WELLCARE HEALTH PLANS, INC.
Form 10-K
February 16, 2018

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, D.C. 20549
FORM 10-K
ý ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the Fiscal Year Ended December 31, 2017
OR
o TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the Transition Period From to

Commission File Number 001-32209
WellCare Health Plans, Inc.
(Exact Name of Registrant as Specified in Its Charter)

Delaware	47-0937650
(State or Other Jurisdiction of Incorporation or Organization)	(I.R.S. Employer Identification No.)

8735 Henderson Road, Renaissance One Tampa, Florida	33634
(Address of Principal Executive Offices)	(Zip Code)

(813) 290-6200
Registrant's telephone number, including area code

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

Common Stock, par value $0.01 per share	New York Stock Exchange
(Title of Class)	(Name of Each Exchange on which Registered)

Securities registered pursuant to Section 12(g) of the Exchange Act:
NONE
Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ý Noo
Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 of Section 15(d) of the Act. Yes o Noý
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 ý No o
Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Website, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ý No o
Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§ 229.405) 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. ý
Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, smaller reporting company, or an emerging growth company. See the definitions of “large accelerated filer,” “accelerated filer,” “smaller reporting company,” and “emerging growth company” in Rule 12b-2 of the Exchange Act. (Check one):
Large accelerated filer x Accelerated filer o Non-accelerated filer o (do not check if a smaller reporting company)

Smaller reporting company o Emerging growth company o

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

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

The aggregate market value of Common Stock held by non-affiliates of the registrant (assuming solely for the purposes of this calculation that all directors and executive officers of the registrant are "affiliates") as of June 30, 2017 was approximately $8.0 billion (based on the closing sale price of the registrant's Common Stock on that date as reported on the New York Stock Exchange).

As of February 13, 2018, there were 44,529,151 outstanding shares of the registrant's Common Stock, par value $0.01 per share.

Documents Incorporated by Reference: Portions of the registrant's definitive Proxy Statement for the 2018 Annual Meeting of Stockholders are incorporated by reference into Part III of this Form 10-K.

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References to the "Company," "WellCare," "we," "our," and "us" in this Annual Report on Form 10-K for the fiscal year ended December 31, 2017 (the "2017 Form 10-K") refer to WellCare Health Plans, Inc., together, in each case, with our subsidiaries and any predecessor entities unless the context suggests otherwise.

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FORWARD-LOOKING STATEMENTS

Statements contained in this Form 10-K for the year ended December 31, 2017 ("2017 Form 10-K"), which are not historical fact may be forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 and Section 21E of the Securities Exchange Act of 1934, as amended, (the "Exchange Act"), and we intend such statements to be covered by the safe harbor provisions for forward-looking statements contained therein. Such statements, which may address, among other things, our financial outlook, the timing of the launch of new programs, pending new Medicaid contracts, the appropriation and payment to us by state governments of Medicaid premiums receivable, the financial effect of recent acquisitions, including integration costs, rate changes, market acceptance of our products and services, our ability to finance growth opportunities, our ability to respond to changes in laws and government regulations, including any repeal, replacement or modification of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, the "ACA"), implementation of our growth strategies, projected capital expenditures, liquidity and the availability of additional funding sources may be found in the sections of this 2017 Form 10-K entitled "Business," "Risk Factors," "Management's Discussion and Analysis of Financial Condition and Results of Operations" and elsewhere in this report generally. In some cases, you can identify forward-looking statements by terminology such as "may," "will," "should," "expects," "plans," "anticipates," "believes," "estimates," "targets," "predicts," "potential," "continues" or the negative of such terms or other comparable terminology. Forward-looking statements involve risks and uncertainties, including economic, regulatory, competitive and other factors that may affect our business. These forward-looking statements are inherently susceptible to uncertainty and changes in circumstances, as they are based on management's expectations and beliefs about future events and circumstances. Given the risks and uncertainties inherent in forward-looking statements, any of our forward-looking statements could be incorrect and investors are cautioned not to place undue reliance on any of our forward-looking statements. Subsequent events and developments may cause actual results to differ, perhaps materially, from our forward-looking statements. We undertake no duty and expressly disclaim any obligation to update publicly any forward-looking statements for any reason, even if new information becomes available or other events occur in the future.

Our actual results may differ materially from those indicated by forward-looking statements as a result of various important factors, including the expiration, cancellation, delay, suspension or amendment of our state and federal contracts. In addition, our results of operations and estimates of future earnings depend, in large part, on accurately estimating and effectively managing health care benefits and other operating expenses. A variety of factors may affect our premium revenue, medical expenses, profitability, cash flows, and liquidity including the outcome of any protests and litigation related to Medicaid awards, competition, changes in health care practices, changes in the demographics of our members, higher than expected utilization of health care services by our members, changes in federal or state laws and regulations or their interpretations, inflation, provider contract changes, changes in or suspensions or terminations of our contracts with government agencies, new technologies, such as new, expensive medications, potential reductions in Medicaid and Medicare revenue, the appropriation and payment to us by state governments of Medicaid premiums receivable, our ability to negotiate actuarially sound rates, especially in new programs with limited experience, government-imposed surcharges, taxes or assessments, changes to how provider payments are made by governmental payors, the ability of state customers to launch new programs on their announced timelines, or at all, the timing of the approval by the Centers for Medicare & Medicaid Services ("CMS") of Medicaid contracts, or changes to the contracts or rates required to obtain CMS approval, major epidemics, disasters and numerous other factors affecting the delivery and cost of health care, such as major health care providers' inability to maintain their operations, and our ability to implement health care value-added programs and our ability to control our medical costs and other operating expenses, including through our vendors. Governmental action or inaction could result in premium revenues not increasing to offset any increase in medical costs, the annual premium-based health insurance industry assessment (the "ACA industry fee") or other operating expenses. Once set, premiums are generally fixed for one-year periods and, accordingly, costs that exceed our estimates or our regulators' actuarial pricing assumptions during such periods generally may not be able to be recovered through higher premiums or rate adjustments.

Furthermore, if we are unable to estimate accurately incurred but not reported medical costs in the current period, our future profitability may be adversely affected. Due to these factors and risks, we cannot provide any assurance regarding our future premium levels or our ability to control our future medical costs.

In addition, the risks and uncertainties include, but are not limited to, our progress on top priorities such as integrating care management, advocating for our members, building advanced relationships with providers and government partners, delivering prudent, profitable growth, our ability to effectively estimate and manage growth, our ability to address operational challenges relating to new business, including, but not limited to, the outcome of any protests and litigation related to Medicaid awards, our ability to meet the requirements of readiness reviews, the timing and ability to satisfy closing conditions for pending acquisitions, including receipt of regulatory approvals, adjustments to the purchase price of pending acquisitions and its manner of payment, our ability to effectively identify, execute and integrate acquisitions, and the performance of our acquisitions once acquired. Due to these factors and risks, we may be required to write down or take impairment charges of assets associated with acquisitions. Furthermore, at both the federal and state government levels, legislative and regulatory proposals have been

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made related to, or potentially affecting, the health care industry, including but not limited to, repeal, replacement or modification of the ACA, reform of the Medicaid and Medicare programs, limitations on managed care organizations, changes to membership eligibility, and benefit mandates. Any such legislative or regulatory action could have the effect of reducing the premiums paid to us by governmental programs, increasing our medical and administrative costs or requiring us to materially alter the manner in which we operate. We are unable to predict the specific content of any future legislation, action or regulation that may be enacted or when any such future legislation or regulation will be adopted. Therefore, we cannot predict accurately the effect or ramifications of such future legislation, action or regulation on our business, financial condition, results of operations, and/or cash flows.

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PART I

Item 1. Business.

OVERVIEW

We are a leading managed care company, headquartered in Tampa, Florida, focusing exclusively on providing government-sponsored managed care services, primarily through Medicaid, Medicare Advantage ("MA") and Medicare Prescription Drug Plans ("PDPs") to families, children, seniors and individuals with complex medical needs. As of December 31, 2017, we served approximately 4.4 million members in 50 states and the District of Columbia. We estimate that we are among the largest managed care organizations providing Medicaid managed care services plans, MA plans and PDPs, as measured by membership. Our broad range of experience and government focus allows us to effectively serve our members, partner with our providers, government clients and communities we serve, and efficiently manage our ongoing operations.

We were formed as a Delaware limited liability company in May 2002 and began our operations in Florida, New York, and Connecticut through two concurrent health plan acquisitions completed in July 2002. In July 2004, immediately prior to the closing of our initial public offering, we merged the limited liability company into a Delaware corporation and changed our name to WellCare Health Plans, Inc.

As of December 31, 2017, we operated Medicaid health plans in Arizona, Florida, Georgia, Hawaii, Illinois, Kentucky, Missouri, Nebraska, New Jersey, New York, South Carolina and Texas. We began serving Medicaid and Medicare members in Arizona, effective December 31, 2016, in connection with the acquisition of Care1st Health Plan Arizona, Inc. and One Care by Care1st Health Plan of Arizona, Inc. (together, "Care1st Arizona"). Effective January 1, 2017, we began serving Medicaid members statewide in Nebraska.

In addition, as of December 31, 2017, we offered MA coordinated care plans ("CCPs") in certain counties in Arizona, Arkansas, California, Connecticut, Florida, Georgia, Hawaii, Illinois, Kentucky, Louisiana, Maine, Mississippi, New Jersey, New York, South Carolina, Tennessee and Texas. We also offered stand-alone Medicare PDPs in 50 states and the District of Columbia. Effective January 1, 2018, we expanded our MA service area into the state of North Carolina.

We manage our business in three reportable segments: Medicaid Health Plans, Medicare Health Plans and Medicare PDPs. See Our Product Segments below for further discussion.

Membership Concentration

In the following table, we have summarized membership for our business segments in each state that exceeded 5% of our total membership, as well as all other states in the aggregate, as of December 31, 2017.

State	Medicaid Health Plans [2]	Medicare Health Plans [2]	Medicare PDPs	Total Membership	Percent of Total Membership	
Florida	751,000	101,000	30,000	882,000	20.2	%
Georgia	513,000	47,000	19,000	579,000	13.2	%
Kentucky	448,000	9,000	24,000	481,000	11.0	%
Missouri	286,000	—	17,000	303,000	6.9	%
New York	146,000	89,000	57,000	292,000	6.7	%
Texas	14,000	105,000	105,000	224,000	5.1	%
All other states [1]	565,000	145,000	900,000	1,610,000	36.9	%
Total	2,723,000	496,000	1,152,000	4,371,000	100.0	%

(1) Represents the aggregate of all states that individually have less than 5% of total membership.

(2) Medicaid Health Plans and Medicare Health Plans membership includes members who are dually-eligible and participate in both our Medicaid and Medicare programs. The dually-eligible membership was 52,000 at December 31, 2017.

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Acquisitions

On May 1, 2017, we completed our acquisition of certain assets from Phoenix Health Plan ("PHP"), including Arizona Medicaid membership and certain provider contracts. The transaction included the transfer of approximately 42,000 Medicaid members to Care1st Arizona, a wholly owned subsidiary of the Company. The transaction was funded with available cash on hand.

On April 28, 2017, we acquired all of the outstanding shares of Universal American Corp. ("Universal American"). The transaction was valued at approximately $770.0 million, and, as of December 31, 2017, served approximately 119,000 MA members in Texas, New York and Maine, strengthens our business by increasing our MA membership by one-third, deepening our presence in two key markets, Texas and New York, and diversifying our business portfolio. In addition, Universal American has joined with provider groups to operate Accountable Care Organizations (“ACOs”) under the Medicare Shared Saving Program ("MSSP") and Next Generation ACO models. As of December 31, 2017, we operate 16 MSSP ACOs and two Next Generation ACOs.

On December 31, 2016, we completed the acquisition of Care1st Arizona. The purchase price was approximately $163.8 million, inclusive of statutory capital and subject to certain adjustments. As of December 31, 2017, Care1st Arizona served approximately 153,000 Medicaid members in Arizona, including the previously noted membership acquired from PHP. Given that the transaction was completed on December 31, 2016, Care1st Arizona's 2016 results of operations were not significant to our consolidated statement of comprehensive income for the year ended December 31, 2016.

OUR VISION, MISSION AND STRATEGY

We focus exclusively on government-sponsored managed care services primarily through Medicaid, MA and PDPs that serve families, children, seniors and individuals with complex medical needs, with a focus on lower-income beneficiaries. We are committed to operating our business in a manner that serves our key constituents - members, providers, government partners, and associates - while delivering competitive returns for our investors.

Vision

Our vision is to be a leader in government-sponsored health care programs in collaboration with our members, providers, and government partners. We foster a rewarding and enriching culture to inspire our associates to do well for others.

Mission

At WellCare, our members are our reason for being. We help those eligible for government-sponsored health care programs live better, healthier lives.

Strategy

Overview

We focus on serving Medicaid and Medicare members, by understanding their special needs, challenges, and the communities in which they live. We have developed expertise in three major areas of government-sponsored managed care: Medicaid, MA and PDPs.

Our strategy is to diversify our sources of revenue and earnings, and, consequently, to provide a strong and stable capital position so we can serve our government partners and members. Our vision and mission are achieved by focusing on integrated care management, local markets and community advocacy, regulatory and provider partnerships and delivering prudent, profitable long-term growth.

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Integrated Care Management

The members that we serve include lower income individuals, members with medically-complex conditions, and those who are dually eligible for Medicaid and Medicare. We are committed to continually improving the quality of care and service that we provide to our members, and to help them access the right care at the right time in the appropriate setting. We are focused on preventive health, wellness and an integrated care management model bringing together medical, behavioral, social and pharmacy programs that assist our government partners to provide quality care within their fiscal constraints. We have invested in a flexible model of care that adapts to the needs of our members through appropriate degrees of intensity, which we anticipate will improve our member care, quality, accreditations, Star Ratings and, ultimately, our financial results. Providing a more comprehensive and integrated set of services provides a better care experience for our members.

Local Markets and Community Advocacy

WellCare's "mission to serve" starts with our members, but it does not end there. We achieve greater presence and support through our local market structure. In each of the states in which we operate, we have a market leader who manages customer-facing functions such as member outreach, provider engagement and quality management, and state regulatory and government relations. We are committed to closing the social care gaps with our care model through collaboration with local community and social groups that are targeted at serving members who may be economically disadvantaged. Our commitment includes breaking down barriers preventing our members from attaining the health care they need by connecting them not only to medical professionals, but also to community-based resources such as food banks, housing assistance, transportation, and child care and education programs.

Regulatory and Provider Partnerships

We build advanced government and provider partnerships to further enhance health care delivery and improve the quality of and access to health care services for our members via high-performing, cost-effective health care solutions. Our provider networks, community support relationships, service infrastructure, and other elements of our business model all are targeted to serving Medicaid and Medicare eligible members who may be economically disadvantaged. In each community that WellCare serves, we focus on developing a comprehensive and collaborative provider network, which is essential to delivering quality health care to our members and value to our government partners. Our experience, exclusive commitment to government-sponsored managed care programs and regulatory relationships, provides improved budget predictability and innovative health care solutions that emphasize collaborative and holistic care coordination, supportive disease management and preventative care.

Delivering prudent, profitable long-term growth

We pursue opportunities for prudent, profitable growth through bidding on Medicaid procurements of new and existing programs. These markets can have a substantial concentration of dual-eligible and medically-complex members, such as long-term services and supports and the aged, blind and disabled. Long-term growth also includes our intent to enter new service areas for Medicare Advantage. We grow organically by creating provider networks, community advocacy, marketing and other capabilities required to expand progressively into new service areas and offer new products. We also seek to acquire and integrate attractive Medicare or Medicaid related businesses that strengthen our market position or capabilities.

We align our expense structure with our revenue base and continually assess opportunities to maintain appropriate medical benefit ratios, obtain actuarially-sound rates, and manage administrative costs to generate earnings that enable us to reinvest in our business and members. With respect to medical benefits expense, our initiatives are focused on quality improvement, reductions in unit costs, optimizing utilization of services, and eliminating waste and abuse. We

also continue to invest in technology, regulatory compliance and other infrastructure with the objectives, among others, of improving efficiency and service quality to our members. For more information regarding our SG&A ratio, please see Item 6 - Selected Financial Data as well as Item 7 - Management's Discussion and Analysis of Financial Condition and Results of Operations.

For a list of key developments and accomplishments relating to progress on our business strategy that occurred or affected our results of operations, financial condition or cash flows during 2017, and in the 2018 period prior to issuance of this 2017 Form 10-K, please see Item 7 – Management's Discussion and Analysis of Financial Condition and Results of Operations, Key Developments and Accomplishments.

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OUR BUSINESS - MEDICAID AND MEDICARE HEALTH PROGRAMS

Government-sponsored coverage in the United States is an important element of the health care system. According to CMS, federal and state spending on Medicaid, Children's Health Insurance Programs ("CHIPs"), and Medicare is estimated to have exceeded $1.3 trillion and aided over 130 million people in 2017. By 2025, CMS anticipates spending on these three programs will increase by 68%. In 2017, the Congressional Budget Office ("CBO") estimated, based on average monthly enrollment, that approximately 77 million people were covered by the joint state and federally funded Medicaid program (including CHIPs) and approximately 58 million people were covered by the federally funded Medicare program.

Managed care solutions have a well-established track record of helping governments improve health care quality and access for beneficiaries while strengthening the fiscal sustainability of these programs. Given economic conditions, demographics, budget challenges, and the proven success of managed care programs, we believe federal and state governments will continue to turn to managed care solutions to help achieve program objectives.

