, the fair value of $750 million of our long term debt varies with market interest rates. Assuming a hypothetical and immediate 1% increase in market interest rates at December 31, 2015, the fair value of our debt would decrease by approximately $31 million. An increase in interest rates decreases the fair value of the debt and conversely, a decrease in interest rates increases the value.

For a discussion of the interest rate risk that our investments are subject to, see "Risk Factors–Risks Related to Our Business–Our investment portfolio may suffer losses from reductions in market interest rates and changes in market conditions which could materially and adversely affect our results of operations or liquidity."

INFLATION

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

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

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Item 8. Financial Statements and Supplementary Data

Report of Independent Registered Public Accounting Firm
The Board of Directors and Stockholders
Centene Corporation:
We have audited the accompanying consolidated balance sheets of Centene Corporation and subsidiaries as of December 31, 2015 and 2014, and the related consolidated statements of operations, comprehensive earnings, stockholders' equity, and cash flows for each of the years in the three-year period ended December 31, 2015. 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 conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.
In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Centene Corporation and subsidiaries as of December 31, 2015 and 2014, and the results of their operations and their cash flows for each of the years in the three-year period ended December 31, 2015, 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), Centene Corporation's internal control over financial reporting as of December 31, 2015, based on criteria established in Internal Control - Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO), and our report dated February 22, 2016 expressed an unqualified opinion on the effectiveness of the Company's internal control over financial reporting.

/s/ KPMG LLP

St. Louis, Missouri
February 22, 2016

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CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED BALANCE SHEETS
(In millions, except share data)

	December 31, 2015	December 31, 2014
ASSETS		
Current assets:		
Cash and cash equivalents	$1,760	$1,610
Premium and related receivables	1,279	912
Short term investments	176	177
Other current assets	390	252
Total current assets	3,605	2,951
Long term investments	1,927	1,280
Restricted deposits	115	100
Property, software and equipment, net	518	445
Goodwill	842	754
Intangible assets, net	155	120
Other long term assets	177	174
Total assets	$7,339	$5,824
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims liability	$2,298	$1,723
Accounts payable and accrued expenses	976	768
Return of premium payable	207	236
Unearned revenue	143	168
Current portion of long term debt	5	5
Total current liabilities	3,629	2,900
Long term debt	1,216	874
Other long term liabilities	170	159
Total liabilities	5,015	3,933
Commitments and contingencies		
Redeemable noncontrolling interest	156	148
Stockholders' equity:		
Preferred stock, $0.001 par value; authorized 10,000,000 shares; no shares issued or outstanding at December 31, 2015 and December 31, 2014	—	—
Common stock, $.001 par value; authorized 400,000,000 shares; 126,855,477 issued and 120,342,981 outstanding at December 31, 2015, and 124,274,864 issued and 118,433,416 outstanding at December 31, 2014	—	—
Additional paid-in capital	956	840
Accumulated other comprehensive loss	(10)	(1)
Retained earnings	1,358	1,003
Treasury stock, at cost (6,512,496 and 5,841,448 shares, respectively)	(147)	(98)
Total Centene stockholders' equity	2,157	1,744
Noncontrolling interest	11	(1)
Total stockholders' equity	2,168	1,743
Total liabilities and stockholders' equity	$7,339	$5,824

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

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

	Year Ended December 31,		
	2015	2014	2013
Revenues:			
Premium	$19,389	$14,198	$10,153
Service	1,876	1,469	373
Premium and service revenues	21,265	15,667	10,526
Premium tax and health insurer fee	1,495	893	337
Total revenues	22,760	16,560	10,863
Expenses:			
Medical costs	17,242	12,678	8,995
Cost of services	1,621	1,280	327
General and administrative expenses	1,826	1,314	931
Premium tax expense	1,151	698	333
Health insurer fee expense	215	126	—
Total operating expenses	22,055	16,096	10,586
Earnings from operations	705	464	277
Other income (expense):			
Investment and other income	35	28	19
Interest expense	(43)	(35)	(27)
Earnings from continuing operations, before income tax expense	697	457	269
Income tax expense	339	196	107
Earnings from continuing operations, net of income tax expense	358	261	162
Discontinued operations, net of income tax expense (benefit) of $(1), $1, and $2, respectively	(1)	3	4
Net earnings	357	264	166
(Earnings) loss attributable to noncontrolling interests	(2)	7	(1)
Net earnings attributable to Centene Corporation	$355	$271	$165
Amounts attributable to Centene Corporation common shareholders:			
Earnings from continuing operations, net of income tax expense	$356	$268	$161
Discontinued operations, net of income tax expense (benefit)	(1)	3	4
Net earnings	$355	$271	$165
Net earnings (loss) per common share attributable to Centene Corporation:			
Basic:			
Continuing operations	$2.99	$2.30	$1.49
Discontinued operations	(0.01)	0.03	0.03
Basic earnings per common share	$2.98	$2.33	$1.52
Diluted:			
Continuing operations	$2.89	$2.23	$1.43
Discontinued operations	(0.01)	0.02	0.04
Diluted earnings per common share	$2.88	$2.25	$1.47
Weighted average number of common shares outstanding:			

Basic	119,100,744	116,345,764	108,253,090
Diluted	123,066,370	120,360,212	112,494,346

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

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

	Year Ended December 31,		
	2015	2014	2013
Net earnings	$357	$264	$166
Reclassification adjustment, net of tax	—	—	(1)
Change in unrealized gain (loss) on investments, net of tax	(4)	3	(7)
Foreign currency translation adjustments, net of tax	(5)	(1)	—
Other comprehensive earnings (loss)	(9)	2	(8)
Comprehensive earnings	348	266	158
Comprehensive (earnings) loss attributable to the noncontrolling interest	(2)	7	(1)
Comprehensive earnings attributable to Centene Corporation	$346	$273	$157

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

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CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
(In millions, except share data)

	Centene Stockholders' Equity								
	Common Stock					Treasury Stock			
	$.001 Par Value Shares	Amt	Additional Paid-in Capital	Accumulated Other Comprehensive Income (Loss)	Retained Earnings	$.001 Par Value Shares	Amt	Non controlling Interest	Total
Balance, December 31, 2012	110,678,320	$—	$ 451	$ 5	$ 567	6,019,824	$(70)	$ 1	$ 954
Net earnings	—	—	—	—	165	—	—	1	166
Other comprehensive earnings (loss), net of $(4) tax	—	—	—	(8)	—	—	—	—	(8)
Common stock issued for acquisition	3,433,380	—	75	—	—	—	—	—	75
Common stock issued for stock offering	685,280	—	15	—	—	—	—	—	15
Common stock issued for employee benefit plans	2,549,450	—	10	—	—	—	—	—	10
Common stock repurchases	—	—	—	—	—	688,128	(19)	—	(19)
Stock compensation expense	—	—	37	—	—	—	—	—	37
Excess tax benefits from stock compensation	—	—	6	—	—	—	—	—	6
Contribution from noncontrolling interest	—	—	—	—	—	—	—	7	7
Balance, December 31, 2013	117,346,430	$—	$ 594	$ (3)	$ 732	6,707,952	$(89)	$ 9	$ 1,243
Net earnings (loss)	—	—	—	—	271	—	—	(1)	270
Other comprehensive earnings, net of $1 tax	—	—	—	2	—	—	—	—	2
Common stock issued for acquisitions	4,486,434	—	170	—	—	(1,492,738)	20	—	190
Common stock issued for employee benefit plans	2,442,000	—	9	—	—	—	—	—	9
Common stock repurchases	—	—	—	—	—	626,234	(29)	—	(29)
Stock compensation expense	—	—	48	—	—	—	—	—	48
Excess tax benefits from stock	—	—	19	—	—	—	—	—	19

compensation									
Reclassification to redeemable noncontrolling interest	—	—	—	—	—	—	—	(9)	(9)
Balance, December 31, 2014	124,274,864	$—	$ 840	$ (1)	$ 1,003	5,841,448	$(98)	$ (1)	$ 1,743
Net earnings	—	—	—	—	355	—	—	—	355
Other comprehensive earnings (loss), net of $3 tax	—	—	—	(9)	—	—	—	—	(9)
Common stock issued for acquisitions	—	—	8	—	—	(247,580)	4	—	12
Common stock issued for employee benefit plans	2,580,613	—	12	—	—	—	—	—	12
Common stock repurchases	—	—	—	—	—	918,628	(53)	—	(53)
Stock compensation expense	—	—	71	—	—	—	—	—	71
Excess tax benefits from stock compensation	—	—	25	—	—	—	—	—	25
Contribution from noncontrolling interest	—	—	—	—	—	—	—	11	11
Reclassification to redeemable noncontrolling interest	—	—	—	—	—	—	—	1	1
Balance, December 31, 2015	126,855,477	$—	$ 956	$ (10)	$ 1,358	6,512,496	$(147)	$ 11	$2,168

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

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

	Year Ended December 31,		
	2015	2014	2013
Cash flows from operating activities:			
Net earnings	$357	$264	$166
Adjustments to reconcile net earnings to net cash provided by operating activities			
Depreciation and amortization	111	89	67
Stock compensation expense	71	48	37
Deferred income taxes	(17)	(42)	(2)
Gain on contingent consideration	(44)	—	—
Goodwill and intangible adjustment	38	—	—
Changes in assets and liabilities			
Premium and related receivables	(360)	(463)	(143)
Other current assets	(96)	(5)	(80)
Other assets	(9)	(8)	(1)
Medical claims liabilities	536	609	172
Unearned revenue	(27)	129	3
Accounts payable and accrued expenses	39	506	152
Other long term liabilities	51	89	8
Other operating activities	8	7	3
Net cash provided by operating activities	658	1,223	382
Cash flows from investing activities:			
Capital expenditures	(150)	(103)	(68)
Purchases of investments	(1,321)	(1,015)	(790)
Sales and maturities of investments	669	406	579
Proceeds from asset sale	7	—	—
Investments in acquisitions, net of cash acquired	(18)	(136)	(63)
Net cash used in investing activities	(813)	(848)	(342)
Cash flows from financing activities:			
Proceeds from exercise of stock options	13	8	9
Proceeds from borrowings	1,925	1,875	180
Proceeds from stock offering	—	—	15
Payment of long term debt	(1,583)	(1,674)	(41)
Excess tax benefits from stock compensation	25	19	6
Common stock repurchases	(53)	(29)	(19)
Contribution from noncontrolling interest	11	6	8
Debt issue costs	(4)	(7)	(4)
Payment of contingent consideration obligation	(29)	—	—
Net cash provided by financing activities	305	198	154
Effect of exchange rate changes on cash and cash equivalents	—	(1)	—
Net increase in cash and cash equivalents	150	572	194
Cash and cash equivalents, beginning of period	1,610	1,038	844
Cash and cash equivalents, end of period	$1,760	$1,610	$1,038
Supplemental disclosures of cash flow information:			
Interest paid	$55	$40	$30
Income taxes paid	$328	$237	$85

Equity issued in connection with acquisitions	$12	$190	$75

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

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CENTENE CORPORATION AND SUBSIDIARIES
NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS

1. Organization and Operations

Centene Corporation, or the Company, is a diversified, multi-national healthcare enterprise operating in two segments: Managed Care and Specialty Services. The Managed Care segment provides Medicaid and Medicaid-related health plan coverage to individuals through the government subsidized programs, including Medicaid, the State Children's Health Insurance Program (CHIP), Long Term Care (LTC), Foster Care, dual-eligible individuals (Duals) in Medicare Special Needs Plans and the Supplemental Security Income Program, also known as the Aged, Blind or Disabled Program, or collectively ABD and the Health Insurance Marketplace. The Specialty Services segment consists of our specialty companies offering auxiliary healthcare services and products to state programs, healthcare organizations, employer groups and other commercial organizations, as well as to our own subsidiaries.

On February 2, 2015, the Board of Directors declared a two-for-one split of Centene's common stock in the form of a 100% stock dividend distributed February 19, 2015 to stockholders of record on February 12, 2015. All share and per share information presented in this Form 10-K has been adjusted for the two-for-one stock split.