A “managed care” plan is an integrated health care delivery system that manages health care services for an enrolled population rather than simply providing or paying for these services. Services within managed care plans are usually delivered by providers who are under contract to, or employed by, the plan. Managed care plans use a variety of approaches to “manage” care, including, but not limited to, care and disease management, capitation, risk-sharing or value-based arrangements with providers, the use of primary care physicians to act as health care "gatekeepers" and the use of preferred provider networks.

As of December 31, 2017, our Medicare plans are offered under the WellCare name, for which we hold a federal trademark registration, with the exception of our Hawaii CCP and California CCP, which we offer under the names 'Ohana and Easy Choice, respectively. Additionally, certain of our Texas and northeast plans are offered under the Texan Plus and Today's Options names, respectively. For our Medicaid plans, we offered a number of brand names depending on the state, consisting of Care1st Arizona, Staywell in Florida, 'Ohana in Hawaii, Harmony in Illinois, Missouri Care in Missouri and the WellCare brand name in Georgia, Kentucky, Nebraska, New Jersey, New York and South Carolina.

Medicaid

Medicaid provides medical assistance to low-income and disabled persons and is implemented and operated by each state. Medicaid is funded and regulated by both the state and federal governments. Within federal guidelines, each state establishes its own eligibility standards; determines the type, amount, duration and scope of services; sets the rate of payment for services; and administers its own program. This results in considerable variation in the types of services covered and the amount of care provided across states. Many states offer a variety of public programs, including Temporary Assistance for Needy Families ("TANF"), Supplemental Security Income ("SSI"), Aged, Blind and Disabled ("ABD") as well as other state-based programs that are not part of the Medicaid program, such as CHIPs and Long-Term Services and Supports ("LTSS"). TANF generally provides assistance to low-income families with children. ABD and SSI generally provide assistance to low-income aged, blind or disabled individuals. CHIPs provide assistance to qualifying families who are not eligible for Medicaid because their income exceeds the applicable income thresholds. See further discussion below under "Children's Health Insurance Program (CHIP)". LTSS programs are designed to help people with chronic illnesses or who have disabilities and need health and long-term care services, such as home care or adult day care, to enable them to stay in their homes and communities as long as possible.

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We have entered into contracts with Medicaid agencies in each state in which we operate Medicaid plans. Some of the states in which we operate award contracts to applicants that can demonstrate that they meet the state's minimum requirements. Other states engage in a competitive bidding process for all or certain programs. In either case, we must demonstrate to the satisfaction of the respective agency that we are able to meet certain operational and financial requirements. For example, depending on the state:

- we must coordinate care that encompasses the full breadth of a member's needs including their physical health, behavioral health, pharmacy, LTSS and, increasingly, their need for social services;
- we must measure provider access and availability in terms of the time needed for a member to reach the doctor's office;
- our quality improvement programs must emphasize member education, member outreach and include measures designed to promote utilization of preventive services;
- we must have linkages with schools, city or county health departments and other community-based providers of health care in order to demonstrate our ability to coordinate all of the sources from which our members may receive care;
- we must have the capability to meet the needs of members with complex conditions including those with co-occurring conditions and those who are disabled;
- our providers and member service representatives must be able to communicate with members who do not speak English or who are hearing impaired;
- our member handbook, newsletters and other communications must be written at the prescribed reading level and must be available in certain languages other than English;
- we must have the capabilities to meet any specialized waiver requirements, such as member premium payments or work eligibility requirements; and
- we must demonstrate our readiness to meet contract requirements prior to the commencement date of services.

Once awarded, our Medicaid program contracts generally have terms of one to three years. Most of these contracts provide for renewal upon mutual agreement of the parties, or at the option of the government agency, and both parties have certain early termination rights. Generally, under state regulation, these contracts are only renewable for a limited amount of time prior to reprocurement in the states that require procurements. In addition to the operating requirements listed above, state contract requirements and regulatory provisions applicable to us generally set forth detailed provisions relating to subcontractors, marketing, safeguarding of member information, fraud, waste and abuse reporting, grievance procedures, and timely submission of encounter data and other cost reporting.

Our compliance with the provisions of our contracts is subject to monitoring or examination by state regulators and their agents. Certain contracts require us to be subject to quality assurance evaluations and accreditation by a third-party organization.

Children's Health Insurance Program (CHIP)

We provide services under CHIPs in ten states, including our Nebraska program, which commenced on January 1, 2017. In some states, like Hawaii, those beneficiaries are served as a part of the state’s Medicaid program. These CHIPs are referred to as expansion programs. In other states, including New York and Florida, the state’s CHIP is operated separately. CHIP was established in 1997 to serve low-income, uninsured children. In some states, the program was extended to the parents of those children. As a result of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, the "ACA"), parents previously covered under CHIP may now instead be covered through the state’s Medicaid expansion or may be eligible for premium assistance and other subsidies through the state or federal exchange, as applicable. The ACA maintained CHIP eligibility standards for children in place as of enactment through 2019. On January 22, 2018, CHIP funding was extended for six years as part of a broader continuing resolution to fund the federal government and further

extended to 2027 by the Bipartisan Budget Act of 2018, on February 9, 2018. In addition, the resolution continued the enhanced federal match rate for CHIP established by the ACA initially, but reduced the rate over time. The resolution also extended the requirement for states to maintain coverage for children from 2019 through 2023, but after October 1, 2019, the requirement is limited to children in families with incomes at or below 300% of the federal poverty level.

Medicare

The Medicare program provides health care coverage primarily to individuals age 65 or older as well as to individuals with certain disabilities and consists of four parts, labeled A through D. Part A provides hospitalization benefits financed largely through Social Security taxes and requires beneficiaries to pay out-of-pocket deductibles and coinsurance. Part B provides benefits for medically necessary services and supplies including outpatient care, physician services, and home health care. Beneficiaries enrolled in Part B are required to pay monthly premiums and are subject to annual deductibles. Parts A and B are referred to as “Original Medicare.”

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Medicare beneficiaries may elect to receive their Medicare benefits through MA plans as an alternative to Original Medicare. Under MA, private health plans, including health maintenance organizations ("HMO") and preferred provider organizations ("PPO"), contract with CMS to provide benefits that are comparable to, or that may be more attractive (such as including prescription drug coverage and supplemental benefits) to Medicare beneficiaries than Original Medicare in exchange for a fixed monthly per member payment that varies based on the county in which a member resides, the demographics of the member and the member's health condition. MA plans may also charge beneficiaries monthly premiums and other copayments for Medicare-covered services or for certain extra benefits.

Our 2017 acquisition of Universal American added a PPO product to our Medicare portfolio. PPO products offer seniors the ability to obtain services from out-of-network providers with additional out-of-pocket expenses. For the year ended December 31, 2017, there are approximately 22,000 members enrolled in the Universal American PPO product. Effective January 1, 2018, we offer PPO products in two additional Medicare markets. As more seniors opt for plan flexibility, our ability to offer a choice of products will be important to attracting more customers.

Additionally, through our acquisition of Universal American in 2017, we added a Medicare private-fee-for-service (“PFFS”) product to our Medicare portfolio. PFFS plans are open-access plans that allow members to be seen by any physician or facility that participates in the Original Medicare program and are subject to our network terms and conditions. PFFS beneficiaries can join a PFFS plan that has Part D drug coverage or join a plan without such coverage. Our PFFS plans are offered under contracts with CMS and provide enhanced health care benefits compared to Original Medicare, subject to cost sharing and other limitations. We actively coordinate care for these members in a similar manner to our PPO and HMO plans. In addition to a fixed monthly payment per member from CMS, individuals in these plans may be required to pay a monthly premium in selected counties or for selected enhanced products.

Also effective January 1, 2018, we offer a Chronic Special Needs Plan ("C-SNP"), which limits enrollment to individuals with specific severe or disabling chronic conditions. C-SNP plans focus on monitoring health status, managing chronic diseases, avoiding inappropriate hospitalizations and helping beneficiaries move from high risk to lower risk on the care continuum. CMS has approved 15 C-SNPs specific to certain chronic conditions. Our C-SNP program targets cardiovascular disorders and is limited to certain counties in Florida.
Beneficiaries enrolled in Original Medicare can either join a stand-alone PDP plan or forgo Part D prescription drug coverage. Beneficiaries enrolled in Medicare Advantage plans can join a plan with Part D coverage (a "MA-PD" plan), select a stand-alone PDP plan or forgo Part D prescription drug coverage. Beneficiaries who are dually eligible for Medicare and Medicaid, and certain beneficiaries who qualify for a low-income subsidy ("LIS"), but who do not enroll in a MA plan with drug benefits or a PDP, are automatically assigned to a plan by CMS. These assignments are made among those PDPs that submitted bids below the applicable regional benchmarks for standard Part D plans established annually by CMS.

All managed care plans offering Part D (PDP and MA-PD) bid on providing Part D benefits in June of each year. Based on the bids submitted, CMS establishes a benchmark for each of the 34 regions. CMS pays the Part D plans a percentage of the benchmark on a per member per month ("PMPM") basis with the remaining portion of the premium being paid by the Medicare member. Members whose income falls below 150% of the federal poverty level qualify for the federal LIS, through which the federal government helps pay the member's Part D premium and certain other cost sharing expenses.

Our MA and PDP plan contracts with CMS are on a calendar-year basis. CMS requires that each plan meet certain regulatory requirements including, as applicable: provisions related to enrollment and disenrollment; restrictions on marketing activities; benefits or formulary requirements; quality assessment; encounter data reports; fraud, waste and abuse monitoring; maintaining relationships with health care providers; and responding to appeals and grievances.

Dual-eligibles

Individuals qualifying for both Medicare and Medicaid are referred to as "dual-eligibles." For dual-eligibles, if a service is covered by Medicare and Medicaid, Medicare is the primary payer. Medicaid pays for services available under the state's Medicaid program, which exceed or supplement what Medicare covers, often referred to as wrap-around coverage. Medicaid may also cover some beneficiary cost-sharing associated with Medicare services. For Medicaid benefits that are not covered by Medicare, such as certain long-term care services, Medicaid covers the cost of these benefits unless there is another liable third-party payer. Medicaid is generally the payer of last resort.

Improved care coordination is imperative to enhance care options for dual-eligibles as an aging population and increased life expectancy among Americans with disabilities increase the dual-eligible population. As such, dual-eligible programs have become an immediate target for both spending reductions and attempts to improve the quality of care beneficiaries receive. The

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ACA created a federal Medicare-Medicaid Coordination Office to serve dual-eligibles. This Medicare-Medicaid Coordination Office has initiated a series of state Duals Demonstration Programs intended to provide better coordination and integration of care between Medicare and Medicaid on a capitated or fee-for-service basis, which is required to produce cost savings. As of January 1, 2018, we operate dual special needs plans ("D-SNPs") in 16 states.

General Economic and Political Environment Affecting our Business

We expect overall spending on health care in the U.S. to continue to rise due to inflation, evolving medical technology, pharmaceutical advancement, regulatory requirements, demographic trends in the U.S. population and national interest in health and well-being. The rate of market growth may be affected by a variety of factors, including macro-economic conditions and enacted health care reforms, which could also affect our results of operations. We expect that the state and federal governments will continue to look for budgetary cost control savings through reductions in health care expenses.

Congress has proposed several plans to cut or restructure Medicare including raising the Medicare eligibility age, moving Medicare to a defined contribution model, converting Medicare to a voucher system and various other modifications including cuts to provider reimbursement. Medicaid is similarly situated, consuming ever greater portions of the federal budget. As a result, several proposals have been suggested to modify the Medicaid program including moving from a match program to block grants, moving to a per-capita capitation system, limiting the use of provider taxes to fund the state’s portion of the Medicaid program, as well as modifying the ACA Medicaid expansions. We do not know whether any of these proposals will pass or the effect any ultimate reform will have on our business.

In addition, states are looking for more flexibility to design their Medicaid programs to manage their state health care budgets, including by imposing premium and work requirements to maintain Medicaid eligibility. For example, the State of Kentucky expects to implement new premium and work requirements for certain members to maintain their eligibility for the Medicaid program beginning on July 1, 2018, which may reduce our Medicaid membership in Kentucky.

On May 6, 2016, CMS published regulations that overhauled Medicaid managed care requirements. These regulations include requirements that state Medicaid programs evaluate network adequacy standards; impose a requirement of managed care organizations ("MCO") to report medical loss ratios ("MLRs") annually to states; and a requirement that states set MCO rates to reasonably achieve an MLR of greater than 85% as long as the capitation rates are actuarially sound. Additionally, these regulations expand federal financial participation reimbursement opportunities related to members with behavioral health issues who receive short term services in an alternative mental health institution and outline requirements for value-based provider contracting. Under the regulations, the states may also be tasked with developing and publicizing plan quality rating results. These changes may be phased in over the course of three years with some regulations being effective immediately on May 6, 2016; however, the degree of federal oversight in implementing these regulations is uncertain, and the states may retain substantial flexibility in designing their Medicaid programs.

In addition, on December 21, 2017, the Tax Cuts and Jobs Act of 2017 was enacted, which reformed tax rates beginning January 1, 2018. For additional discussion, refer to Note 14 - Income Taxes to the consolidated financial statements included in this 2017 Form 10-K.

Health Care Reform

In March 2010, the ACA became law and significantly reformed various aspects of the U.S. health insurance industry. Financing for these reforms comes in part from substantial additional fees and taxes on us and other health insurers,

health plans and individuals, as well as reductions in certain levels of payments to us and other health plans under Medicare. The majority of regulations and interpretive guidance on provisions of the ACA have been issued by the Department of Health and Human Services ("HHS"), the Department of Labor, the Treasury Department, and the National Association of Insurance Commissioners ("NAIC"). There may be provisions of the legislation that receive additional guidance and clarification in the form of regulations and interpretations. The funding of the ACA is uncertain under the current presidential administration.

On February 9, 2018, the Bipartisan Budget Act of 2018 was enacted, which among other things, extended CHIP for an additional four years, until 2027, added additional flexibility to how ACOs can operate and accelerated the timing of the closure of the Part D “coverage gap” (i.e., the dollar threshold at which an individual has to pay full price for his or her medications). As a result, Part D beneficiaries' co-pays will be reduced to 25% of prescription costs in 2019, instead of that reduction occurring in 2020 under prior law. In addition, MA special needs plans were permanently reauthorized, but additional requirements for care coordination and integration of long-term services and supports were imposed. We are still assessing the affect these changes may have on our business.

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The ACA included a number of changes that affected the way plans operate, such as reduced Medicare premium rates, CMS Star Ratings, minimum MLRs and other provisions.

Reduced Medicare Premium Rates

In April 2017, the CMS final call letter revised the proposed 2018 MA and Part D rates. We estimate the 2018 rates, compared to 2017, will decrease slightly, excluding Medicare coding trends and the return of the ACA industry fee.

CMS Star Ratings

Certain provisions in the ACA provide additional Medicare revenue related to the achievement of higher Star Ratings that can be used to offer more attractive benefit packages to members and/or achieve higher profit margins. In addition, plans with Star Ratings of 4.0 or higher are eligible for year-round open enrollment, whereas plans with lower Star Ratings have more restrictions on enrollment criteria and timing. Part C or Part D Medicare plans with Star Ratings of less than three stars for three consecutive years are denoted as "low performing" plans on the CMS website and in the CMS "Medicare and You" handbook. In addition, CMS could exercise its authority to terminate the MA and PDP contracts for plans rated below three stars for three consecutive years for the plan year 2020. As a result, plans that achieve higher Star Ratings may have a competitive advantage over plans with lower Star Ratings.

CMS's current quality measurement methodology does not fully account for socio-economic determinants of health. Because we have a greater percentage of low-income members, we may be unable to achieve or maintain a 4.0 Star Rating for some or all of our plans without a legislative or regulatory adjustment to the quality measurement methodology. Though various regulatory and legislative solutions have been proposed, we continue to work with our legislative and regulatory partners to ensure this issue is adequately addressed.

In October 2017, CMS announced 2018 MA and PDP Star Ratings. Three of our 16 active MA contracts received an overall rating of 4.0 stars or higher and served approximately 38.7% of our December 31, 2017 MA membership, including contracts serving certain of our members in Florida, Maine, New York and Texas. Four of our MA contracts received an overall rating of 3.5 stars and served approximately 11.7% of our December 31, 2017 MA membership, including contracts serving certain of our members in Arizona, California, New Jersey, and New York. Eight of our MA contracts received an overall rating of 3.0 stars, while we have one MA plan that received an overall score of 2.5 stars serving our members in Hawaii and Louisiana.

Our MA plan serving Arkansas, Illinois, Mississippi, South Carolina and Tennessee received a score of 2.5 stars for its Part C operations for 2017 and 2018 and could be subject to termination by CMS if the score does not improve for 2019. Additionally, our PDP plan received a score of 2.5 stars for 2017 and 2018 and could subject the contract to termination by CMS if the score does not improve for 2019.

Minimum Medical Loss Ratio

Beginning in 2014, the ACA established a minimum MLR for MA and Part D plans, requiring plans to spend not less than 85% of premiums on medical and pharmacy benefits. The rules implementing the minimum MLR impose financial and other penalties for failing to achieve the minimum MLR, including requirements to refund to CMS shortfalls in amounts spent on medical benefits and termination of a plan’s MA contract for prolonged failure to achieve the minimum MLR. The MLR prescribed by HHS differs from the MLR calculation under generally accepted accounting principles in the United States of America ("GAAP") and is determined by adding a plan’s spending for clinical services, prescription drugs and other direct member benefits, plus the plan's total spending on quality

improvement activities and dividing the total by earned premiums (after subtracting specific identified taxes and other fees). This provision has not had a material effect on our results of operations.