2. Summary of Significant Accounting Policies

Principles of Consolidation

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. The assets, liabilities and results of operations of Kentucky Spirit Health Plan are classified as discontinued operations for all periods presented.

Certain amounts in the consolidated financial statements have been reclassified to conform to the 2015 presentation. These reclassifications have no effect on net earnings or stockholders' equity as previously reported.

Use of Estimates

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

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 and 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.

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

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

Restricted Deposits

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

Fair Value Measurements

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

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

- Available for sale investments and restricted deposits: The carrying amount is stated at fair value, based on quoted market prices, where available. For securities not actively traded, fair values were estimated using values obtained from independent pricing services or quoted market prices of comparable instruments.
- Senior unsecured notes: Estimated based on third-party quoted market prices for the same or similar issues.
- Variable rate debt: The carrying amount of our floating rate debt approximates fair value since the interest rates adjust based on market rate adjustments.
- Interest rate swap: Estimated based on third-party market prices based on the forward 3-month LIBOR curve.
- Contingent consideration: Estimate based on expected membership retained at contract commencement and per member purchase price in the acquisition agreement.

Property, Software and Equipment

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

and equipment are depreciated over the following periods:

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

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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 customer relationships, purchased contract rights, provider contracts, trade names and goodwill. Intangible assets are amortized using the straight-line method over the following periods:

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

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

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

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

If the two-step quantitative test is deemed necessary, the Company determines an appropriate valuation technique to estimate a reporting unit's fair value as of the testing date. The Company utilizes either the income approach or the market approach, whichever is most appropriate for the respective reporting unit. The income approach is based on an internally developed discounted cash flow model that includes many assumptions related to future growth rates, discount factors, future tax rates, etc. The market approach is based on financial multiples of comparable companies derived from current market data. Changes in economic and operating conditions impacting assumptions used in our

analyses could result in goodwill impairment in future periods.

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Medical Claims Liability

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

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

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

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

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

Revenue Recognition

The Company's health plans generate revenues primarily from premiums received from the states in which it operates health plans. The Company receives a fixed premium per member per month pursuant to its state contracts. The Company generally receives premium payments during the month it provides services and recognizes premium revenue during the period in which it is obligated to provide services to its members. 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 analyzing submissions of processed claims data to determine the acuity of the Company's membership relative to the entire state's Medicaid membership. 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. Some contracts allow for additional

premiums related to certain supplemental services provided such as maternity deliveries.

Revenues are recorded based on membership and eligibility data provided by the states, which is adjusted on a monthly basis by the states 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.

The Company's specialty companies generate revenues under contracts with state programs, individuals, healthcare organizations and other commercial organizations, as well as from the Company's own subsidiaries. Revenues are recognized when the related services are provided or as ratably earned over the covered period of service.

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Health Insurance Marketplace

The Affordable Care Act (ACA) established risk spreading premium stabilization programs effective January 1, 2014 for the Health Insurance Marketplace product. These programs, commonly referred to as the “three Rs,” include a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridor program. 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 revenue to reflect the year to date impact of the risk adjustment based on its best estimate. The Company expects to refine its estimate as new information becomes available. As of December 31, 2015, the Company recorded a payable of $108 million associated with risk adjustment, and $44 million at December 31, 2014.

Reinsurance

The ACA established a transitional three-year reinsurance program whereby the Company’s claims costs incurred for qualified members will be reimbursed when they exceed a specific threshold. For the 2015 benefit year, qualified member claims that exceeded $45,000 entitled the Company to reimbursement from the programs at 50% coinsurance. The Company accounts for reinsurance recoveries as a reduction of Medical Costs based on each individual case that exceeds the reinsurance threshold established by the program. As of December 31, 2015, the Company recorded a receivable of $24 million associated with reinsurance, and $11 million at December 31, 2014.

Risk Corridor

The temporary, three-year risk corridor program established by the ACA applies to qualified individual and small group health plans operating both inside and outside of the Health Insurance Marketplace. The risk corridor program limits the Company’s gains and losses in the Health Insurance Marketplace by comparing certain medical and administrative costs to a target amount and sharing the risk for allowable costs with the federal government. Allowable medical costs are adjusted for risk adjustment settlements, transitional reinsurance recoveries, and cost sharing reductions received from the federal government. The Company records a risk corridor receivable or payable as an adjustment to Premium Revenue on a year to date basis based on where its estimated annual costs fall within the risk corridor range. As of December 31, 2015, the Company recorded a payable of $4 million associated with risk corridor, and $9 million at December 31, 2014.

Minimum Medical Loss Ratio

Additionally, the ACA established a minimum annual medical loss ratio for the Health Insurance Marketplace. Each of the three R programs described above are taken into consideration to determine if the Company’s estimated annual medical costs are less than the minimum loss ratio and require an adjustment to Premium revenue to meet the minimum medical loss ratio. As of December 31, 2015, the Company recorded a payable of $15 million associated with minimum medical loss ratio, and $6 million at December 31, 2014.

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Premium and Related 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 related receivables and are recorded net of an allowance based on historical trends and management's judgment on the collectibility of these accounts. As the Company generally receives payments during the month in which services are provided, the allowance is typically not significant in comparison to total revenues and does not have a material impact on the presentation of the financial condition or results of operations. Activity in the allowance for uncollectible accounts for the years ended December 31, is summarized below ($ in millions):

	2015	2014	2013
Allowances, beginning of year	$5	$1	$1
Amounts charged to expense	12	8	3
Write-offs of uncollectible receivables	(7)	(4)	(3)
Allowances, end of year	$10	$5	$1

Significant Customers

Centene receives the majority of its revenues under contracts or subcontracts with state Medicaid managed care programs. The current contracts expire on various dates between April 30, 2016 and June 30, 2019. States where the aggregate annual contract value exceeded 10% of total annual revenues included Texas, where the percentage of the Company's total revenue was 22%, 25% and 37% for the years ended December 31, 2015, 2014, and 2013, respectively, and Florida where the percentage of the Company's total revenue was 14% for the years ended December 31, 2015 and 2014.