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Other Provisions

The ACA imposed certain new taxes and fees, including limitations on the amount of compensation that is tax deductible, as well as an annual premium-based health insurance industry assessment (the "ACA industry fee") on health insurers, which began in 2014. The total ACA industry fee levied on the health insurance industry was $11.3 billion in both 2015 and 2016, increasing to $14.3 billion in 2018. After 2018, the ACA industry fee increases according to an index based on net premium growth. The assessment is being levied on certain health insurers that provide insurance in the assessment year, and is allocated to health insurers based on each health insurer's share of net premiums for all U.S health insurers in the year preceding the assessment. The ACA industry fee is not deductible for income tax purposes, which has significantly increased our effective income tax rate. In December 2015, President Obama signed the Consolidated Appropriations Act, 2016 which, among other provisions, included a one-year moratorium on the ACA industry fee for 2017. While the ACA industry fee will be assessed in 2018, the continuing resolution approved in January 2018 provides for an additional one-year moratorium for 2019 for the ACA industry fee.

We received amendments, written agreements or other documentation from all our Medicaid customers that commit them to reimburse us for the portion of the ACA industry fee on our Medicaid plans, including its non-deductibility for income tax purposes. CMS does not directly reimburse us for the effect of the ACA industry fee related to MA and PDP premiums.

In addition, the Medicare Access and CHIP Reauthorization Act of 2015 is gradually increasing rates on the provider fee schedule from June 30, 2015 to 2019. After 2019, the provider fee schedules will also adjust rates based on quality performance. This Act also provided for incentive payments for those providers that participate in an alternative payment model, such as a demonstration program.

The ACA also established Medicare Shared Savings ACOs as a tool to improve quality and lower costs through increased care coordination in the Medicare fee-for-service (“FFS”) program, which covers the majority of the Medicare-eligible population. CMS established the Medicare Shared Service Program (“MSSP”) to facilitate coordination and cooperation among providers to improve the quality of care for FFS beneficiaries and reduce unnecessary costs. The MSSP shares savings with the ACOs when they generate savings above a minimum savings rate and meet quality of care performance standards. The future of the ACOs is uncertain given the uncertain funding status of the ACA, or its modification.

The reforms in the ACA present both challenges and opportunities for Medicaid plans. The reforms provide states the option to expand eligibility for Medicaid programs. However, some states have decided not to participate in the Medicaid expansion. In addition, state budgets continue to be strained due to economic conditions and uncertain levels of federal financing for current and expansion populations. As a result, the effects of any potential future expansions are uncertain, including whether states that have expanded will maintain their expansion, making it difficult to determine whether the net effect of the ACA, or any modification, will be positive or negative for Medicaid plans.

We currently serve the ACA Medicaid expansion population in Arizona, Hawaii, Illinois, Kentucky, New Jersey and New York. Our other Medicaid states, Florida, Georgia, Missouri, Nebraska and South Carolina, have not expanded their Medicaid eligibility.

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OUR PRODUCT SEGMENTS

Our operations are conducted in three reportable segments: Medicaid Health Plans, Medicare Health Plans and Medicare PDPs, which correspond with the Medicaid and Medicare products that we offer.

Membership by segment, and as a percentage of consolidated totals, is as follows.

	For the Years Ended December 31,								
	2017			2016			2015		
Segment	Membership	Percentage of Total		Membership	Percentage of Total		Membership	Percentage of Total	
Medicaid Health Plans	2,723,000	62.3	%	2,544,000	65.3	%	2,388,000	63.4	%
Medicare Health Plans	496,000	11.3	%	345,000	8.9	%	354,000	9.4	%
Medicare PDPs	1,152,000	26.4	%	1,009,000	25.8	%	1,025,000	27.2	%
Total	4,371,000	100.0	%	3,898,000	100.0	%	3,767,000	100.0	%

Premium revenue by segment, and as a percentage of consolidated totals, is as follows (in millions, except percentages).

	For the Years Ended December 31,								
	2017			2016			2015		
Segment	Premium Revenue	Percentage of Total		Premium Revenue	Percentage of Total		Premium Revenue	Percentage of Total	
Medicaid Health Plans	$10,726.3	63.2	%	$9,499.3	66.8	%	$9,074.3	65.4	%
Medicare Health Plans	5,320.2	31.4	%	3,876.6	27.3	%	3,898.8	28.1	%
Medicare PDPs	913.8	5.4	%	845.0	5.9	%	901.7	6.5	%
Total	$16,960.3	100.0	%	$14,220.9	100.0	%	$13,874.8	100.0	%

Medicaid Health Plans

Our Medicaid Health Plans segment includes plans for beneficiaries of TANF, SSI and ABD programs and other state-based programs that are not part of the Medicaid program, such as CHIP and LTSS. For purposes of our Medicaid Health Plans segment, we define our customer as the state and related governmental agencies that have common control over the contracts under which we operate in that particular state. As of January 1, 2018, we are the largest Medicaid health plan by membership in Florida, Georgia, Kentucky and Missouri.

The Medicaid programs and services we offer to our members vary by state and county and are designed to effectively serve our constituencies in the communities in which we operate. Although our Medicaid contracts determine, to a large extent, the type and scope of health care services that we arrange for our members, in certain markets we customize our benefits in ways that we believe make our products more attractive. Our Medicaid plans provide our members with access to a broad spectrum of medical benefits from primary care and preventive programs to full hospitalization and long-term care.

In general, members are required to use our network to receive care, except in cases of emergencies, transition of care or when network providers are unavailable to meet their medical needs. In addition, members generally must receive referrals from their primary care providers ("PCPs") in order to receive health care from a specialist, such as an orthopedic surgeon or neurologist. Members generally do not pay any premiums, deductibles or co-payments for most of our Medicaid plans; however, the Kentucky Medicaid program is expected to have certain member premiums and

work requirements for eligibility purposes starting on July 1, 2018.

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Medicaid Health Plans Membership

The following table summarizes our Medicaid Health Plans segment membership by the programs we offer.

	As of December 31,		
	2017	2016	2015
Medicaid Health Plans			
TANF	2,278,000	2,119,000	1,988,000
SSI, ABD, duals, and LTSS	301,000	290,000	274,000
CHIP and other	144,000	135,000	126,000
Total	2,723,000	2,544,000	2,388,000

We received over 10% of our consolidated premium revenue in 2017, 2016 and 2015, individually, from the states of Florida and Kentucky, and in 2016 and 2015, Georgia. Due to the addition of a competing fourth managed care organization to the Georgia program during 2017, Georgia Medicaid premium revenue declined to less than 10% of our consolidated premium revenue for the year ended December 31, 2017. The membership for these states is summarized in the following table.

	As of December 31,		
	2017	2016	2015
Medicaid Health Plans			
Florida	751,000	780,000	781,000
Georgia	513,000	571,000	585,000
Kentucky	448,000	440,000	440,000
All other states [(1)]	1,011,000	753,000	582,000
Total	2,723,000	2,544,000	2,388,000

(1) "All other states" consists of Hawaii, Illinois, Missouri, New Jersey, New York, South Carolina and Texas during all years presented. In 2016 and 2017, it also includes Arizona, as well as Nebraska in 2017.

As of January 1, 2018, we served approximately 2,715,000 Medicaid members, a decrease of approximately 8,000 compared with December 31, 2017. Refer to Item 7 – Management's Discussion and Analysis of Financial Condition and Results of Operations for membership discussion by segment for 2017, 2016 and 2015.

Medicaid Health Plans Segment Revenues

Our Medicaid Health Plans segment generates revenues primarily from premiums received from the states in which we operate health plans. We receive a fixed premium PMPM pursuant to our state contracts. Our Medicaid contracts with state governments are generally multi-year contracts subject to annual renewal provisions. We generally receive premium payments during the month in which we provide services, although from time to time, we have experienced delays in receiving payments from certain states. In some instances, our base premiums are subject to risk score adjustments based on our members' acuity. Generally, the risk score is determined by the state by analyzing encounter submissions of processed claims data to determine the acuity of our membership relative to the entire state's Medicaid membership. Additionally, in some states we are subject to meeting certain quality measures, operational measures or both in order to earn a contractual withhold of a percentage of our revenue or receive an incentive payment over and above our base premiums. We are also eligible to receive supplemental payments for obstetric deliveries and newborns in Arizona, Florida, Georgia, Illinois (through December 31, 2017), Missouri, Nebraska, New Jersey, New York and South Carolina.

Each contract is specific as to how and when these supplemental payments are earned and paid. Revenues are recorded based on membership and eligibility data provided by the states, which may be adjusted by the states for any subsequent updates to this data.

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The following table sets forth information relating to Medicaid premium revenues from the states of Kentucky, Florida and Georgia, as well as all other states on an aggregate basis (in millions, except percentages).

	For the Years Ended December 31,								
	2017			2016			2015		
State	Revenue	Percentage of Total Segment		Revenue	Percentage of Total Segment		Revenue	Percentage of Total Segment	
Kentucky	$2,612.7	24.4	%	$2,590.2	27.3	%	$2,610.9	28.8	%
Florida	2,541.4	23.7	%	2,506.6	26.4	%	2,305.9	25.4	%
Georgia	1,590.4	14.8	%	1,615.9	17.0	%	1,636.2	18.0	%
All other states[1]	3,981.8	37.1	%	2,786.6	29.3	%	2,521.3	27.8	%
Total	$10,726.3	100.0	%	$9,499.3	100.0	%	$9,074.3	100.0	%

(1) "All other states" consists of Hawaii, Illinois, Missouri, New Jersey, New York, South Carolina and Texas during all years presented. In 2017, it also includes Arizona and Nebraska. Given that the Care1st transaction was completed on December 31, 2016, Care1st Arizona's 2016 results of operations were not significant to our consolidated statement of comprehensive income for the year ended December 31, 2016.

Certain of our Medicaid contracts require us to expend a minimum percentage of premiums on eligible medical benefits expense. To the extent that we expend less than the minimum percentage of the premiums on eligible medical benefits and quality-related expenses, we are required to refund to the state all or some portion of the difference between the minimum and our actual allowable medical benefits expense. We estimate the amounts due to the state agencies as a return of premium based on the terms of our contracts with the applicable state agency. Additionally, certain of our Medicaid contracts provide profit sharing arrangements as a result of medical cost reduction. We estimate the amounts due from the state agencies as profit sharing based on the terms of our contracts with the applicable state agency.

We recognized $244.9 million and $219.2 million of reimbursement for the ACA industry fee, including its non-deductibility for income tax purposes, as premium revenue for the years ended December 31, 2016 and 2015, respectively.

Certain contracts expired in 2015 and 2016; however, we are still serving members as if these contracts were still effective and expect the contracts to be renewed. Our other current Medicaid contracts are set to expire or renew between June 2018 and December 2021. The following table sets forth the terms and expiration dates of our Medicaid contracts with the State of Florida and the Commonwealth of Kentucky, the two states that each accounted for greater than 10% of our consolidated premium revenues during 2017.

State	Line of Business	Term of Contract	Expiration Date of Current Term	Expiration Date if All Renewal Options Exercised
Florida	Medicaid (MMA)	February 4, 2014 - December 31, 2018	December 31, 2018	December 31, 2018
Kentucky	Medicaid and CHIP	One potential one-year renewal[1]	June 30, 2018	June 30, 2019[1]

(1) In December 2017, we entered into a contract amendment with the Kentucky Department of Medicaid Services that renewed our participation in the Kentucky Medicaid program through June 30, 2018, and included one additional one-year renewal period upon mutual agreement.

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Medicare Health Plans

We contract with CMS under the Medicare program to provide a comprehensive array of Part C and Part D benefits to Medicare eligible persons, through our MA plans. Our MA plans are comprised of CCPs which are administered through HMOs and generally require members to seek health care services and select a PCP from a network of health care providers. In addition, we offer Medicare Part D coverage, which provides prescription drug benefits, as a component of our MA plans.

As of December 31, 2017, we offered MA plans in a total of 485 counties across 17 states to 496,000 members. As of January 1, 2018, we are offering MA plans in a total of 494 counties across 18 states to 504,000 members. We offer D-SNPs in 83.8% of the MA counties that we serve, and approximately 31% of our MA members are "dually-eligible" for Medicare and Medicaid and are enrolled in one of our D-SNPs. We cover a wide spectrum of medical services through our MA plans. For many of our plans, we provide additional benefits not covered by Original Medicare, such as vision, dental and hearing services. Through these enhanced benefits, out-of-pocket expenses incurred by our members are generally reduced, which allows our members to better manage their health care costs. We believe that our D-SNPs are attractive to these beneficiaries due to the enhanced benefit offerings and clinical support programs.

Some of our MA plans require members to pay a co-payment, which varies depending on the services and level of benefits provided. Typically, members of our MA CCPs are required to use our network of providers, except in specific cases such as emergencies, transition of care or when specialty providers in our network are unavailable to meet their medical needs. MA CCP members may see out-of-network specialists if they receive referrals from their PCPs and may be required to pay incremental cost-sharing.

We continue to focus on three main areas in MA, including:

- Execution on medical expense and quality initiatives led by our clinical services group;
- Continued application of a more disciplined portfolio approach to our MA bids, including a focus on net income; and
- Improving Star Ratings, both in terms of execution on quality initiatives and our advocacy position to properly match the ratings, rules and economics with the prevalent data that demonstrates the connection between socio-economic status and lower quality ratings.

Medicare Health Plans Membership

As of December 31, 2017, 2016 and 2015, our Medicare Health Plans segment had approximately 496,000, 345,000 and 354,000 members, respectively. Refer to Item 7 – Management's Discussion and Analysis of Financial Condition and Results of Operations for membership discussion by segment for 2017, 2016 and 2015.

As of January 1, 2018, our Medicare Health Plans segment had approximately 504,000 members, an increase of 5,000 compared with December 31, 2017.

Medicare Health Plans Segment Revenues

The amount of premiums we receive for each MA member is established by contract, although the rates vary according to a combination of factors, including the plan's quality score, upper payment limits established by CMS, the member's geographic location, age, gender, medical history or condition, or the services rendered to the member. MA premiums are due monthly and are recognized as revenue during the period in which we are obligated to provide services to members. We record adjustments to revenues based on member retroactivity. These adjustments reflect changes in the number and eligibility status of enrollees subsequent to when revenue was billed. We estimate the amount of outstanding retroactivity adjustments each period and adjust premium revenue accordingly. The estimates of retroactivity adjustments are based on historical trends, premiums billed, the volume of member and contract renewal activity and other information. Changes in member retroactivity adjustment estimates have not had a material

effect on premiums recorded during the periods presented.

CMS provides risk-adjusted payments for MA plans and PDPs based on the demographics and health severity of enrollees. The risk-adjusted premiums we receive are based on claims and encounter data that we submit to CMS within prescribed deadlines. We develop our estimates for risk-adjusted premiums utilizing historical experience, or other data, and predictive models as sufficient member risk score data becomes available over the course of each CMS plan year. We recognize periodic changes to risk-adjusted premiums as revenue when the amounts are determinable and collection is reasonably assured, which are possible as additional diagnosis code information is reported to CMS, when the ultimate adjustment settlements are received from CMS, or we receive notification of such settlement amounts. CMS adjusts premiums on two separate occasions on a retrospective basis. The first retrospective adjustment for a given plan year generally occurs during the third quarter of that year. This initial settlement represents the update of risk scores for the current plan year based on the severity of claims incurred in

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the prior plan year. CMS then issues a final retrospective risk adjusted premium settlement for that plan year in the following year.

The data provided to CMS to determine the risk score is subject to audit by CMS even after the annual settlements occur. Our Florida and Arizona MA plans have been selected by CMS for audits of the 2011 contract year and it is possible that CMS may conduct audits of other contracts and contract years on an ongoing basis. An audit may result in the refund of premiums to CMS. While our experience to date has not resulted in a material refund, future refunds could be significant, which would reduce our premium revenue in the year that CMS determines repayment is required.

Medicare Health Plans premium revenue for the year ended December 31, 2017, 2016 and 2015 was approximately $5.3 billion, $3.9 billion and $3.9 billion, respectively. Our MA contracts with CMS all have one year terms that expire at the end of each calendar year and are renewable for successive one-year terms unless CMS does not authorize a renewal or we notify CMS of our decision not to renew. Our current MA contracts expire on December 31, 2018.

Medicare PDPs

We have contracted with CMS to serve as a plan sponsor offering stand-alone Medicare Part D PDP plans to Medicare-eligible beneficiaries through our Medicare PDPs segment. As of January 1, 2018, we offer PDPs in 50 states and the District of Columbia. Our PDPs offer national in-network prescription drug coverage, including a preferred pharmacy network, subject to limitations in certain circumstances.

The PDP benefit design generally results in our incurring a greater portion of the responsibility for total prescription drug costs in the early stages of a plan year, and less in the latter stages of a plan year, due to the members' share of cumulative out-of-pocket costs increasing throughout the plan year. As a result, the PDP medical benefits ratio ("MBR") generally decreases throughout the year.

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

Medicare PDPs Membership

As of December 31, 2017, 2016 and 2015, we served approximately 1,152,000, 1,009,000 and 1,025,000 PDP members, respectively. Refer to Item 7 – Management's Discussion and Analysis of Financial Condition and Results of Operations for membership discussion by segment for 2017, 2016 and 2015.

Our 2018 PDP bids resulted in one of our basic plans being below the benchmarks in 25 of the 34 CMS regions, and within the de minimis range in five other regions, compared with our 2017 bids, in which we were below the benchmarks in 30 of the 34 CMS regions, and within the de minimis range in three other regions. As of January 1, 2018, we served approximately 1,078,000 PDP members, a decrease of approximately 74,000 from December 31, 2017 resulting from our 2018 bid positioning.

Medicare PDPs Segment Revenues

Annually, we provide written bids to CMS for our PDPs, which reflect the estimated costs of providing prescription drug benefits over the plan year. Substantially all of the entire premium for this insurance is paid by the federal government, and the balance is due from the enrolled beneficiaries and, in some cases, state pharmacy assistance

programs. The premium and subsidy components under Part D are described below.

Member Premium—We receive a monthly premium from members based on the plan year bid we submitted to CMS. The member premium, which is fixed for the entire plan year, is recognized over the contract period and reported as premium revenue.

CMS Direct Premium Subsidy—Represents monthly premiums from CMS based on the plan year bid submitted by us as a plan sponsor. The monthly payment is a risk-adjusted amount per member and is based upon the member's health status as determined by CMS. Refer to the "Medicare Risk-Adjusted Premiums" section under the "Medicare Advantage (MA)" segment discussion above for a more detailed description of risk-adjusted premiums.

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Low-Income Premium Subsidy—For qualifying low-income subsidy ("LIS") members, CMS pays for some or all of the LIS member's monthly premium. The CMS payment is dependent upon the member's income level, which is determined by the Social Security Administration.

Low-Income Cost Sharing Subsidy ("LICS")—For qualifying LIS members, CMS reimburses us for all or a portion of the LIS member's deductible, coinsurance and co-payment amounts above the out-of-pocket threshold. LICS subsidies are paid by CMS prospectively as a fixed PMPM amount, as determined based upon the plan year bids submitted by us as a plan sponsor to CMS. Approximately nine to ten months subsequent to the end of the plan year, a settlement payment is made between CMS and our plans based on actual claims experience.

Catastrophic Reinsurance Subsidy—CMS reimburses plans for 80% of the drug costs after a member reaches his or her out-of-pocket catastrophic threshold through a catastrophic reinsurance subsidy. Catastrophic reinsurance subsidies are paid by CMS prospectively as a fixed PMPM amount, and are determined based upon the plan year bids submitted by us as a plan sponsor to CMS. Approximately nine to ten months subsequent to the end of the plan year, a settlement payment is made between CMS and our plans based on actual claims experience.

Coverage Gap Discount Subsidy—CMS provides monthly prospective payments for pharmaceutical manufacturer discounts made available to members. The prospective discount payments are determined based upon the plan year bid submitted by plan sponsors to CMS and current plan enrollment. Following the plan year, CMS performs an annual reconciliation of the prospective discount payments received by our plan to the amount of actual manufacturer discounts made available to each plan's enrollees under the program.

Catastrophic reinsurance subsidies and the low-income member cost sharing subsidies represent cost reimbursements under the Medicare Part D program. We are fully reimbursed by CMS for costs incurred for these contract elements and, accordingly, there is no insurance risk to us. Therefore, amounts received for these subsidies are not considered premium revenue, and are reported, net of the subsidy benefits paid, as Funds receivable/held for the benefit of members in the consolidated balance sheets. The receipts and payments between us and CMS are presented on a net basis as financing activity in our consolidated statements of cash flows because we are essentially administering and paying the benefit subsidies on behalf of CMS. Historically, the settlement payments between us and CMS have not been materially different from our recorded estimates.

Coverage gap discount subsidies ("CGD") advance payments are recorded as funds receivable/held for the benefit of members in the consolidated balance sheets. Receivables are set up for manufacturer-invoiced amounts. Manufacturer payments reduce the receivable as payments are received. After the end of the contract year, during the Medicare Part D Payment reconciliation process for the CGD, CMS will perform a cost-based reconciliation to ensure the Medicare Part D sponsor is paid for gap discounts advanced at the point of sale, based on accepted claims data.

CMS Risk Corridor—Premiums from CMS are subject to risk sharing through the Medicare Part D risk corridor provisions. The CMS risk corridor calculation compares the target amount of prescription drug costs (limited to costs under the standard coverage as defined by CMS) less rebates in the plan year bid to actual experience. Variances of more than 5% above the target amount will result in CMS making additional payments to plan sponsors and variances of more than 5% below the target amount will require plan sponsors to refund to CMS a portion of the premiums received. Historically, we have not experienced material adjustments related to the CMS settlement of the prior plan year risk corridor estimate.

PDP premium revenue for the year ended December 31, 2017, 2016 and 2015 was approximately $913.8 million, $845.0 million and $901.7 million, respectively.

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OUR OPERATIONS

Provider Networks and Provider Reimbursement Methods

As of December 31, 2017, we contracted with approximately 427,000 health care providers and 42,000 pharmacies to provide our members with access to medically necessary services. Our contracted providers deliver a variety of services to our members including: primary and specialty physician care; laboratory and imaging services; inpatient, outpatient, home health and skilled facility care; medication and injectable drug therapy; ancillary services; durable medical equipment and related services; mental health and chemical dependency counseling and treatment; transportation; and dental, hearing and vision care.

The following are the types of providers in our Medicaid and MA CCP contracted networks:

- Professionals such as PCPs, provider groups, specialty care physicians, psychologists and licensed social workers;
- Facilities such as hospitals with inpatient, outpatient and emergency services, skilled nursing facilities, outpatient surgical facilities and diagnostic imaging centers;
- Ancillary providers such as laboratory providers, radiology, home health, physical therapy, speech therapy, occupational therapy, ambulance providers and transportation providers; and
- Pharmacies, including retail pharmacies, mail order pharmacies and specialty pharmacies.

These providers are contracted through a variety of mechanisms, including agreements with individual providers, groups of providers, independent provider associations, integrated delivery systems and local and national provider chains such as hospitals, surgical centers and ancillary providers. We also contract with other companies who provide access to contracted providers, such as pharmacy, dental, hearing, vision, transportation and mental health benefit managers.

Facility, pharmacy, dental, vision and behavioral health contracts cover medically necessary services and, under some of our plans, enhanced benefits. These contracts typically have terms of one to four years with some of the agreements automatically renewing at the end of the contract period, unless otherwise specified in writing by either party. During the contract period, these agreements typically can be terminated without cause upon written notice by either party, but the notification period may range from 90 to 180 days and early termination may subject the terminating party to financial penalties.

The contract terms require providers to participate in our quality improvement and utilization review programs, which we may modify from time to time. Providers must also adhere to applicable state and federal regulations.

We periodically review payments made to providers and make adjustments, as necessary. Generally, our contracts with providers do not allow for automatic annual increases in reimbursement levels; however, we review these contracts periodically to ensure competitiveness. Among the factors generally considered in routine adjustments are changes to state Medicaid or Medicare fee schedules, competitive environment, current market conditions, anticipated utilization patterns and projected medical expenses. Some provider contracts are directly tied to state Medicaid or Medicare fee schedules, in which case, reimbursement levels will be adjusted up or down, generally on a prospective basis, based on adjustments made by the state or CMS to the appropriate fee schedule.

Physicians and Provider Groups

PCPs play an important role in coordinating and managing the care of our Medicaid and MA CCP members. This coordination includes delivering preventive services as well as referring members to other providers for medically necessary services. PCPs are typically trained in internal medicine, pediatrics, family practice, general practice or, in

some markets, obstetrics and gynecology. In rare instances, a physician trained in sub-specialty care will perform primary care services for a member with a chronic condition.

Additionally, mental health and substance abuse are increasing areas of focus in our overall population's health, providing a growing priority for our behavioral health providers. In response, we are forging new partnerships to support more comprehensive and integrated care including behavioral health homes and integrated health homes.

PCPs and specialty care providers are typically reimbursed a specified fee for the service performed, which is known as fee-for-service. The specified fee is set as a percentage of the amount Medicaid or Medicare would pay under the applicable fee-for-service program.

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We reimburse some of our PCPs and specialty care provider groups on a fixed-fee PMPM basis. This type of reimbursement methodology is commonly referred to as capitation. The reimbursement covers care provided directly by the provider as well as coordination of care from other providers, as described above. In certain markets, we may also reimburse certain services such as vaccinations and laboratory or screening services delivered by the PCP in addition to the capitation payment.

Consistent with our long-term business priorities and emerging regulatory guidance, we have increased emphasis on aligning provider incentives with our objective of improving health care quality by employing a continuum of performance-based arrangements to incentivize providers to improve the quality of care they provide to our members. Beginning in 2017, substantially all of our contracted PCPs are eligible to participate in our quality incentive programs and/or other value-based arrangements. These arrangements consisted of additional payments for achieving specified quality of care targets. In 2017, 72% of Medicare and 45% of Medicaid payments were made through these value-based arrangements.

We also maintain shared-surplus, shared-risk and full-risk arrangements related to credentialing, utilization management and care coordination by establishing an operating fund for provider groups participating in these types of arrangements. We monitor the performance of this fund to determine whether these providers are eligible for shared savings payments or whether they should reimburse us if the contracts include shared or full risk provisions. Payments due to us are normally carried forward and offset against future potential surplus payments. PCPs participating in these specialized risk arrangements cover 74% and 32% of our MA and Medicaid membership, respectively, as of December 31, 2017.

In all instances, we require providers to submit data reporting all direct encounters with members. This data helps us to monitor the amount and levels of medical treatment provided to our members to help improve the quality of care provided and comply with regulatory reporting requirements. Our regulators use the encounter data that we submit, as well as data submitted by other health plans, to set reimbursement rates, assign membership, assess the quality of care being provided to members and evaluate contractual and regulatory compliance.

To help ensure quality of care, we credential and recredential all professional providers with whom we contract, including physicians, psychologists, licensed social workers, certified nurse midwives, advanced registered nurse practitioners and physician assistants who provide care under the supervision of a physician directly or through delegated arrangements. This credentialing and recredentialing is performed in accordance with standards required by CMS and consistent with the standards of the NCQA.

Facilities

Our health plans arrange for hospital care primarily through contracts with selected hospitals in their service areas for coverage of medically necessary care. These hospital contracts generally have multi-year terms or annual terms with automatic renewals and provide for payments on a variety of bases, including capitation, per diem rates, case rates and discounted fee-for-service schedules. These contracts typically can be canceled by either party, without cause, usually upon 90 days written notice. In some cases, a longer notice period may be required, such as where a longer period is required by regulation or the applicable government contract.

Inpatient services are sometimes reimbursed as a fixed global payment for an admission based on the associated diagnosis related group, or DRG, as defined by CMS. In many instances, certain services, such as implantable devices or particularly expensive admissions, are reimbursed as a percentage of hospital charges either in addition to, or in lieu of, the DRG payment. Certain facilities in our networks are reimbursed on a negotiated rate paid for each day of the member's admission, known as a per diem. This payment varies based upon the intensity of services provided to the member during admission, such as intensive care, which is reimbursed at a higher rate than general medical services.

Facility outpatient services are reimbursed either as a percentage of charges or based on a fixed-fee schedule for the services rendered, in accordance with ambulatory payment groups or ambulatory payment categories, both as defined by CMS. Outpatient services for diagnostic imaging are reimbursed on a fixed-fee schedule as a percentage of the applicable Medicare or Medicaid fee-for-service schedule or a capitation payment.

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Ancillary Providers

Our typical ancillary agreements provide for coverage of medically necessary care and, in general, have terms of one year. These contracts automatically renew for successive one-year periods unless otherwise specified in writing by either party. These contracts typically can be canceled by either party, without cause, usually upon 90 days written notice. In some cases, a longer notice period may be required, such as where a longer period is required by regulation or the applicable government contract.

Ancillary providers, who provide services such as laboratory services, home health, physical, speech and occupational therapy, and ambulance and transportation services, are reimbursed on a capitation or fee-for-service basis.

Pharmacies

Pharmacy services are reimbursed based on a fixed fee for dispensing medication and a separate payment for the ingredients. Ingredients produced by multiple manufacturers are reimbursed based on a maximum allowable cost for the ingredient. Ingredients produced by a single manufacturer are reimbursed as a percentage of the average wholesale price. In certain instances, we may contract directly with the sole-source manufacturer of an ingredient to receive a rebate, which may vary based upon volumes dispensed during the year. Effective April 1, 2015, we outsourced pharmacy rebate management to a third party. As of January 1, 2016, we expanded the vendor relationship to include all pharmacy benefit management services, including rebates processing, claims processing, pre-authorization, utilization management and other related services.

Out-of-Network Providers

When our traditional HMO members receive services for which we are responsible from a provider outside our network, such as in the case of emergency room services from non-contracted hospitals, we generally attempt to negotiate a rate with that provider. In most cases, when a member is treated by a non-contracted provider, we are typically obligated to pay only the amount that the provider would have received from traditional Medicaid or Medicare.

Member Recruitment

Our member recruitment and marketing efforts for both Medicaid and Medicare members are heavily regulated by state agencies and CMS. For many products, we rely on the auto-assignment of members into our plans, including our PDP plan. The auto-assignment of a beneficiary into a health or prescription drug plan generally occurs when that beneficiary does not choose a plan. The agency with responsibility for the program determines the approach by which a beneficiary becomes a member of a plan serving the program. Some programs assign members to a plan automatically based on predetermined criteria. These criteria frequently include a plan's rates, the outcome of a bidding process, quality scores or similar factors. For example, CMS auto-assigns PDP members based on whether a plan's rate bids during the annual renewal process are above or below the CMS benchmark for that region. In most states, our Medicaid health plans benefit from auto-assignment of individuals who do not choose a plan, but for whom participation in managed care programs is mandatory. Each state differs in its approach to auto-assignment, but one or more of the following criteria is typical in auto-assignment algorithms: a Medicaid beneficiary's previous enrollment with a health plan or experience with a particular provider contracted with a health plan, enrolling family members in the same plan, a plan's quality or performance status, a plan's network and enrollment size, awarding all auto-assignments to a plan with the lowest bid in a county or region, and equal assignment of individuals who do not choose a plan in a specified county or region.

Our Medicaid marketing efforts are regulated by the states in which we operate, each of which imposes different requirements for, or restrictions on, Medicaid sales and marketing. These requirements and restrictions can be revised from time to time. Several states, including our three largest Medicaid states, Florida, Georgia and Kentucky, do not permit direct sales by Medicaid health plans. We rely on member selection and auto-assignment of Medicaid members into our plans in those states.

Our Medicare marketing and sales activities are regulated by CMS and the states in which we operate. CMS has oversight over all marketing materials used by MA plans, and in some cases has imposed advance approval requirements. Also, our sales activities are limited to those such as conveying information regarding benefits, describing the operations of our managed care plans and providing information about eligibility requirements.

We employ our own insurance agents and contract with independent, licensed insurance agents to market our MA and PDP products. We have continued to expand our use of independent agents whose cost is largely variable in nature and whose engagement is more conducive to the shortened Medicare selling season and the open enrollment period. The activities of our

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independently licensed insurance agents are also regulated by CMS. We also use direct mail, mass media and the Internet to market our products.

A significant portion of our PDP membership is obtained from the auto-assignment of beneficiaries, which is dependent on the outcome of a bid process whereby plans submit bids to CMS based on their estimated cost to provide services in designated regions. Plans that submit bids below the benchmark of other plans' bids in their bidding region are eligible for auto-assignment of LIS beneficiaries.

Quality Improvement

We are focused on improving quality across all of our lines of business, which is critical to the continued growth and success of our business. We continually seek to improve the quality of care delivered by our network providers to our members and our ability to measure the quality of care provided. Our quality improvement program provides the basis for our quality and utilization management functions. It outlines ongoing processes designed to improve the delivery of quality health care services to our members, as well as to enhance compliance with regulatory and accreditation standards. This program consists of a multi-year improvement plan with a more rigorous quality governance structure focused on driving better quality results.

Our quality improvement activities will continue to focus on:
- Access;
- Preventive health and wellness;
- Care and disease management;
- Health plan accreditation;
- Provider credentialing;
- Provider education and incentives for closing care gaps;
- Member education and outreach;
- Information technology initiatives related to the above activities;
- Advocacy and community-based programs; and
- Oversight and audits.

Access

We are focused on improving our members' access to a high-performing network of providers, including PCPs, specialists and ancillary providers, and ensuring that members see the appropriate providers, based on clinical condition. We help members access the right care at the right time in the appropriate setting through coordinated care teams and community partnerships. We recently added additional clinical resources in our markets to implement new care models.

Preventive health and wellness

We sponsor a number of initiatives aimed at the promotion of healthy lifestyles and the prevention of disease. These include programs focusing on preventive screenings, health education programs to inform members about health care issues and healthy behaviors, health assessment and counseling to inform members how to use the resources and services available to them to help reduce preventable diseases.

Care and disease management

We have enhanced our care management model to more effectively serve our most medically complex members. The model leverages both field-based and telephonic resources using state-specific, multi-disciplinary care teams. Our

D-SNP care management helps reduce the fragmentation that exists in the current health care system, improving member access to quality care. We also employ intervention programs that include: a prenatal care management program to help women with high-risk pregnancies; a program to reduce the number of inappropriate emergency room visits; and disease management programs to decrease the need for emergency room visits and hospitalizations.

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Health plan accreditation

All current WellCare health plans are either accredited or actively seeking accreditation by the National Committee for Quality Assurance ("NCQA"). NCQA Accreditation is the most comprehensive evaluation in the industry, and the only assessment that includes results of clinical performance (i.e., HEDIS measures) and consumer experience (i.e., Consumer Assessment of Healthcare Provider and Systems measures). We have achieved accreditation for our Medicaid health plans in Florida, Georgia, Hawaii, Illinois, Kentucky, Missouri, Nebraska, New Jersey, New York and South Carolina. Our Florida, Georgia, Hawaii, Illinois, Kentucky, New Jersey, New York, Tennessee, Arkansas, Mississippi, Texas, South Carolina, Connecticut, and Louisiana Medicare Health Plans are also NCQA accredited.