Other Income (Expense)

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

Income Taxes

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

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

Contingencies

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

Company expenses professional fees associated with litigation claims and assessments as incurred.

Stock Based Compensation

The fair value of the Company's employee share options and similar instruments are estimated using the Black-Scholes option-pricing model. That cost is recognized over the period during which an employee is required to provide service in exchange for the award. Excess tax benefits related to stock compensation are presented as a cash inflow from financing activities.

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Foreign Currency Translation

The Company is exposed to foreign currency exchange risk through its equity method investment in Ribera Salud S.A. (Ribera Salud), a Spanish health management group whose functional currency is the Euro. The assets and liabilities of the Company's investment are translated into United States dollars at the balance sheet date. The Company translates its proportionate share of earnings using average rates during the year. The resulting foreign currency translation adjustments are recorded as a separate component of accumulated other comprehensive income.

Recent Accounting Pronouncements

In November 2015, the Financial Accounting Standards Board (FASB) issued an Accounting Standards Update (ASU) which requires entities to present deferred tax assets and deferred tax liabilities as noncurrent in a classified balance sheet. The new standards simplifies the current guidance, which requires entities to separately present deferred tax assets and deferred tax liabilities as current and noncurrent in a classified balance sheet. It is effective for annual and interim periods beginning after December 15, 2016. Early adoption is permitted. The Company elected to adopt this guidance in the current fiscal year and applied the new standard retrospectively to all prior periods. The reclassification of deferred tax assets and deferred tax liabilities impacted the Consolidated Balance Sheets by decreasing Other Current Assets and increasing Other Long Term Assets by $102 million and $83 million at December 31, 2015 and December 31, 2014. These reclassifications have no effect on net earnings or stockholders' equity as previously reported.

In September 2015, the FASB issued an ASU which simplifies the accounting for measurement-period adjustments in business combinations. The new standard eliminates the requirement for an acquirer in a business combination to account for measurement-period adjustments retrospectively. Instead, acquirers must recognize measurement-period adjustments during the period in which they determine the amounts, including any amounts they would have recorded in previous periods if the accounting had been completed at the acquisition date. Additionally, the acquirer must disclose the portion of the amount that would have been recorded in previous reporting periods. It is effective for annual and interim periods beginning after December 15, 2016. Early adoption is permitted. The Company elected to adopt this guidance in the current fiscal year.

In May 2015, the FASB issued an ASU which expands the disclosure requirements for insurance companies that issue short-duration contracts. The new standard will increase the level of disclosure around the Company's Medical Claims Liability to include the following: claims development by year; claim frequency; a rollforward of the claims liability; and a description of methods and assumptions used for determining the liability. It is effective for annual periods beginning after December 15, 2015 and interim periods beginning after December 15, 2016. Early adoption is permitted. The Company is currently evaluating the effect of the new disclosure requirements.

In April 2015, the FASB issued an ASU which changes the presentation of debt issuance costs in financial statements. Under the new standard, debt issuance costs are presented in the balance sheet as a direct deduction of the related debt liability rather than as an asset. Amortization of the cost is reported as interest expense. The new standard is effective for annual and interim periods beginning after December 15, 2015 and early adoption is permitted. The Company elected to adopt this guidance beginning in the first quarter of 2015 and has applied the new standard retrospectively to all prior periods. The reclassification of debt issuance costs impacted the Consolidated Balance Sheets by decreasing both Other Long Term Assets and Long Term Debt by $14 million at December 31, 2015 and December 31, 2014. These reclassifications have no effect on net earnings or stockholders' equity as previously reported.

In May 2014, the FASB issued an ASU which supersedes existing revenue recognition standards with a single model unless those contracts are within the scope of other standards (e.g., an insurance entity's insurance contracts). Under

the new standard, recognition of revenue occurs when a customer obtains control of promised goods or services in an amount that reflects the consideration which the entity expects to receive in exchange for those goods or services. In addition, the standard requires disclosure of the nature, amount, timing and uncertainty of revenue and cash flows arising from contracts with customers. The new effective date is for annual and interim periods beginning after December 15, 2017. Early adoption is permitted. The Company is currently evaluating the effect of the new revenue recognition guidance.

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

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3. Health Net Merger

On July 2, 2015, the Company announced that the Company and two direct, newly formed subsidiaries of the Company had entered into a definitive merger agreement with Health Net, Inc. (Health Net) under which the Company will acquire all of the issued and outstanding shares of Health Net. Under the terms of the agreement, at the closing of the transaction, Health Net stockholders (with limited exceptions) would receive 0.622 of a validly issued, fully paid, non-assessable share of Centene common stock and $28.25 in cash for each share of Health Net common stock. The transaction is valued at approximately $5.5 billion (based on the Centene closing stock price on February 17, 2016), including the assumption of debt.

The transaction is expected to close in early 2016 and is subject to approvals by relevant state insurance and healthcare regulators and other customary closing conditions. In August 2015, the Company announced the early termination of the waiting period required under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended. In October 2015, the Company and Health Net announced the transaction was approved by both the Centene and Health Net stockholders. The Company expects to fund the cash portion of the acquisition through a combination of the debt financing completed in February 2016, borrowings on the Company's revolving credit facility and existing cash on hand.

4. Acquisitions and Noncontrolling Interest

Acquisitions

Agate Resources, Inc. In September 2015, the Company completed the acquisition of Agate Resources, Inc. (Agate) for $109 million. Agate is a diversified holding company that offers primarily Medicaid and other healthcare products and services to Oregon residents. The fair value of consideration of $109 million consists of initial cash consideration of $93 million, the present value of future cash payments of $7 million to be paid out over a three year period, and the fair value of estimated contingent consideration of $9 million. A portion of the contingent consideration is based on the achievement of underwriting targets and will be paid in cash over a three year period; the remainder is based on the net proceeds of a retrospective rate adjustment to be settled in 2016.

The Company's preliminary allocation of fair value resulted in goodwill of $48 million and other identifiable intangible assets of $39 million. The Company has not finalized the allocation of the fair value of assets and liabilities. The goodwill is not deductible for income tax purposes. The acquisition is recorded in the Managed Care segment.

Community Health Solutions of America, Inc. In July 2014, the Company completed a transaction whereby Community Health Solutions of America, Inc. assigned its contract with the Louisiana Department of Health and Hospitals under the Bayou Health Shared Savings Program to the Company's subsidiary, Louisiana Healthcare Connections (LHC). The fair value of consideration transferred included the present value of the estimated contingent consideration, subject to membership retained by LHC in the first quarter of 2015. The fair value of contingent consideration was $18 million at December 31, 2014. During the first quarter of 2015, the Company determined the amount of the actual contingent consideration to be $8 million. A gain of $10 million related to the settlement of the obligation was recorded in General and Administrative expense.

Fidelis SecureCare of Michigan, Inc. In May 2015, the Company acquired 100% of Fidelis SecureCare of Michigan, Inc. (Fidelis) a subsidiary of Concerto Healthcare. Fidelis was previously selected by the Michigan Department of Community Health to provide integrated healthcare services to members who are dually eligible for Medicare and Medicaid in Macomb and Wayne counties. The fair value of consideration of $57 million consisted of initial cash consideration of $7 million and the fair value of estimated contingent consideration of $50 million. The contingent consideration is based on duals membership and revenue per member during the first year of the contract (July 2015 -

June 2016), including reconciliation payments settled over a two year period. The contingent consideration fair value is estimated based on expected membership during the first year of the contract as well as estimated revenue per member reflecting both member mix and risk adjustment. The Company's allocation of fair value resulted in goodwill of $29 million and other identifiable intangible assets of $23 million. 100% of the goodwill is deductible for income tax purposes. The acquisition is recorded in the Managed Care segment.

During 2015, the Company experienced higher than anticipated opt-out rates and member attrition in the dual demonstration program, resulting in lower than expected membership and lower blended premium rates. As a result, the fair value of estimated contingent consideration was reduced from $50 million to $16 million, and the Company recorded a gain of $34 million in general and administrative expenses. In connection with the lower membership and revenue outlook, the Company conducted an impairment analysis of the identifiable intangible assets and goodwill, resulting in a reduction of goodwill and intangible assets of $38 million which was recorded in general and administrative expenses. At December 31, 2015, the Company had goodwill of $11 million and other identifiable intangible assets of $1 million, net of $2 million of amortization, remaining on the balance sheet.

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LiveHealthier, Inc. In January 2015, the Company acquired the remaining 79% of LiveHealthier, Inc. (LiveHealthier) for $28 million , bringing its total ownership to 100%. LiveHealthier is a provider of technology and service-based health management solutions. The fair value of consideration of $28 million consists of cash paid of $11 million, Centene common stock issued at closing of $13 million, and the fair value of estimated contingent consideration of $4 million to be paid in cash over a three year period. The contingent consideration will not exceed $9 million.

The Company's allocation of fair value resulted in goodwill of $26 million and other identifiable intangible assets of $15 million. The goodwill is not deductible for income tax purposes. The acquisition is recorded in the Managed Care segment.

Ribera Salud, S.A. In July 2014, the Company purchased a noncontrolling interest in Ribera Salud S.A. (Ribera Salud), a Spanish health management group for $17 million. Centene is a 50% joint shareholder with Ribera Salud's remaining investor, Banco Sabadell S.A. The Company is accounting for its investment using the equity method of accounting. Any basis difference between the Company's share of underlying net assets and the purchase price will be attributable to certain intangible assets and will be accreted into earnings over their useful lives.

Upon closing, the Company executed letters of credit for $52 million (valued at the December 31, 2015 conversion rate), or €48 million, representing its proportional share of the letters of credit issued to support Ribera Salud’s outstanding debt. Refer to Note 11, Debt for outstanding balance as of December 31, 2015.

U.S. Medical Management. In January 2014, the Company acquired 68% of U.S. Medical Management, LLC (USMM), a management services organization and provider of in-home health services for high acuity populations, for $213 million in total consideration. The transaction consideration consisted of $133 million of Centene common stock and $80 million of cash.

The total fair value of 100% of USMM on the date of acquisition was $352 million ($213 million for the Company's interest and $139 million for the redeemable noncontrolling interest). The Company's allocation of fair value resulted in goodwill of $280 million and other identifiable intangible assets of $78 million. Approximately 45% of the goodwill is deductible for income tax purposes. The acquisition is recorded in the Specialty Services segment.

In connection with the acquisition, the Company entered into call and put agreements with the noncontrolling interest holder to purchase the noncontrolling interest at a later date. Under these agreements, the Company may purchase or be required to purchase up to the total remaining interests in USMM over a period beginning in 2015 and continuing through 2017. Under certain circumstances, the agreements may be extended through 2020. At the Company’s sole option, up to 50% of the consideration to be issued for the purchase of the additional interests under these agreements may be funded with shares of the Company's common stock.

Noncontrolling Interest

The Company has consolidated subsidiaries where it maintains less than 100% ownership. The Company’s ownership interest for each subsidiary as of December 31, are as follows:

	2015		2014		2013	
Celtic Insurance Company	75	%	100	%	100	%
Centurion	51	%	51	%	51	%
Home State Health Plan	95	%	95	%	95	%
U.S. Medical Management	68	%	68	%	—	

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Net income attributable to Centene Corporation and transfers from (to) noncontrolling interest entities are as follows ($ in millions):

	Year Ended December 31,		
	2015	2014	2013
Net earnings attributable to Centene Corporation	$356	$268	$161
Transfers from (to) the noncontrolling interest:			
Increase in equity for distributions from and consolidation of noncontrolling interest	11	—	7
Reclassification to redeemable noncontrolling interest	1	(9)	—
Net transfers from (to) noncontrolling interest	12	(9)	7
Changes from net earnings attributable to Centene Corporation and net transfers from (to) the noncontrolling interest	$368	$259	$168

Redeemable Noncontrolling Interest

As a result of put option agreements, noncontrolling interest is considered redeemable and is classified in the Redeemable Noncontrolling Interest section of the consolidated balance sheets. Noncontrolling interest is initially measured at fair value using the binomial lattice model as of the acquisition date. The Company has elected to accrete changes in the redemption value through additional paid-in capital over the period from the date of issuance to the earliest redemption date following the effective interest method.