Provider credentialing

We credential physicians, hospitals and other health care professionals in our participating provider networks using quality criteria, which meet or exceed the standards of external accreditation or state regulatory agencies, or both. Typically, most health care professionals are re-credentialed every three years, depending on applicable state laws.

Provider education and incentives for closing care gaps

We expanded our Quality Practice Advisory program, which pairs a WellCare nurse clinician with a provider to assist our providers in identifying and closing gaps in member care. We believe that this program has been effective in closing care gaps and improving our quality scores in future years. As part of our quality improvement program, we implemented changes to our reimbursement methods to reward certain providers who encourage preventive care, such as well-child check-ups, prenatal care and/or who adopts evidence based guidelines for members with chronic conditions. Additionally, all of our markets offer provider incentives for closing care gaps inherent to the health care system. This initiative has resulted in increased member encounters to drive improvement in the quality of care.

Member education and outreach

We are focused on improving our members' access to a high-performing network of providers, including PCPs, specialists and ancillary providers. This will ensure that members see the appropriate providers, based on clinical condition. We have strengthened our resources focused exclusively on outreach to Medicaid and Medicare members to educate them on care gaps and assist with care gap closure. Intervention and support activities include arranging transportation assistance, three-way calls with a member and his/her primary care physician to schedule appointments, and arranging for home visits to assess and close care gaps. In addition, our medication therapy management initiatives empower patients to take an active role in managing their medications. We are focused on enhancing our members' experience by improving service and reducing complaint levels through improved grievance and appeals processes which we believe will result in improved member satisfaction survey results.

Information technology initiatives

We understand the importance of information technology in improving the level of service that we can provide to our members. Accordingly, we continue to invest in our information technology infrastructure and capabilities including tools that support our focus on improving our ability to ensure our members receive quality health care. We have specialized systems to support our quality improvement activities and to gather information from our systems to identify opportunities to improve care and track the outcomes of the services provided to achieve those improvements, such as evaluating the effects of particular preventive measures and improving member experience by addressing member specific needs.

Advocacy and community-based programs

WellCare connects community resources to help improve health outcomes and lower the overall cost of health care. We work to link people to social services such as food banks or meal delivery, housing assistance, financial assistance, transportation, education support, legal assistance and employment services.

Oversight and audits

Internally, our quality improvement programs benefit from executive oversight and project management processes. Additionally, each of our health plans has a Quality Improvement Committee comprised of senior members of management, medical directors and other key associates. Each of these committees reports directly to the applicable health plan board of directors, which has ultimate oversight responsibility for the quality of care rendered to our members. The Quality

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Improvement Committees also have a number of subcommittees that are charged with monitoring certain aspects of care and service, such as health care utilization, pharmacy services and provider credentialing and re-credentialing. Several of these subcommittees include physicians as committee members.

Our board of directors recognizes the importance of delivering quality care and providing access to that care for our members and has established the Health Care Quality and Access Committee of the board. The primary purpose of this committee is to assist the board by reviewing, and providing general oversight of, our health care quality and access strategy, including our policies and procedures governing health care quality and access for our members. This input helps provide overall direction and guidance to our Quality Improvement Committees.

We conduct routine site audits of select providers and medical record audits to ensure the effectiveness of our quality improvement programs.

Information Technology

The accurate and timely capture, processing and analysis of critical data are cornerstones for providing managed care services. Focusing on data is also essential to operating our business in a cost effective manner. Data processing and data-driven decision making are key components of both administrative efficiency and medical cost management. We use our information systems for premium billing, claims processing, utilization management, reporting, medical cost trending, planning and analysis. The systems also support member and provider service functions, including enrollment, member eligibility verification, primary care and specialist physician roster access, claims status inquiries, and referrals and authorizations.

On an ongoing basis, we evaluate the ability of our existing operations to support our current and future business needs and to maintain our compliance requirements. As a result, we periodically consolidate, integrate, upgrade and expand our information systems capabilities as a result of technology initiatives, industry trends and recently enacted regulations, changes in our system platforms and integration of new business acquisitions. Our information systems require an ongoing commitment of significant resources to maintain, protect and enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving systems and regulatory standards and changing customer preferences.

Secure maintenance of personal information and information technology systems is critical to our business operations. As a result, cybersecurity, physical security and the continued development and enhancement of our controls, processes and practices designed to protect our facilities, information systems and data from attack, damage or unauthorized access remain a priority for us. To ensure information security, we have implemented multiple layers of controls to protect the confidentiality, integrity and availability of this data and the systems that store and transmit such data. We utilize current security technologies, and our defenses are monitored and routinely tested internally and by external parties.

We have a disaster recovery plan that addresses how we recover business functionality within stated timelines. We have an agreement with a nationally-recognized, third-party vendor to provide for the restoration of our general support systems at a remote processing center. We perform disaster recovery testing at least annually for those business applications that we consider critical.

Our board of directors believes that information security is a critical component of the enterprise-wide risk management program. Our information security risk management practices are a core component of our enterprise-wide risk management program. The board’s information security oversight responsibilities include providing oversight of information security strategies and risk management; and assuring financial and other resources, including insurance related to information security events, are in place to support risk management. The

board's information security oversight includes regular reporting from members of senior management who are responsible for information security risk management practices. Reports cover areas such as process improvements, relevant risks and strategic initiatives. Pursuant to its charter, the Audit, Finance and Regulatory Compliance Committee (the "AFRC Committee") of the board assists the board in the oversight of the enterprise risk management function, including information security.

Additionally, the Information Technology Oversight Committee of the board assists with oversight of major information technology initiatives and programs, consults with senior management regarding information strategy, assists the board in its oversight of information technology security programs and assists the AFRC Committee in its oversight of information technology internal controls and disaster recovery capabilities and strategies.

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Outsourcing Arrangements

We determined, based on an evaluation of factors including cost, compliance, quality and procurement success, that it is more efficient to use third parties instead of our personnel for certain functions. As a result, we contract with a number of vendors to provide significant operational support including, but not limited to, pharmacy benefit management for our members as well as certain enrollment, billing, call center, benefit administration, claims processing, mail order pharmacy, reinsurance, sales and marketing and certain aspects of utilization management. Where a vendor provides services that we are required to provide under a contract with a government customer, we are responsible for such performance and will be held accountable by our government customers for any failure of performance by our vendors. We evaluate the competency and solvency of our third-party vendors prior to execution of contracts and endeavor to include service level guarantees and information security safeguards in our contracts, where appropriate. When we need to share PHI with a vendor, we ensure that a compliant HIPAA Business Associate Agreement is put in place. Additionally, we perform ongoing vendor oversight activities to identify any performance or other issues related to our vendors.

We maintain insurance that includes coverage for certain costs related to information security events.

Centralized Management Services

We provide centralized management services to each of our health plans from our Tampa, Florida headquarters and call centers. These services are provided by an affiliated administrator and include, among others, information technology, product development and administration, finance, human resources, accounting, legal, public relations, marketing, insurance, purchasing, risk management, internal audit, actuarial, underwriting, claims processing, customer service and certain aspects of clinical service.

Employees

As of December 31, 2017, we had approximately 8,900 full-time employees. Our employees are not represented by any collective bargaining agreement, and we have never experienced a work stoppage.

OUR COMPETITION

Competitive Environment

We operate in a highly competitive environment to obtain government health care program beneficiaries and manage the cost and quality of services that are delivered to these beneficiaries. We currently compete in this environment by offering Medicare and Medicaid health plans in which we accept all or nearly all of the financial risk for management of beneficiary care under these programs.

New entrants into the marketplace have contributed to the competitive environment. In addition, the increased use of technology to interact with members, providers and customers, increase the risks we currently face from new entrants and disruptive actions by existing competitors compared with prior periods.

We typically must be awarded a contract by the government agency with responsibility for a program in order to offer our services in a particular location. Some government programs choose to limit the number of plans that may offer services to beneficiaries, while other agencies allow an unlimited number of plans to serve a program, subject to each plan meeting certain contract requirements. When the number of plans participating in a program is limited, an agency generally employs a bidding process to select the participating plans.

As a result, the number of companies with which we compete varies significantly depending on the geographic market, business segment and line of business.

We believe that the significant factors that distinguish competing health plans include the perceived overall quality (including accreditation status), level of service, comprehensiveness of coverage, cost (including premium rates, provider arrangements and member out-of-pocket costs), financial stability and ratings, breadth and quality of provider networks, and quality of member support and care management programs. We believe that we are competitive on each of these factors. Some of our competitors may be more established with larger market share, greater financial resources or better quality scores than we have in some markets. Our ability to increase the number of persons covered by our plans or to increase our revenues is

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affected by our ability to differentiate ourselves from our competitors on these factors. Competition may also affect the availability of services from health care providers, including primary care physicians, specialists and hospitals.

Competitive Factors—Program Participation

Regardless of whether the number of health plans serving a program is limited, we believe government agencies determine program participation based on several criteria. We compete for government program participation, renewals of those government contracts and members who have the ability to change health plans on the basis of the terms set in the bids as well as the breadth and depth of a plan's provider network; quality and utilization management processes; responsiveness to member complaints and grievances; timeliness and accuracy of claims payment; financial resources; historical contractual and regulatory compliance; quality scores, references and accreditation; and other factors. If not auto-assigned, potential members typically choose a health plan based on a specific provider being a part of the network, the quality of care and services available, accessibility of services, and reputation or name recognition of the health plan. As discussed in Our Operations-Member Recruitment above, a significant portion of our PDP membership is obtained from the auto-assignment of beneficiaries, which is dependent on the outcome of a bid process.

If we fail to compete effectively to maintain or increase our program participation, including by maintaining or increasing enrollments in existing government programs, our results of operations, financial position and cash flows could be materially and adversely affected.

Competitive Factors—Network Providers

We compete with other health plans to contract with hospitals, physicians, pharmacies and other providers for inclusion in our networks that serve government program beneficiaries. We believe providers select plans in which they participate based on several criteria. These criteria generally include reimbursement rates, timeliness and accuracy of claims payment, potential to deliver new patient volume and/or retain existing patients, effectiveness of resolution of calls and complaints, and other factors.

Medicaid Competitors

In the Medicaid managed care market, our principal competitors for state contracts, members and providers include the following types of organizations:

- MCOs—Managed care organizations ("MCOs") that, like us, receive state funding to provide Medicaid benefits to members. Many of these competitors operate in a single or small number of geographic locations. There are a few multi-state Medicaid organizations that are able to leverage their infrastructure over a larger membership base. Competitors include private and public companies, which can be either for-profit or non-profit organizations, with varying degrees of focus on serving Medicaid populations.

- Medicaid Fee-For-Service—Traditional Medicaid offered directly by the states or a modified version whereby the state administers a primary care case management model.

- PSNs—A Provider Service Network ("PSN") is a network of providers that is established and operated by a health care provider or group of affiliated health care providers. A PSN operates as either a fee-for-service ("FFS") health plan or as a prepaid health plan that, like us, receives a capitated premium to provide Medicaid benefits to members. A PSN that operates as a FFS health plan is not at risk for medical benefit costs. FFS PSNs are at risk for 50% of their administrative cost allocation if their total costs exceed the estimated at-risk capitation amount.

Medicare Competitors

In the Medicare market, which includes Medicare Advantage and Prescription Drug Plans, our primary competitors for contracts, members and providers include the following types of competitors:

- Original Fee-For-Service Medicare—Original Medicare is available nationally and is a fee-for-service plan managed by the federal government. Beneficiaries enrolled in Original Medicare can go to any doctor, supplier, hospital or other facility that accepts Medicare and is accepting new Medicare patients.

- Medicare Advantage and Prescription Drug Plans—MA and stand-alone Part D plans are offered by national, regional and local MCOs and insurance companies that serve Medicare beneficiaries. In addition, prescription drug plans are

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being offered by or co-branded with retail drug store chains or other retail store chains, which may be able to offer lower priced plans and achieve benefits from integration with their pharmacy benefit management operations.

- Employer-Sponsored Coverage—Employers and unions may subsidize Medicare benefits for their retirees in their commercial group. The group sponsor solicits proposals from MA plans and may select an HMO, preferred provider organization ("PPO") and/or PDP to provide these benefits.

- Accountable Care Organizations - Accountable Care Organizations (“ACOs”) are groups of doctors, hospitals, and other health care providers who come together voluntarily to provide coordinated high quality care to their patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

REGULATION AFFECTING OUR BUSINESS

Our health care operations are highly regulated by both state and federal government agencies. Regulation of managed care products and health care services is an ever-evolving 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, statutes, regulations and interpretive guidance occur frequently. These changes may include a requirement to provide health care services not contemplated in our current contracted premium rate or to pay providers at a state-mandated fee schedule without a commensurate adjustment to the premium rate. For further information, see the discussion above under Our Operations- Provider Networks and Provider Reimbursement Methods. In addition, government agencies may impose taxes, fees or other assessments upon us and other managed care companies at any time.

Our contracts with various state government agencies and CMS to provide managed health care services include provisions regarding provider network adequacy, maintenance of quality measures, accurate submission of encounter and health care cost information, maintaining standards of call center performance, prompt payment of claims, accuracy of provider directories and other requirements specific to government and program regulations. We must also have adequate financial resources to protect the state, our providers and our members against the risk of our insolvency. Our failure to comply with these requirements may result in the assessment of penalties, fines and liquidated damages. For further information on data provided to CMS that is subject to audit, refer to the discussion above under Product Segments-Medicare Health Plans- Medicare Health Plans Segment Revenues.

Our Medicaid plans are subject to periodic financial and informational reporting and comprehensive quality assurance evaluations. We regularly submit periodic financial, encounters, utilization and operations reports and other information to the appropriate Medicaid program regulatory agencies.

Our MA and PDP plans perform ongoing monitoring of our compliance with the CMS requirements, including functions performed by vendors. From time to time, CMS conducts examinations of our compliance with the provisions of our MA and PDP contracts.

Government enforcement authorities have become increasingly active in recent years in their review and scrutiny of various sectors of the health care industry, including health insurers and managed care organizations. We routinely respond to subpoenas and requests for information from these entities and, more generally, we endeavor to cooperate fully with all government agencies that regulate our business.

Licensing and Solvency Regulation

Our operations are conducted primarily through HMO and insurance subsidiaries. These subsidiaries are licensed by the insurance departments in the states in which they operate, except our New York HMO subsidiary, which is licensed as a prepaid health services plan by the New York State Department of Health, and our California HMO, which is licensed by the California Department of Managed Health Care. The subsidiaries are subject to the rules, regulations and oversight of the applicable state agencies in the areas of licensing and solvency. State insurance laws and regulations prescribe accounting practices for determining statutory net income, capital and surplus. Each of our regulated subsidiaries is required to report regularly on its operational and financial performance to the appropriate regulatory agency in the state in which it is licensed. These reports describe each of our regulated subsidiaries' capital structure, ownership, financial condition, certain intercompany transactions and business operations. From time to time, any of our regulated subsidiaries may be selected to undergo periodic audits, examinations or reviews by the applicable state agency of our operational and financial assertions.

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Our regulated subsidiaries generally must obtain approval from, or provide notice to, the state in which it is domiciled before entering into certain transactions such as declaring dividends in excess of certain thresholds, entering into other arrangements with related parties, acquisitions or similar transactions involving an HMO or insurance company, or any change in control. For purposes of these laws, in general, control commonly is presumed to exist over an entity when a person, group of persons or entity, directly or indirectly, owns, controls or holds the power to vote 10% or more of the voting securities of that entity.

Each of our HMO and insurance subsidiaries must maintain a minimum amount of statutory capital determined by statute or regulation. For additional information on regulatory requirements, see Item 7 – Management's Discussion and Analysis of Financial Condition and Results of Operations – Regulatory Capital and Dividend Restrictions and Note 17 – Regulatory Capital and Dividend Restrictions to the consolidated financial statements.

HIPAA, HITECH, State Privacy Laws and Breach Notification Laws

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the regulations adopted under HIPAA are intended to improve the portability and continuity of health insurance coverage and simplify the administration of health insurance claims and related transactions.

The Health Information Technology for Economic and Clinical Health Act of 2009 (the "HITECH Act") modified certain provisions of HIPAA by, among other things, extending the privacy and security provisions to business associates, mandating new regulations around electronic health records, expanding enforcement mechanisms, and increasing penalties for violations.

On January 25, 2013, the U.S. Department of Health and Human Services ("HHS"), as required by the HITECH Act, issued the Final Omnibus Rules that provide final modifications to HIPAA rules to implement the HITECH Act.

The HITECH Act also contains a number of provisions that provide incentives for states to initiate certain programs related to health care and health care technology, such as electronic health records. While provisions such as these do not apply to us directly, states wishing to apply for grants under the HITECH Act, or otherwise participating in such programs, may impose new health care technology requirements on us through our contracts with state Medicaid agencies.

All health plans, including ours, are considered covered entities subject to HIPAA. HIPAA generally requires health plans, as well as their providers and vendors, to:

- protect patient privacy and safeguard individually identifiable health information; and
- establish the capability to receive and transmit electronically certain administrative health care transactions, such as claims payments, in a standardized format.

Specifically, the HIPAA Privacy Rule regulates use and disclosure of individually identifiable health information, known as “protected health information” (“PHI”). The HIPAA Security Rule requires covered entities to implement administrative, physical and technical safeguards to protect the security of electronic PHI. Certain provisions of the security and privacy regulations apply to business associates (entities that handle PHI on behalf of covered entities), and business associates are subject to direct liability for violation of these provisions. Furthermore, a covered entity may be subject to penalties as a result of a business associate violating HIPAA, if the business associate is found to be an agent of the covered entity.

Covered entities must report breaches of unsecured PHI to affected individuals without unreasonable delay, but not to exceed 60 days of discovery of the breach by a covered entity or its agents. Notification must also be made to HHS

and, in certain situations involving large breaches, to the media. HHS is required to publish on its website a list of all covered entities that report a breach involving more than 500 individuals. All non-permitted uses or disclosures of unsecured PHI are presumed to be breaches unless the covered entity or business associate establishes that there is a low probability the information has been compromised. Various state laws and regulations may also require us to notify affected individuals in the event of a data breach involving individually identifiable information.

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HIPAA violations by covered entities may result in civil and criminal penalties. Covered entities could face civil monetary penalties up to an annual maximum of $1.5 million for uncorrected violations based on willful neglect. HHS enforces the regulations and performs audits to confirm compliance. Investigations of violations that indicate willful neglect, for which penalties are mandatory, are statutorily required. HHS may also resolve HIPAA violations through informal means, such as allowing a covered entity to implement a corrective action plan, but HHS has the discretion to move directly to impose monetary penalties and is required to impose penalties for violations resulting from willful neglect. In addition, state attorneys general are authorized to bring civil actions seeking either injunctions or damages in response to violations of HIPAA privacy and security regulations that threaten the privacy of state residents.

We enforce a HIPAA compliance plan, which we believe complies with the HIPAA privacy and security regulations. We have dedicated resources to monitor compliance with our HIPAA compliance program.

We, our providers, and certain of our vendors are also subject to numerous other privacy and security laws and regulations at the federal and state levels. We remain subject to any federal or state privacy-related laws that are more restrictive than the privacy regulations issued under HIPAA. These laws vary and violations may result in additional penalties.

Fraud and Abuse Laws

Federal and state enforcement authorities have prioritized the investigation and prosecution of health care fraud, waste and abuse. Fraud, waste and abuse prohibitions encompass a wide range of operating activities, including kickbacks or other inducements for referral of members or for the coverage of products (such as prescription drugs) by a plan, billing for unnecessary medical services by a provider, improper marketing and violation of patient privacy rights. Companies involved in public health care programs such as Medicaid and Medicare are required to maintain compliance programs to detect and deter fraud, waste and abuse, and are often the subject of fraud, waste and abuse investigations and audits. The regulations and contractual requirements applicable to participants in these public-sector programs are complex and subject to change. Although we have structured our compliance program with care in an effort to meet all statutory and regulatory requirements, our policies and procedures are continuously under review and subject to updates and our training and education programs are always evolving. We have invested significant resources to enhance our compliance efforts and we expect to continue to do so.

Federal and state laws and regulations governing submission of information and claims to agencies

We are subject to federal and state laws and regulations that apply to the submission of information and claims to various agencies. For example, the federal False Claims Act provides, in part, that the federal government may bring a lawsuit against any person or entity who it believes has knowingly presented, or caused to be presented, a false or fraudulent request for payment from the federal government, or who has made a false statement or used a false record to get a claim approved. The federal government has taken the position that claims presented in violation of the federal anti-kickback statute may be considered a violation of the federal False Claims Act. Violations of the False Claims Act are punishable by treble damages and penalties of up to a specified dollar amount per false claim. In addition, a special provision under the False Claims Act allows a private person (for example, a "whistleblower" such as a disgruntled former associate, competitor or member) to bring an action under the False Claims Act on behalf of the government alleging that an entity has defrauded the federal government and permits the private person to share in any settlement of, or judgment entered in, the lawsuit. A number of states, including states in which we operate, have adopted false claims acts that are similar to the federal False Claims Act.

PRINCIPAL EXECUTIVE OFFICES

Our principal executive offices are located at 8735 Henderson Road, Renaissance One, Tampa, Florida 33634, and our telephone number is (813) 290-6200.

AVAILABILITY OF REPORTS AND OTHER INFORMATION

Our corporate website is http://www.wellcare.com. We make available on this website or in print, free of charge, our Annual Report on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K, Proxy Statement and amendments to those materials filed or furnished pursuant to Section 13(a) or 15(d) of the Securities and Exchange Act of 1934, as amended, as soon as reasonably practicable after we electronically file such materials with, or furnish such materials to, the Securities and Exchange Commission ("SEC").

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Also available on our website, or in print to any stockholder upon request, are WellCare's Corporate Governance Guidelines and Code of Conduct and Business Ethics, as well as charters of the following committees of the board of directors: the Audit, Finance and Regulatory Compliance Committee, Compensation Committee, Health Care Quality and Access Committee, Information Technology Oversight Committee and Nominating and Corporate Governance Committee. In addition, we intend to disclose any amendments to, or waivers of, our Code of Conduct and Business Ethics on our website. To obtain printed materials contact Investor Relations at WellCare Health Plans, Inc., 8735 Henderson Road, Tampa, Florida 33634. In addition, the SEC's website is http://www.sec.gov. The SEC makes available on its website, free of charge, reports, proxy and information statements, and other information regarding issuers, such as us, that file electronically with the SEC. Information provided on our website or on the SEC's website is not part of this Annual Report on Form 10-K.

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Item 1A. Risk Factors

You should carefully consider the following factors, together with all of the other information included in this report, in evaluating our company and our business. If any of the following risks actually occur, our business, results of operations, financial condition and cash flows could be materially and adversely affected, and the value of our stock could decline. The risks and uncertainties described below are those that we currently believe may materially affect our company. Additional risks and uncertainties not presently known to us or that we currently deem immaterial also may impair our business operations. As such, you should not consider this list to be a complete statement of all potential risks or uncertainties.

Risks Related to Our Business

The requirements of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, the "ACA"), or its modification, may have a material adverse effect on our results of operations, financial condition and cash flows.

We believe the ACA, or its modification, will continue to bring about significant changes to the American health care system. The costs of funding the ACA, or its modification, may continue to be financed, in part, from substantial additional fees and taxes on us and other health insurers, health plans and individuals, as well as reductions in certain levels of payments to us and other health plans under Medicare.

The Medicaid expansion provisions remain optional for states. Some states have decided not to participate in the Medicaid expansion, and states currently participating may choose not to participate in the future. Congress may also withhold the funding necessary to operate the ACA, or its modification. Given the breadth of possible changes and the uncertainties of interpretation, implementation and timing of these changes, which we expect to occur over the next several years, the ACA, or any modification, could change the way we do business, potentially affecting our pricing, benefit design, product mix, geographic mix and distribution channels.

New or amended regulations and policies, as well as future legislative changes, may have a material adverse effect on our results of operations, financial condition, and cash flows by:

- reducing the federal matching payments to state Medicaid programs;
- restricting revenue, enrollment and premium growth in certain products and market segments;
- restricting our ability to expand into new markets;
- increasing our medical and administrative costs;
- lowering our Medicare payment rates and/or increasing our expenses associated with the non-deductible federal premium tax and other assessments;
- encouraging states to contract with organizations that are not subject to the annual premium-based health insurance industry assessment imposed by the ACA (the "ACA industry fee") for their Medicaid programs; and
- encouraging states to integrate Medicare and Medicaid using a limited number of health plans or a fee for service model.

In addition, the response of other companies to these policy, regulatory and legislative changes and adjustments to their offerings, if any, could have a meaningful effect in the health care markets.

The ACA included a number of changes that have affected the way plans operate, such as reduced Medicare premium rates, minimum MLR and other provisions.

Reduced Medicare Premium Rates

In April 2017, the CMS final call letter revised the proposed 2018 MA and Part D rates. We estimate the 2018 rates, as compared with 2017, will decrease slightly, excluding Medicare coding trends and the return of the ACA industry fee.

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Minimum Medical Loss Ratio

Beginning in 2014, the ACA established a minimum MLR for MA and Part D plans, requiring plans to spend not less than 85% of premiums on medical and pharmacy benefits. The rules implementing the minimum MLR impose financial and other penalties for failing to achieve the minimum MLR, including requirements to refund to CMS shortfalls in amounts spent on medical benefits and termination of a plan's MA contract for prolonged failure to achieve the minimum MLR. The MLR prescribed by HHS differs from the MLR calculation under generally accepted accounting principles in the United States of America ("GAAP") and is determined by adding a plan's spending for clinical services, prescription drugs and other direct patient benefits, plus its total spending on quality improvement activities and dividing the total by earned premiums (after subtracting specific identified taxes and other fees). These provisions have not had a material effect on our results of operations in 2015, 2016 or 2017.

Other Provisions

The ACA imposed certain new taxes and fees, including limitations on the amount of compensation that is tax deductible, as well as the ACA industry fee on health insurers, which began in 2014. The ACA imposed certain new taxes and fees, including limitations on the amount of compensation that is tax deductible, as well as an annual premium-based health insurance industry assessment (the "ACA industry fee") on health insurers, which began in 2014. The total ACA industry fee levied on the health insurance industry was $11.3 billion in both 2015 and 2016, increasing to $14.3 billion in 2018. After 2018, the ACA industry fee increases according to an index based on net premium growth. The assessment is being levied on certain health insurers that provide insurance in the assessment year, and is allocated to health insurers based on each health insurer's share of net premiums for all U.S health insurers in the year preceding the assessment. The ACA industry fee is not deductible for income tax purposes, which has significantly increased our effective income tax rate. In December 2015, President Obama signed the Consolidated Appropriations Act, 2016 which, among other provisions, included a one-year moratorium on the ACA industry fee for 2017. While the ACA industry fee will be assessed in 2018, the continuing resolution approved in January 2018 provides for an additional one-year moratorium for 2019 for the ACA industry fee. The re-imposition of the ACA industry fee in 2018 and any future increases to the ACA industry fee could increase our tax rates and could adversely affect our results of operations, financial condition and cash flows.

The health reforms in the ACA allow, but do not require, states to expand eligibility for Medicaid programs. In addition, the uncertainty of federal matching funds for the state Medicaid programs, including the Medicaid expansion populations, may make states more likely to further delay expanding Medicaid eligibility. As a result, the effects of any potential future expansions and future federal financing are uncertain, making it difficult to determine whether the net effect of the ACA, or any modification, will be positive or negative for our Medicaid business.

Any failure by us to manage acquisitions, expansions, divestitures or other significant transactions successfully may have a material adverse effect on our quality scores, results of operations, financial condition and cash flows.

Our membership has grown substantially due to acquisitions, such as that of Universal American Corp. ("Universal American") in 2017, geographic expansions and organic growth, such as the statewide expansion of Medicaid in Missouri. We may not be successful in enhancing our infrastructure to support this continued growth, and delays in infrastructure improvements may have a material adverse effect on our quality scores, results of operations, financial condition and cash flows. In addition, due to the substantial initial costs related to acquisitions and expansions, such growth could adversely affect our short-term profitability and liquidity.

As part of our growth strategy, we identify potential acquisition targets, bid and negotiate acquisition terms, work with regulators to receive regulatory approval for the acquisition and once the transaction is closed, we must integrate the acquisition into our operations.

Once an attractive acquisition target is identified, we may not be successful in bidding against competitors. Even if we are successful in bidding against competitors, we may not be able to obtain the regulatory approval from federal and state agencies required to complete the acquisition. Depending on the transaction size, we may not be able to obtain appropriate financing. We may not be able to comply with the regulatory requirements necessary for approval of the acquisition or state regulators may give preference to competing offers made by locally-owned entities, competitors with higher quality scores or not-for-profit entities.

Once acquired, we may have difficulties integrating the businesses within our existing operations, due to factors such as:

- new associates who must become familiar with our operations and company culture;

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- acquired provider networks that operate on different terms than our existing networks and whose contracts may need to be renegotiated;
- existing members who decide to switch to another health care plan;
- disparate administrative and information technology systems; and
- difficulties implementing our operations strategy to operate the acquired businesses profitably.

As a result, our acquired businesses may not perform as we anticipated, or in line with our existing businesses. In addition, if the expected future profitability of the acquired business declines, we may need to write down or incur impairment charges of the acquired assets. In the future, we may incur material expenses in connection with the integration and execution of acquisitions, expansions, and other significant transactions.

Furthermore, we may incur significant transaction expenses in connection with a potential acquisition or expansion opportunity that is not successful. If we are unable to effectively execute our acquisition strategy or integrate acquired businesses, our future growth may suffer and our profitability may decrease.

Our rate of expansion into other geographic areas may also be inhibited by factors such as:

- the time and costs associated with obtaining the necessary licenses and approvals to operate;
- lower quality scores compared to our competitors;
- participation in fewer lines of business compared to our competitors;
- our inability to develop a network of physicians, hospitals and other health care providers that meets our requirements and those of government regulators;
- delays in the procurement, renewal or implementation of Medicaid or similar programs in new or existing states;
- CMS or state contract provisions regarding quality measures, such as CMS Star Ratings;
- competition, which increases the cost of recruiting members;
- the cost of providing health care services in those areas;
- demographics and population density; and
- applicable state regulations that, among other things, require the maintenance of minimum levels of capital and surplus.

In any program start-up, acquisition, expansion or re-bid, the implementation of the contract, as designed, may be affected by factors beyond our control. These include political considerations, network development, contract appeals, incumbent Medicaid contractors, participation in other lines of business, membership assignment (allocation of members who do not self-select), errors in the bidding process, changes to the program design or implementation timing, difficulties experienced by other private vendors involved in the implementation, such as enrollment brokers, and noncompliance with contractual requirements with which we do not yet have experience and similar risks. As a result, our business, particularly plans for expansion or increased membership levels, could be negatively affected.

In addition, when making award determinations and evaluating proposed acquisitions and expansions, regulators frequently consider the plan’s historical regulatory compliance, litigation and reputation and we are required to disclose material investigations and litigation, including in some cases investigations and litigation that occurred in the past. As a result of our previous federal and state investigations, stockholder and derivative litigation, the restatement during 2009 of our previously issued financial statements and related matters, and the criminal trial of certain of our former executives and employees that concluded in the second quarter of 2013, we have been, and may continue to be, the subject of negative publicity. In addition, the Iowa Medicaid bid protest, and the subsequent ruling to exclude the Company from the program has resulted in negative publicity. Continuing negative publicity and other negative perceptions regarding these matters may adversely affect our ability to grow.

If we are unable to estimate and manage medical benefits expense effectively, our profitability likely will be reduced or we could become unprofitable.

Our profitability depends, to a significant degree, on our ability to estimate and effectively manage our costs related to the provision of health care services. Relatively small changes in the ratio of our expenses related to health care services to the premiums we receive (the "medical benefits ratio" or "MBR") can create significant changes in our financial results. Many aspects of the managed care business are not predictable, and estimating medical benefits expense is a continuous process, which depends on the information available to us and our ability to utilize such information. Factors that may cause medical benefits expense to exceed our estimates include, but are not limited to:

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- the addition of new members, whether by acquisition, new enrollment, program startup or expansion (including geographic expansion), whose risk profiles are uncertain or unknown and for whom initiatives to manage their care take longer than expected;
- an increase in the cost of health care services and supplies, including pharmaceuticals, whether as a result of the introduction of new products or technologies, inflation or otherwise;
- the performance of our pharmaceutical benefit manager in managing our pharmaceutical costs;
- higher-than-expected utilization of health care services;
- contractual provisions related to continuity of care for new members;
- contractual provisions or regulatory requirements restricting the use and design of medical expense initiatives, including the ability to control the pharmaceutical formulary in Medicaid programs;
- periodic renegotiation of hospital, physician and/or other provider contracts;
- the occurrence of catastrophes, natural disasters, epidemics, pandemics, terrorism or bio-terrorism;
- changes in the demographics of our members and medical trends affecting them;
- challenges in implementing medical expense cost control initiatives, especially during the first year of a new Medicaid program;
- new mandated benefits, increased mandated provider reimbursement rates or other changes in health care laws, regulations, public policy and/or practices;
- emerging changes in the economy;
- changes in members' behavior and health care utilization patterns;
- provider billing practices; and
- changes in the fee schedules, rate design, and reimbursement structure for health care services.

The factors and assumptions that are used to develop our estimates of costs, including medical benefits expense, inherently are subject to greater variability when there is more limited experience or information available to us, or the state or federal client, such as when we commence operations in a new state or region or commence participation in a new program. In many cases, the degree of our ability to accurately estimate medical benefits expense may not be known until we have sufficient experience and more complete information. For example, levels of plan utilization and members’ use of medical services, provider claims submissions, our payment processes and other factors can result in identifiable patterns emerging only following the passage of a significant period of time after the occurrence of the underlying causes of deviations from our assumptions. If our medical benefits expense increases and we are unable to manage these medical costs effectively in the future, our profits would likely be reduced or we may not remain profitable, which would also affect our liquidity, cash flows and our ability to comply with statutory requirements.

Our medical benefits expense may exceed our estimates or our regulators’ actuarial pricing assumptions, and we may be unable to adjust the premiums we receive under our current contracts, which could have a material adverse effect on our results of operations, financial condition and cash flows.

Assumptions and estimates are utilized in establishing premium deficiency reserves. For example, we have established a premium deficiency reserve of $45.6 million in connection with the expanded Illinois Medicaid program. If our assumptions in establishing reserves are inconsistent with actual experience, our reserves may be inadequate to pay medical costs. We may be required to increase our premium deficiency reserve, or establish new premium deficiency reserves in connection with other contracts, which could have a material adverse effect on our results of operations and financial condition.

Our MA and PDP plans, as well as certain of our Medicaid plans, are subject to a minimum MLR, which requires health plans to spend not less than a certain percentage of premiums on medical benefits. If a minimum MLR is not met, then we could be required to refund a portion of our premiums back to the state or CMS, as applicable.