A reconciliation of the changes in the Redeemable Noncontrolling Interest is as follows ($ in millions):

Balance, December 31, 2014	$148
Fair value of noncontrolling interest sold	7
Reclassification to redeemable noncontrolling interest	(1)
Net earnings attributable to noncontrolling interest	2
Balance, December 31, 2015	$156

Ownership changes are described in more detail below.

Celtic Insurance Company In January 2015, the Company sold 25% of its ownership in Celtic Insurance Company for $7 million. No gain or loss was recognized on the sale of the ownership interest. Celtic Insurance Company is included in the Managed Care segment. In connection with the sale of the ownership interest, the Company entered into a put agreement with the noncontrolling interest holder, allowing the noncontrolling interest holder to put its interest back to the Company beginning in 2022. As a result of put option agreements, the noncontrolling interest is considered redeemable and is classified in the Redeemable Noncontrolling Interest section of the consolidated balance sheets.

Pro forma disclosures related to the acquisitions have been excluded as immaterial.

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5. 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, 2015				December 31, 2014			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$431	$—	$(2)	$429	$393	$1	$(2)	$392
Corporate securities	859	2	(8)	853	556	2	(2)	556
Restricted certificates of deposit	5	—	—	5	6	—	—	6
Restricted cash equivalents	78	—	—	78	79	—	—	79
Municipal securities	496	2	(1)	497	174	1	—	175
Asset backed securities	163	—	(1)	162	180	—	—	180
Residential mortgage backed securities	66	1	—	67	84	1	—	85
Commercial mortgage backed securities	40	—	—	40	—	—	—	—
Cost and equity method investments	71	—	—	71	68	—	—	68
Life insurance contracts	16	—	—	16	16	—	—	16
Total	$2,225	$5	$(12)	$2,218	$1,556	$5	$(4)	$1,557

The Company’s investments are classified as available-for-sale with the exception of life insurance contracts and certain cost and equity method investments. The Company’s investment policies are designed to provide liquidity, preserve capital and maximize total return on invested assets with the focus on high credit quality securities. The Company limits the size of investment in any single issuer other than U.S. treasury securities and obligations of U.S. government corporations and agencies. The Company's mortgage backed securities are issued by the Federal National Mortgage Association and carry guarantees by the U.S. government. As of December 31, 2015, 99% of the Company’s investments in rated securities carry an investment grade rating by S&P or Moody’s. At December 31, 2015, the Company held certificates of deposit, life insurance contracts and cost and equity method investments which did not carry a credit rating.

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The fair value of available-for-sale investments 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, 2015				December 31, 2014			
	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)	$294	$—	$14	$—	$72	$(2)	$180
Corporate securities	(6)	561	(2)	41	(2)	311	—	1
Municipal securities	(1)	208	—	5	—	20	—	7
Asset backed securities	(1)	121	—	8	—	70	—	10
Residential Mortgage backed securities	—	30	—	—	—	18	—	—
Commercial mortgage backed securities	—	34	—	—	—	—	—	—
Total	$(10)	$1,248	$(2)	$68	$(2)	$491	$(2)	$198

As of December 31, 2015, the gross unrealized losses were generated from 429 positions out of a total of 733 positions. The change in fair value of fixed income securities is a result of movement in interest rates subsequent to the purchase of the security.

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

During the year ended December 31, 2015, the company recognized $8 million of income from equity method investments.

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

	December 31, 2015				December 31, 2014			
	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	$176	$176	$93	$93	$176	$177	$92	$92
One year through five years	1,662	1,654	22	22	1,121	1,121	8	8

Five years through ten years	267	268	—	—	121	120	—	—
Greater than ten years	5	5	—	—	38	39	—	—
Total	$2,110	$2,103	$115	$115	$1,456	$1,457	$100	$100

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

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

6. 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 the 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, 2015, 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	$1,760	$—	$—	$1,760
Investments available for sale:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$325	$72	$—	$397
Corporate securities	—	853	—	853
Municipal securities	—	497	—	497
Asset backed securities	—	162	—	162
Residential mortgage backed securities	—	67	—	67
Commercial mortgage backed securities	—	40	—	40
Total investments	$325	$1,691	$—	$2,016
Restricted deposits available for sale:				
Cash and cash equivalents	$78	$—	$—	$78
Certificates of deposit	5	—	—	5
U.S. Treasury securities and obligations of U.S. government corporations and agencies	32	—	—	32
Total restricted deposits	$115	$—	$—	$115
Other long term assets:				
Interest rate swap agreements	$—	$11	$—	$11
Total assets at fair value	$2,200	$1,702	$—	$3,902
Liabilities				
Other long term liabilities:				
Interest rate swap agreements	$—	$2	$—	$2

Total liabilities at fair value	$—	$2	$—	$2

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The following table summarizes fair value measurements by level at December 31, 2014, 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	$1,610	$—	$—	$1,610
Investments available for sale:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$360	$17	$—	$377
Corporate securities	—	556	—	556
Municipal securities	—	175	—	175
Asset backed securities	—	180	—	180
Residential mortgage backed securities	—	85	—	85
Commercial mortgage backed securities	—	—	—	—
Total investments	$360	$1,013	$—	$1,373
Restricted deposits available for sale:				
Cash and cash equivalents	$79	$—	$—	$79
Certificates of deposit	6	—	—	6
U.S. Treasury securities and obligations of U.S. government corporations and agencies	15	—	—	15
Total restricted deposits	$100	$—	$—	$100
Other long term assets:				
Interest rate swap agreements	$—	$11	$—	$11
Total assets at fair value	$2,070	$1,024	$—	$3,094

The Company periodically transfers U.S. Treasury securities and obligations of U.S. government corporations and agencies between Level I and Level II fair value measurements dependent upon the level of trading activity for the specific securities at the measurement date. The Company's policy regarding the timing of transfers between Level I and Level II is to measure and record the transfers at the end of the reporting period. At December 31, 2015, there were $53 million of transfers from Level I to Level II and no transfers from Level II to Level I. The Company utilizes matrix pricing services to estimate fair value for securities which are not actively traded on the measurement date. The Company designates these securities as Level II fair value measurements. The aggregate carrying amount of the Company's life insurance contracts and other non-majority owned investments, which approximates fair value, was $87 million and $84 million as of December 31, 2015 and December 31, 2014, respectively.