In addition, there are sometimes wide variations in the established rates per member in both our Medicaid and Medicare lines of business. For instance, the rates we receive for a Supplemental Security Income ("SSI") member are generally significantly higher than for a non-SSI member who is otherwise similarly situated. As the composition of our membership base changes as the result of programmatic, competitive, regulatory, benefit design, economic or other changes; there is a corresponding change to our premium revenue, costs and margins, which may have a material adverse effect on our results of operations, financial condition and cash flows.

Some provider contracts are directly tied to state Medicaid or Medicare fee schedules, which the state or CMS, respectively, may increase without granting a corresponding increase in premiums to us. We have experienced similar types of adjustments in states in which we operate. Unless such adjustments are mitigated by an increase in premiums, or if this were to occur in any more of the states in which we operate, our profitability will be negatively affected.

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Also, in some rural areas, it is difficult to maintain a provider network sufficient to meet regulatory requirements. In situations where we have a deficiency in our provider network, regulators require us to allow members to obtain care from out-of-network providers at no additional cost, which could have a material adverse effect on our ability to manage medical benefits expenses. In some states, with respect to certain services, the amount that the health plan must pay to out-of-network providers for services provided to our members is defined by law or regulation, but in certain instances it is either not defined or it is established by a standard that is not clearly translatable into dollar terms. Out-of-network providers may believe they are underpaid for their services and may either litigate or arbitrate their dispute with the health plan. The uncertainty of the amount to pay and the possibility of subsequent adjustments of the payment could adversely affect our results of operations, financial condition and cash flows.

Although we maintain reinsurance to protect us against certain severe or catastrophic medical claims, we cannot assure that such reinsurance coverage currently is or will be adequate or available to us in the future or that the cost of such reinsurance will not limit our ability to obtain it.

Failure to maintain satisfactory quality and service measures could negatively affect our premium rates, subject us to penalties, limit or reduce our membership, impede our ability to compete for new business in existing or new markets or result in the termination of our contracts, which would have a material adverse effect on our business, rate of growth and results of operations, financial condition and cash flows.

Quality scores are used by certain agencies to establish premium rates or, in the case of CMS, to pay bonuses to MA plans that enable high scoring plans to offer enhanced health benefits, which are attractive to members.

Certain provisions in the ACA provide additional Medicare revenue related to the achievement of higher Star Ratings that can be used to offer more attractive benefit packages to members and/or achieve higher profit margins. In addition, plans with Star Ratings of 4.0 or higher are eligible for year-round open enrollment, whereas plans with lower Star Ratings have more restrictions on enrollment criteria and timing. Part C or Part D Medicare plans with Star Ratings of less than three stars for three consecutive years are denoted as "low performing" plans on the CMS website and in the CMS "Medicare and You" handbook. In addition, CMS could exercise its authority to terminate the MA and PDP contracts for plans rated below three stars for three consecutive years for the plan year 2020. As a result, plans that achieve higher Star Ratings may have a competitive advantage over plans with lower Star Ratings.

CMS’s current quality measurement methodology does not appropriately account for socio-economic determinants of health. Because we have a greater percentage of lower-income members than average, we may be unable to achieve or maintain a 4.0 Star Rating for some or all of our plans without a legislative or regulatory adjustment to the quality measurement methodology. Though various regulatory and legislative solutions have been proposed, we continue to work with our legislative and regulatory partners to ensure this issue is adequately addressed. However, our efforts may not be successful, and we could continue to have plans with Star Ratings lower than our competitors, which could have a material adverse effect on our membership and profitability of our MA and PDP lines of business.

In October 2017, CMS announced 2018 MA and PDP Star Ratings. Three of our 16 active MA contracts received an overall rating of 4.0 stars or higher and served approximately 38.7% of our December 31, 2017 MA membership, including contracts serving certain of our members in Florida, Maine, New York and Texas. Four of our MA contracts received an overall rating of 3.5 stars and served approximately 11.7% of our December 31, 2017 MA membership, including contracts serving certain of our members in Arizona, California, New Jersey, and New York. Eight of our MA contracts received an overall rating of 3.0 stars, while we have one MA plan that received an overall score of 2.5 stars serving our members in Hawaii and Louisiana.

Our MA plan serving Arkansas, Illinois, Mississippi, South Carolina and Tennessee received a score of 2.5 stars for its Part C operations for 2017 and 2018 and could be subject to termination by CMS if the score does not improve for

2019. Additionally, our PDP plan received a score of 2.5 stars for 2017 and 2018 and could subject the contract to termination by CMS if the score does not improve for 2019.

In certain state Medicaid programs, plans that do not meet applicable quality and service measures can be required to refund premiums previously received, may not receive premiums withheld, may not be able to earn quality bonuses, may be required to pay penalties or may be subject to enrollment limitations, including suspension of auto assignment of members, or termination of the contract. In addition, if the state determines that a health plan has failed to meet the contractual requirements for quality measures, these contracts may be subject to termination or other remedies, such as liquidated damages, at the discretion of the state. We are unable to predict what actions a state may take, if any, when assessing our contractual performance.

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In addition, lower quality scores compared to our competitors may adversely affect our ability to attract members and obtain regulatory approval for acquisitions or expansions or succeed in competitive bidding situations. As a result, lower quality scores compared to our competitors could have a material adverse effect on our business, rate of growth, results of operations, financial condition and cash flows.

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

Our contracts require the submission of complete and correct encounter data. The accurate and timely reporting of encounter data is increasingly important to the success of our programs because more states are using encounter data to determine compliance with performance standards and to set premium rates. We have expended and may continue to expend additional effort and incur significant additional costs to collect or correct inaccurate or incomplete encounter data and have been, and continue to be exposed to, operating sanctions and financial fines and penalties for noncompliance. In some instances, our government clients have established retroactive requirements for the encounter data we must submit. There also may be periods of time in which we are unable to meet existing requirements. In either case, it may be prohibitively expensive or impossible for us to collect or reconstruct this historical data.

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

We rely on a number of third parties, and failure of any one of the third parties to perform in accordance with our contracts or applicable law could have a material adverse effect on our business and results of operations.

We have determined, based on an evaluation of factors, including cost, compliance, quality and procurement success, that it is more efficient to use third parties for certain functions and services. As a result, we have contracted with a number of third parties to provide significant operational support including, but not limited to, pharmacy benefit management for our members as well as certain enrollment, billing, call center, benefit administration and claims processing functions, sales and marketing, reinsurance, quality improvement efforts and certain aspects of utilization management. We have limited ability to control the performance of these third parties. If a third party provides services that we are required to provide under a contract with a government client, we are responsible for such performance and will be held accountable by the government client for any failure of performance by our vendors. Significant failure by a third party to perform in accordance with the terms of our contracts or applicable law could subject us to fines or other sanctions or otherwise have a material adverse effect on our business and results of operations. In addition, upon termination of a third party contract, we may encounter difficulties in replacing the third party on favorable terms, transitioning services to another vendor, or in assuming those responsibilities ourselves, which may have a material adverse effect on our business, quality scores and results of operations. Further, we rely on state-operated systems and sub-contractors to qualify and assign eligible members into our health plan. Ineffectiveness of these state operations and sub-contractors can have a material adverse effect on our enrollment.

Our Medicaid operations are concentrated in a limited number of states. Loss of a material contract, insufficient premium rates, delayed payment of earned premiums, refund of overpayments or decreased membership and other factors may adversely affect our business, results of operations, financial condition and cash flows.

Our concentration of Medicaid operations in a limited number of states could cause our revenue, profitability or cash flow to change suddenly and unexpectedly as a result of insufficient premium rates, payment delays, refund of overpayments, loss of a material contract, legislative actions, changes in Medicaid eligibility methodologies, including recertification requirements for eligibility, increased competition, catastrophic claims, epidemics, pandemics, unexpected increases in utilization, advances in medical technology and pharmaceutical therapies, difficulties in managing provider costs, general economic conditions and similar factors in those states. Our inability to continue to operate in any of these states or a significant change in the nature of our existing operations, could adversely affect our business, results of operations, financial condition and cash flows. Unfavorable changes in health care or other benefit costs or reimbursement rates or increased competition in these states could have a disproportionately adverse effect on our operating results.

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For the year ended December 31, 2017, our Medicaid operations in Florida and Kentucky each accounted for greater than 10% of our consolidated premium revenue, net of premium taxes. These customers accounted for contracts that have terms of between one and three years with varying expiration dates.

Our Medicaid contracts are generally intended to run for one to three years and in some cases may be extended for additional years if the state or other sponsoring agency elects to do so. When our state contracts expire, they may be opened for bidding by competing health care plans. For example, the State of Florida is in the process of re-procuring Medicaid services for a five-year term commencing January 1, 2019. There is no guarantee that our contracts will be renewed or extended or, if renewed or extended, on what terms. Further, our contracts with the states are subject to cancellation by the state after a short notice period in the event of unavailability of state funds. Our contracts could also be terminated if we fail to perform in accordance with the standards set by state regulatory agencies. If any of our contracts are terminated, not renewed or extended, renewed or extended on less favorable terms or not renewed or extended on a timely basis or if an increased number of competitors were awarded contracts in these states, our business will suffer, and our results of operations, financial condition and cash flows may be materially affected.

Most of our Medicaid revenues under these contracts are generated by premiums consisting of fixed monthly payments per member and supplemental payments for other services such as maternity deliveries, depending on the type of member in our plans. The payments are generally set based on an estimation of the medical costs using actuarially sound methods based on historical data, factors and assumptions. When we commence operations in a new state or region or commence participation in a new program, the factors and assumptions used to develop premiums and premium rates are subject to greater variability as there is limited experience or information available to us and the state. Actual experience could differ from the assumptions used in the premium-setting process, which could result in premiums being insufficient to cover our medical benefits expense.

In addition, our premium revenues remain subject to reconciliation and recoupment for many years. The refund of premium overpayment to the government customer could be significant and would reduce our premium revenue in the year that the repayment obligation is identified.

State governments generally are experiencing tight budgetary conditions within their Medicaid programs. As a result, government agencies with which we contract may seek funding alternatives, which may result in reductions in funding, or changes to program design, including member eligibility and benefits for their Medicaid programs. For example, the State of Kentucky expects to implement new premium and work requirements for certain members to maintain their eligibility for the Medicaid program beginning on July 1, 2018, which may reduce our Medicaid membership in Kentucky. If any state in which we operate were to decrease premiums paid to us for these reasons or any other reason, decrease members eligible to participate in the programs, reduce the benefits offered by the programs, or pay us less than the amount necessary to keep pace with our cost trends, or delay increases in premiums, these could have a material adverse effect on our revenues and results of operations. We have experienced rate decreases and rate increase delays in the past and may do so in the future. Economic conditions affecting state governments and agencies could also result in delays in receiving premium payments. If there is a significant delay in our receipt of premiums to pay health benefit costs, it could have a material adverse effect on our results of operations, financial condition, cash flows and liquidity.

A significant percentage of our Medicaid plan enrollment results from mandatory enrollment in Medicaid managed care plans. States may mandate that certain types of Medicaid beneficiaries enroll in Medicaid managed care through CMS-approved state plan amendments or, for certain groups, through federal waivers or demonstrations. Waivers and programs under demonstrations are generally approved for two- to five-year periods and can be renewed on an ongoing basis if the state applies and the waiver request is approved or renewed by CMS. We have no control over this renewal process. If a state in which we operate does not mandate managed care enrollment in its state plan or does not renew an existing managed care waiver, our membership would likely decrease, which could have a material

adverse effect on our results of operations.

We derive a significant portion of our cash flow and gross margin from our PDP operations, for which we submit annual bids for participation. The results of our bids could materially affect our results of operations, financial condition and cash flows.

A significant portion of our PDP membership is obtained from the auto-assignment of beneficiaries in CMS-designated regions where our PDP premium bids are below benchmarks of other plans' bids. In general, our premium bids are based on assumptions regarding PDP membership, utilization, drug costs, drug rebates and other factors for each region. Our 2018 PDP bids resulted in one of our basic plans being below the benchmarks in 25 of the 34 CMS regions, and within the de minimis range in five other regions, compared with our 2017 bids, in which we were below the benchmarks in 30 of the 34 CMS regions, and within the de minimis range in three other regions. For those regions in which we are within the de minimis range, we will not be eligible to have new members auto-assigned to us, but we will not lose our existing auto-assigned membership.

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

If our actual costs of providing prescription drugs are higher than our estimated costs of providing prescription drugs when we provided our bids to CMS, our funds receivable from CMS could be higher than we anticipated, which could have a material adverse effect on our cash flow and liquidity.

We may not be able to generate or access sufficient cash to service all of our indebtedness or successfully secure alternatives to satisfy our obligations under our indebtedness.

As of December 31, 2017, we had approximately $1.2 billion in aggregate principal amount of total indebtedness outstanding primarily consisting of $1.2 billion senior notes due 2025 (the "Senior Notes"). Additionally, we had $1.0 billion available for borrowing under our 2016 Revolving Credit Facility (the "Credit Agreement"). Our ability to make scheduled payments on or to refinance our debt obligations depends on our and our subsidiaries' financial condition and operating performance, which is subject to prevailing economic and competitive conditions and to certain financial, business, competitive, legislative, regulatory and other factors beyond our control. As a result, we may not be able to maintain a level of cash flows from operating activities or to access the cash flows of our subsidiaries in an amount sufficient to permit us to pay the principal and interest on our indebtedness, including the Senior Notes and the Credit Agreement. We cannot assure that our business will generate sufficient cash flow from operations or that financing sources will be available to us in amounts sufficient to enable us to pay our indebtedness, including the Senior Notes and the Credit Agreement, or to fund our other liquidity needs.

If our cash flows and capital resources are insufficient to fund our debt service obligations, we may be forced to reduce or delay investments and capital expenditures, or to sell assets, seek additional capital or restructure or refinance our indebtedness, including the Senior Notes. These alternative measures may not be successful and may not permit us to meet our scheduled debt service obligations. Our ability to restructure or refinance our debt will depend on the condition of the capital markets and our financial condition at such time. Any refinancing of our debt could be at higher interest rates and may require us to comply with more onerous covenants, which could further restrict our business operations. The terms of existing or future debt instruments and the indenture that governs the Senior Notes may restrict us from adopting some or all of these alternatives. If we are unable to pay our indebtedness on time, it could result in the acceleration of our indebtedness and materially adversely affect us.

Future changes in health care laws present challenges for our business that could have a material adverse effect on our results of operations, financial condition and cash flows.

Future changes in, or interpretations to, existing health care laws or regulations, or the enactment of new laws or the issuance of new regulations could materially reduce our revenue and/or profitability by, among other things:

- imposing additional license, registration and/or capital requirements;
- increasing our administrative and other costs;
- requiring us to change our operating structure;
- requiring significant additional reporting and technological capabilities;
- imposing additional fees and taxes, which cannot be offset by increased premium revenue;
- increasing mandated benefits, such as the proposed mental health parity regulation;
- further limiting our ability to engage in intra-company transactions with our affiliates and subsidiaries;
- restricting our revenue and enrollment growth;
- requiring us to restructure our relationships with providers; and
- requiring us to implement additional or different programs and systems.

On May 6, 2016, CMS published regulations that overhauled Medicaid managed care requirements. These regulations include requirements that state Medicaid programs evaluate network adequacy standards and impose a requirement of managed care organizations ("MCO") to report MLRs annually to states, as well as a requirement that states set MCO rates to reasonably achieve an MLR of greater than 85% as long as the capitation rates are actuarially sound. Additionally, these regulations expand federal financial participation reimbursement opportunities related to members with behavioral (mental) health issues who receive short term services in an alternative mental disease institution and outline requirements for value-based provider contracting. Under the regulations, the states may also be tasked with developing and publicizing plan quality rating results. The degree of federal oversight in implementing these regulations is uncertain, and the states may retain substantial flexibility

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in designing their Medicaid programs. Implementation or lack of implementation by CMS and the state Medicaid agencies of these regulations may materially adversely affect our results of operations, financial condition and cash flows.

Requirements relating to increased plan information disclosure, expedited appeals and grievance procedures, third party review of certain medical decisions, health plan liability, access to specialists, “clean claim” (a claim for which no additional information is needed), payment methodologies and timing, utilization of mail order pharmacy, administrative simplification, mandatory network inclusion of certain providers, mandated increases in provider reimbursement rates, physician collective bargaining rights, centralized credentialing and confidentiality of medical records either have been enacted or are under consideration. Changes in state law, regulations and rules also may have a material adverse effect on our results of operations, financial condition and cash flows.

The Medicare Access and CHIP Reauthorization Act of 2015 was enacted in April 2015, which, among other things, extended the Special Needs Program through 2018. On January 22, 2018, CHIP funding was extended for six years as part of a broader continuing resolution to fund the federal government. In addition, the resolution continued the enhanced federal match rate for CHIP established by the ACA initially, but reduced the rate over time. The resolution also extended the requirement for states to maintain coverage for children from 2019 through 2023, but after October 1, 2019, the requirement is limited to children in families with incomes at or below 300% of the federal poverty level. On February 9, 2018, the Bipartisan Budget Act of 2018 was enacted, which extended CHIP for an additional four years, until 2027, and permanently reauthorized MA special needs plans but imposed additional requirements for care coordination and integration of long-term services and supports. The funding of the CHIPs and Special Needs Programs by the federal government may be limited further, and eligibility for those programs may also be further restricted. If these programs are further modified or the funding further restricted, states could cease operating these programs, or limit their eligibility or benefits, or impose new requirements, which could have a material adverse effect on our revenues, cash flow, membership and profitability.