7. Property, Software and Equipment

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

	2015	2014
Computer software	$237	$198
Building	223	208
Land	104	87
Computer hardware	105	88
Furniture and office equipment	92	70
Leasehold improvements	108	82
	869	733
Less accumulated depreciation	(351)	(288)
Property, software and equipment, net	$518	$445

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As of December 31, 2015 and 2014, the Company had assets acquired under capital leases included above of $6 million and $7 million, net of accumulated amortization of $4 million and $3 million, respectively. Amortization on assets under capital leases charged to expense is included in depreciation expense. Depreciation expense for the years ended December 31, 2015, 2014 and 2013 was $78 million, $65 million and $52 million, respectively.

8. 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, 2013	$151	$197	$348
Acquisition	125	281	406
Balance as of December 31, 2014	276	478	754
Acquisition	103	3	106
Impairment	(18)	—	(18)
Balance as of December 31, 2015	$361	$481	$842

Goodwill acquisitions were related to the acquisitions and finalization of fair value allocations discussed in Note 4, Acquisitions and Noncontrolling Interest.

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

			Weighted Average Life in Years	
	2015	2014	2015	2014
Purchased contract rights	$71	$28	8.8	7.5
Provider contracts	103	103	11.1	11.1
Customer relationships	26	15	8.1	7.1
Trade names	12	17	7.3	13.1
Developed technology	5	—	5.0	—
Intangible assets	217	163	9.8	10.3
Less accumulated amortization:				
Purchased contract rights	(21)	(14)		
Provider contracts	(24)	(14)		
Customer relationships	(14)	(12)		
Trade names	(2)	(3)		
Developed technology	(1)	—		
Total accumulated amortization	(62)	(43)		
Intangible assets, net	$155	$120		

Amortization expense was $24 million, $16 million and $6 million for the years ended December 31, 2015, 2014 and 2013, respectively. Estimated total amortization expense related to intangible assets for each of the five succeeding fiscal years is as follows ($ in millions):

Year	Expense
2016	$22
2017	19
2018	18
2019	18
2020	16

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9. Medical Claims Liability

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

	Year Ended December 31,		
	2015	2014	2013
Balance, January 1,	$1,723	$1,112	$815
Acquisitions	79	—	—
Incurred related to:			
Current year	17,471	12,820	9,073
Prior years	(229)	(142)	(78)
Total incurred	17,242	12,678	8,995
Paid related to:			
Current year	15,279	11,122	7,975
Prior years	1,467	945	723
Total paid	16,746	12,067	8,698
Balance, December 31,	$2,298	$1,723	$1,112

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 $47 million, $26 million, and $0 million of the “Incurred related to: Prior period” was recorded as a reduction to premium revenues in 2015, 2014 and 2013, respectively. Further, claims processing initiatives yielded increased claim payment recoveries and coordination of benefits related to prior year dates of service. Changes in medical utilization and cost trends and the effect of medical management initiatives may also contribute to changes in medical claim liability estimates. While the Company has evidence that medical management initiatives are effective on a case by case basis, medical management initiatives primarily focus on events and behaviors prior to the incurrence of the medical event and generation of a claim. Accordingly, any change in behavior, leveling of care, or coordination of treatment occurs prior to claim generation and as a result, the costs prior to the medical management initiative are not known by the Company. Additionally, certain medical management initiatives are focused on member and provider education with the intent of influencing behavior to appropriately align the medical services provided with the member's acuity. In these cases, determining whether the medical management initiative changed the behavior cannot be determined. Because of the complexity of its business, the number of states in which it operates, and the volume of claims that it processes, the Company is unable to practically quantify the impact of these initiatives on its changes in estimates of IBNR.

The Company had reinsurance recoverables related to medical claims liability of $31 million and $22 million at December 31, 2015 and 2014, respectively, included in premium and related receivables.

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

10. Health Insurance Marketplace

The Affordable Care Act (ACA) established risk spreading premium stabilization programs effective January 1, 2014 for the Health Insurance Marketplace product. These programs, commonly referred to as the “three Rs,” include a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridor program.

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

In June 2015, CMS released final results on reinsurance and risk-adjustment for the 2014 plan year. In September 2015, the results on risk corridor and the minimum medical loss ratio were finalized for the 2014 plan year. These final results had an insignificant impact to the Company for the 2014 plan year.

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

	December 31, 2015	December 31, 2014
Risk adjustment	$(108)	$(44)
Reinsurance	24	11
Risk corridor	(4)	(9)
Minimum medical loss ratio	(15)	(6)

11. Debt

Debt consists of the following ($ in millions):

	December 31, 2015	December 31, 2014
$425 million 5.75% Senior notes, due June 1, 2017	$428	$429
$500 million 4.75% Senior notes, due May 15, 2022	500	300
Fair value of interest rate swap agreements	9	11
Senior notes	937	740
Revolving credit agreement	225	75
Mortgage notes payable	67	70
Capital leases	6	8
Debt issuance costs	(14)	(14)
Total debt	1,221	879
Less current portion	(5)	(5)
Long term debt	$1,216	$874

Senior Notes

In January 2015, the Company issued an additional $200 million of 4.75% Senior Notes ($200 Million Add-on Notes) at par. The $200 Million Add-on Notes were offered as additional debt securities under the indenture governing the $300 million of 4.75% Senior Notes issued in April 2014. In connection with the January 2015 issuance, the Company entered into interest rate swap agreements for a notional amount of $200 million at a floating rate of interest based on the three month LIBOR plus 2.88%. Gains and losses due to changes in the fair value of the interest rate swap completely offset changes in the fair value of the hedged portion of the underlying debt and are recorded as an adjustment to the $200 Million Add-on Notes.

In April 2014, the Company issued $300 million of 4.75% Senior Notes due May 15, 2022 ($300 Million Notes) at par. In connection with the April 2014 issuance, the Company entered into interest rate swap agreements for a notional amount of $300 million. Gains and losses due to changes in the fair value of the interest rate swap agreements offset changes in the fair value of the hedged portion of the underlying debt and are recorded as an adjustment to the $300 Million Notes.

The indentures governing both the $425 million and the $500 million notes contain non-financial and financial covenants, including requirements of a minimum fixed charge coverage ratio.

Interest Rate Swaps

The Company uses interest rate swap agreements to convert a portion of its interest rate exposure from fixed rates to floating rates to more closely align interest expense with interest income received on its cash equivalent and variable rate investment balances. The Company has $750 million of notional amount of interest rate swap agreements consisting of $250 million which are scheduled to expire on June 1, 2017 and $500 million that are scheduled to expire May 15, 2022. Under the Swap Agreements, the Company receives a fixed rate of interest and pays a variable

rate of the three month LIBOR plus an average 2.85% adjusted quarterly. At December 31, 2015, the weighted average rate was 3.22%.

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

The fair values of the Swap Agreements as of December 31, 2015 were assets of $11 million and liabilities of $2 million, and are included in other long term assets and other long term liabilities, respectively in the Consolidated Balance Sheet. The fair value of the Swap Agreements as of December 31, 2014 were assets of $11 million and are included in other long term assets in the Consolidated Balance Sheet. The fair value of the Swap Agreements excludes accrued interest and takes into consideration current interest rates and current likelihood of the swap counterparties' compliance with its contractual obligations.

Revolving Credit Agreement

The Company has an unsecured $500 million revolving credit facility. Borrowings under the agreement bear interest based upon LIBOR rates, the Federal Funds Rate or the Prime Rate. The agreement has a maturity date of June 1, 2018, provided it will mature 90 days prior to the maturity date of the Company's 5.75% Senior Notes due 2017 if such notes are not refinanced (or extended), certain financial conditions are not met, or the Company does not carry $100 million of unrestricted cash. As of December 31, 2015, the Company had $225 million of borrowings outstanding under the agreement with a weighted average interest rate of 2.05%.

The agreement contains non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios, maximum debt-to-EBITDA ratios and minimum tangible net worth. The Company is required to not exceed a maximum debt-to-EBITDA ratio of 3.0 to 1.0. As of December 31, 2015, there were no limitations on the availability under the revolving credit agreement as a result of the debt-to-EBITDA ratio.

Mortgage Notes Payable

The Company has a non-recourse mortgage note of $67 million at December 31, 2015 collateralized by its corporate headquarters building. The mortgage note is due January 1, 2021 and bears a 5.14% interest rate. The collateralized property had a net book value of $151 million at December 31, 2015.

Letters of Credit & Surety Bonds

The Company had outstanding letters of credit of $47 million as of December 31, 2015, which were not part of the revolving credit facility. As discussed in Note 4, Acquisitions and Noncontrolling Interest, the Company also had letters of credit for $50 million (valued at December 31, 2015 conversion rate), or €46 million, representing its proportional share of the letters of credit issued to support Ribera Salud's outstanding debt which are a part of the revolving credit facility. Collectively, the letters of credit bore interest at 1.55% as of December 31, 2015. The Company had outstanding surety bonds of $305 million as of December 31, 2015.

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

2016	$5
2017	429
2018	228

2019	4
2020	4
Thereafter	553
Total	$1,223

The fair value of outstanding debt was approximately $1,239 million and $901 million at December 31, 2015 and 2014, respectively.

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12. Stockholders' Equity

The Company has 10,000,000 authorized shares of preferred stock at $.001 par value. At December 31, 2015, there were no preferred shares outstanding.

The Company's Board of Directors has authorized a stock repurchase program for up to 8,000,000 shares of the Company's common stock from time to time on the open market or through privately negotiated transactions. No duration has been placed on the repurchase program. The Company has 3,335,448 available shares remaining under the program for repurchases as of December 31, 2015. The Company reserves the right to discontinue the repurchase program at any time. During the year ended December 31, 2015, the Company did not repurchase any shares through this publicly announced program.

As a component of the employee stock compensation plan, employees can use shares of stock which have vested to satisfy minimum statutory tax withholding obligations. As part of this plan, the Company repurchased 918,628 shares at an aggregate cost of $53 million in 2015 and 626,234 shares at an aggregate cost of $29 million in 2014. These shares are included in the Company's treasury stock.

In January 2014, the Company completed the acquisition of 68% of USMM and as a result, issued 4,486,434 shares of Centene common stock to the selling stockholders. Additionally, in July 2014, the Company completed a transaction whereby CHS assigned its contract with the Louisiana Department of Health and Hospitals to Centene's wholly owned subsidiary, LHC. The closing resulted in the issuance of 1,492,738 shares of Centene common stock.

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, 2015 and 2014, Centene's subsidiaries, including Kentucky Spirit Health Plan, had aggregate statutory capital and surplus of $2,284 million and $1,699 million, respectively, compared with the required minimum aggregate statutory capital and surplus of $1,195 million and $851 million, respectively.

14. Income Taxes

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

	2015	2014	2013
Current provision:			
Federal	$332	$225	$121
State and local	26	13	6
Total current provision	358	238	127
Deferred provision	(19)	(42)	(20)
Total provision for income taxes	$339	$196	$107

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The reconciliation of the tax provision at the U.S. Federal Statutory Rate to the provision for income taxes for the years ended December 31 is as follows ($ in millions):

	2015	2014	2013
Earnings from continuing operations, before income tax expense	$697	$457	$269
(Earnings) loss attributable to flow through noncontrolling interest	1	4	(1)
Earnings from continuing operations, less noncontrolling interest, before income tax expense	698	461	268
Tax provision at the U.S. federal statutory rate	244	162	94
State income taxes, net of federal income tax benefit	15		