The Bipartisan Budget Act of 2018 also added additional flexibility to how ACOs can operate and accelerated the timing of the closure of the Part D “coverage gap” (i.e., the dollar threshold at which an individual has to pay full price for his or her medications). As a result, Part D beneficiaries' co-pays will be reduced to 25% of prescription costs in 2019, instead of that reduction occurring in 2020 under prior law. These changes, and other future changes to federal and state health care laws and regulations could have a material adverse effect on our results of operations, financial condition and cash flows.

We encounter significant competition for program participation, members, network providers, key personnel and sales personnel and our failure to compete successfully may limit our ability to increase or maintain membership in the markets we serve, or have a material adverse effect on our business, growth prospects and results of operations.

We operate in a highly competitive industry. The criteria and scoring of the criteria used to award participation in certain government programs, such as Medicaid and CHIP, are subject to substantial discretion and vary greatly among them. Some of our competitors are more established in the insurance and health care industries, with larger market share, greater financial resources and better quality scores than we have in some markets. We also operate in, and may attempt to acquire business in, programs or markets in which premiums are determined on the basis of a competitive premium bidding process. In these programs or markets, funding levels established by bidders with significantly different cost structures, target profitability margins or aggressive bidding strategies could negatively affect our ability to maintain or acquire profitable businesses, which could have a material adverse effect on our results of operations.

Regulatory reform or other initiatives may bring additional competitors into our markets. Regulators may prefer companies that operate in lines of business in which we do not operate when we bid on new business or renewals of

existing business, which may cause our bid or renewal to be unsuccessful.

We compete for members principally on the basis of size and quality of provider network, benefits provided and quality of service. We may not be able to develop innovative products and services that are attractive to members. We cannot be sure that we will continue to remain competitive, nor can we be sure that we will be able to successfully retain or acquire members for our products and services at current levels of profitability.

In addition, we compete with other health plans to contract with hospitals, physicians, pharmacies and other providers for inclusion in our networks that serve government program beneficiaries. We believe providers select plans in which they participate based on several criteria including reimbursement rates, timeliness and accuracy of claims payment, potential to deliver new patient volume and/or retain existing patients, effectiveness of resolution of calls and complaints and other factors. We cannot be sure that we will be able to successfully attract or retain providers under acceptable contract terms to maintain a competitive network in the geographic areas we serve.

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We are dependent on our senior management and we may not be able retain our senior management or attract and retain other qualified management, clinical and commercial personnel in the future due to the intense competition for qualified personnel in the managed care and health care industry. In addition, we have in the past and may in the future modify our senior management structure, which could affect our retention of employees and management. If we are not able to attract and retain necessary personnel to accomplish our business objectives, we may experience constraints that will significantly impede the achievement of our objectives, our ability to raise additional capital and our ability to implement our business strategy. In particular, if we lose any members of our senior management team, we may not be able to find suitable replacements, and our business may be harmed as a result.

Our MA plans are sold primarily through our sales personnel, who frequently work with independent brokers, consultants and agents who assist in the production and servicing of business. The independent brokers, consultants and agents generally are not dedicated to us exclusively and may also recommend and/or market health care benefit products of our competitors, and we must compete intensely for their services and allegiance. Our sales could be adversely affected if we are unable to attract or retain sales personnel and third-party brokers, consultants and agents or if we do not adequately provide support, training and education to this sales network regarding our product portfolio, which is complex, or if our sales strategy is not appropriately aligned across distribution channels.

To the extent that competition intensifies in any market that we serve, our ability to retain or increase members and providers, maintain or increase our revenue growth and control medical cost trends and/or our pricing flexibility may be adversely affected. Failure to compete successfully in the markets we serve may have a material adverse effect on our business, growth prospects and results of operations.

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

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

As a result of the variability of certain factors that determine estimates for risk-adjusted premiums, including plan risk scores, the actual amount of retroactive payments could be materially more or less than our estimates. Consequently, our estimate of our plans' risk scores for any period, and any resulting change in our accrual of premium revenues related thereto, could have a material adverse effect on our results of operations, financial condition and cash flows. The data provided to our government customers to determine the risk score are subject to audit by them even after the annual settlements occur. These audits may result in the refund of premiums to the government customer previously received by us, which could be significant and would reduce our premium revenue in the year that repayment is required.

Government customers have performed and continue to perform audits of selected plans to validate the provider coding practices under the risk adjustment model used to calculate the premium paid for each member. We anticipate that CMS will continue to conduct audits of our Medicare contracts and contract years on an on-going basis. An audit may result in the refund of premiums to CMS. It is likely that a payment adjustment could occur as a result of these audits; and any such adjustment could have a material adverse effect on our results of operations, financial condition and cash flows.

We are subject to extensive government regulation and risk of litigation, and any actual or alleged violation by us of the terms of our contracts, applicable laws or regulations could have a material adverse effect on our results of operations, financial condition and cash flows.

Our business is extensively regulated by the federal government and the states in which we operate. The laws and regulations governing our operations are generally intended to benefit and protect health plan members and providers rather than stockholders and creditors. The government agencies administering these laws and regulations have broad latitude to enforce them. These laws and regulations, along with the terms of our government contracts, regulate how we do business, what services we offer, and how we interact with our members, providers and the public. Any actual or alleged violation by us of applicable laws or regulations could damage our reputation and reduce our revenues and profitability, thereby having a material adverse effect on our results of operations.

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We face a significant risk of class action lawsuits and other litigation and regulatory investigations and actions in the ordinary course of operating our businesses. The following are examples of types of potential litigation and regulatory investigations we face:

- claims by government agencies relating to compliance with laws and regulations;
- claims relating to sales practices;
- claims relating to the methodologies for calculating premiums;
- claims relating to the denial or delay of health care benefit payments;
- claims relating to claims payments and procedures;
- claims relating to provider marketing;
- claims by providers for network termination or exclusion;
- anti-kickback claims;
- medical malpractice or negligence actions based on our medical necessity decisions or brought against us on the theory that we are liable for our providers' malpractice or negligence;
- allegations of anti-competitive and unfair business activities;
- provider disputes over compensation and termination of provider contracts or defamation claims;
- allegations of discrimination;
- allegations of breaches of duties;
- claims relating to inadequate or incorrect disclosure or accounting in our public filings and other statements;
- allegations of agent misconduct;
- claims related to deceptive trade practices;
- claims relating to audits and contract performance;
- protests related to Medicaid awards; and
- violations of state procurement laws and policies.

As we contract with various governmental agencies to provide managed health care services, we are subject to various reviews, audits and investigations to verify our compliance with the contracts and applicable laws and regulations. Any adverse review, audit, investigation or result from litigation could result in:

- loss of our right to participate in government-sponsored programs, including Medicaid and Medicare;
- forfeiture or recoupment of amounts we have been paid pursuant to our government contracts;
- imposition of significant civil or criminal penalties, fines or other sanctions on us and/or our key associates;
- reduction or limitation of our membership;
- damage to our reputation in various markets;
- increased difficulty in marketing our products and services;
- inability to obtain approval for future acquisitions or service or geographic expansion;
- suspension or loss of one or more of our licenses to act as an insurer, HMO or third party administrator or to otherwise provide a service; and
- an event of default under our debt agreements.

In particular, because we receive payments from federal and state governmental agencies, we are subject to various laws commonly referred to as "fraud and abuse" laws, including the federal False Claims Act, which permit agencies and enforcement authorities to institute suit against us for violations and, in some cases, to seek treble damages, penalties and assessments. Many states, including states where we currently operate, have enacted parallel legislation. Liability under such federal and state statutes and regulations may arise if we know, or it is found that we should have known, that information we provide to form the basis for a claim for government payment is false or fraudulent.

Some courts have permitted False Claims Act suits to proceed if the claimant was out of compliance with program requirements. Liability for such matters could have a material adverse effect on our financial condition, results of

operations and cash flows. Qui tam, or "whistleblower" actions under federal and state law can be brought by any individual on behalf of the government. These actions have increased significantly in recent years, causing greater numbers of health care companies to defend false claim actions, pay fines or be excluded from Medicare, Medicaid or other state or federal health care programs as a result of investigations arising out of such actions.

For example, in October 2008, the Civil Division of the United States Department of Justice (the “Civil Division”) informed us that as part of its civil inquiry, it was investigating four complaints filed by relators against us under the whistleblower provisions of the False Claims Act. We also learned from a docket search that a former employee filed an action in state court for Leon County, Florida against several defendants, including us and one of our subsidiaries. With respect to these actions, we reached a settlement with the Civil Division, the Civil Division of the United States Attorney’s Office for the

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Middle District of Florida, and the Civil Division of the United States Attorney's Office for the District of Connecticut. However, other such actions may have been filed against us of which we are presently unaware, or other similar actions may be filed against us in the future.

We are currently undergoing standard periodic audits by several state agencies and CMS to verify compliance with our contracts and applicable laws and regulations. For additional risks associated with these audits, see "Risk-adjustment payment systems make our revenue and results of operations more difficult to estimate and could result in material retroactive adjustments that have a material adverse effect on our results of operations, financial condition and cash flows" above.

In addition, there have been a number of investigations regarding the marketing practices of brokers and agents selling health care and other insurance products and the payments they receive. These have resulted in enforcement actions against companies in our industry and brokers and agents marketing and selling those companies' products. For example, CMS and state departments of insurance have increased their scrutiny of the marketing practices of brokers and agents who market Medicare products. These investigations and enforcement actions could result in penalties and the imposition of corrective action plans and/or changes to industry practices, which could adversely affect our ability to market our products.

We rely on the accuracy of eligibility systems provided by our government clients to have members assigned to us, collect premiums, and any inaccuracies or other problems in those systems may cause states to recoup premium payments from us, or our membership to decline, which could materially reduce our revenues and results of operations.

Members are assigned to us and premium payments that we receive are based upon eligibility systems provided by our government clients. If those eligibility systems do not function properly, fewer members may be assigned to us, which could materially reduce our revenues and could have a material adverse effect on our results of operations. In addition, a state will require us to reimburse it for premiums that we received from the state based on an eligibility list that it later discovers contains individuals who were not eligible for any government-sponsored program, have been enrolled twice in the same program, have secondary insurance, are eligible for a different premium category, are eligible for a different program or did not meet additional eligibility criteria such as premium payments or work requirements. Our review of remittance files may not identify all member eligibility errors and could result in repayment of premiums in years subsequent to the year in which the revenue was recorded. We have established a reserve in anticipation of recoupment by the states of previous overpayments, but ultimately our reserve may not be sufficient to cover the amount, if any, of recoupments. If the amount of any recoupment exceeds our reserves, our revenues could be materially reduced and it could have a material adverse effect on our results of operations.

In addition to recoupment of premiums previously paid, we also face the risk that a state could fail to pay us for members for whom we are entitled to payment, based on any inaccuracies or other errors in the states' eligibility systems. Our results of operations would be reduced as a result of the state's failure to pay us for related payments we made to providers and were unable to recoup.

If we are unable to access sufficient capital, whether as a result of difficulties finding acceptable public or private financing, restrictions under our credit agreement, restrictions under our Senior Notes, restrictions on dividend payments from our subsidiaries or higher levels of required statutory capital, we may be unable to grow or maintain our business, which could have a material adverse effect on our results of operations, financial condition and cash flows.

Our business strategy includes entering new markets by pursuing attractive growth opportunities for our existing product lines and pursuing acquisition opportunities. We may need to access the debt or equity markets and receive

dividends from our subsidiaries to fund these growth activities.

Our ability to enter new markets and purchase existing businesses may be hindered in situations where financing may not be available on terms that are favorable to us, or at all. Financing may only be available to us with unfavorable terms such as high rates of interest, restrictive covenants and other restrictions that could impede our ability to profitably operate our business and increase the expected rate of return we require, making such efforts unfeasible.

Our Credit Agreement and Senior Notes have restrictions on our ability to secure additional capital. Our substantial indebtedness and restrictive covenants:

- limit our ability to borrow additional funds for working capital, capital expenditures, acquisitions and general corporate or other purposes; and
- expose us to greater interest rate risk since the interest rate on borrowings under our Credit Agreement is variable.

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Our debt service obligations require us to use a portion of our operating cash flow to pay interest and principal on indebtedness instead of for other corporate purposes, including funding future expansion of our business and ongoing capital expenditures, which could impede our growth. If our operating cash flow and capital resources are insufficient to comply with the financial covenants in the credit agreement or to service our debt obligations, we may be forced to sell assets, seek additional equity or debt financing or restructure our debt, which could harm our long-term business prospects.

Our Credit Agreement and Senior Notes also contain various restrictions and covenants that restrict our financial and operating flexibility, including our ability to grow our business or declare dividends without lender approval. If we fail to pay any of our indebtedness when due, or if we breach any of the other covenants in the instruments governing our indebtedness, one or more events of default may be triggered. If we are unable to obtain a waiver, these events of default could permit our creditors to declare all amounts owed to be immediately due and payable.

In addition, in most states, we are required to seek the prior approval of state regulatory authorities to transfer money or pay dividends from our regulated subsidiaries in excess of specified amounts or, in some states, any amount. If our state regulators do not approve payments of dividends and/or distributions by certain of our regulated subsidiaries to us or our non-regulated subsidiaries, our liquidity, unregulated cash flows, business and financial condition may be materially adversely affected.

Our licensed HMO and insurance subsidiaries are subject to state regulations that, among other things, require the maintenance of minimum levels of statutory capital and maintenance of certain financial ratios, as defined by each state. States may raise the statutory capital level from time to time, which could have a material adverse effect on our cash flows and liquidity.

Our subsidiaries also may be required to maintain higher levels of statutory capital and are subject to their state regulators' general oversight powers. Regardless of whether a state adopts the risk-based capital requirements, the state's regulators can require our subsidiaries to maintain minimum levels of statutory net worth in excess of amounts required under the applicable state laws if they determine that maintaining such additional statutory net worth is in the best interests of our members and other constituents. For example, if premium rates are inadequate, reduced profits or losses in our regulated subsidiaries may cause regulators to increase the amount of capital required. Any additional capital contribution made to one or more of the affected subsidiaries could have a material adverse effect on our liquidity, cash flows and growth potential. In addition, increases of statutory capital requirements could cause us to withdraw from certain programs or markets where it becomes economically difficult to continue operating profitably.

Our indemnification obligations and the limitations of our director and officer liability insurance may have a material adverse effect on our results of operations, financial condition and cash flows.

Under Delaware law, our charter and bylaws and certain indemnification agreements to which we are a party, we have an obligation to indemnify, or we have otherwise agreed to indemnify, certain of our current and former directors, officers and associates with respect to current and future investigations and litigation. In connection with some pending matters, including the criminal trial of certain of our former executives and associates, we are required to, or we have otherwise agreed to, advance, and have advanced, significant legal fees and related expenses and expect to continue to do so while these matters are pending, subject to the caps provided in our settlement agreements with certain individuals. We have exhausted our insurance for the expenses associated with the criminal trial of our former executive officers and associates, and the related government investigations that commenced in 2007, and further expenses incurred by us for these matters will not be reimbursed.

We currently maintain insurance which provides coverage for our independent directors and officers hired after January 24, 2008 for certain potential matters to the extent they occur after October 2007. We cannot provide any

assurances that pending claims, or claims yet to arise, will not exceed the limits of our insurance policies, that such claims are covered by the terms of our insurance policies or that our insurance carrier will be able to cover our claims.

We are exposed to fluctuations in the securities and debt markets, which could affect our investment portfolio and our results of operations, financial condition, cash flows and liquidity.

Our investment portfolio represents a significant portion of our assets and is subject to general credit, liquidity, and market and interest rate risks. Market fluctuations in the securities and credit markets could affect the value or liquidity of our investment portfolio and adversely affect interest income. As a result, we may experience a reduction in value or loss of liquidity which may materially affect our results of operations, financial condition, cash flows and liquidity.

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Risks Related to Ownership of Our Stock

We are subject to laws and government regulations that may delay, deter or prevent a change in control of our Company, which could have a material adverse effect on our ability to enter into transactions favorable to stockholders.

Our operating subsidiaries are subject to state laws that require prior regulatory approval for any change of control of an HMO or insurance company. For purposes of these laws, in most states "control" of an entity is presumed to exist when a person, group of persons or entity acquires the power to vote 10% or more of the voting securities of that entity, subject to certain exceptions. These laws may discourage acquisition proposals and may delay, deter or prevent a change of control of our company, including through transactions, and in particular through unsolicited transactions, which could have a material adverse effect on our ability to enter into transactions that some or all of our stockholders find favorable.

Our stock price and trading volume may be volatile and future sales of our common stock could adversely affect the trading price of our common stock.

From time to time, the price and trading volume of our common stock, as well as the stock of other companies in the health care industry, may experience periods of significant volatility. Company-specific issues and developments generally in the health care industry (including the regulatory environment) and the capital markets and the economy in general may cause this volatility. Our stock price and trading volume may fluctuate in response to a number of events and factors, including:

- variations in our operating results;
- changes in our or the market's expectations about our future operating results;
- changes in financial estimates and recommendations by securities analysts concerning our Company or the health care industry generally;
- operating and stock price performance of other companies that investors may deem comparable;
- news reports relating to trends in our markets;
- changes or proposed changes in the laws, regulations and policies affecting our business;
- acquisitions and financings by us or others in our industry;
- changes in our senior management;
- sales of substantial amounts of our common stock by our directors and executive officers or principal stockholders, or the perception that such sales could occur; and
- the risks described in “Risks Related to Our Business” above.

We may issue equity securities in the future, including securities that are convertible into or exchangeable for, or that represent the right to receive, common stock. We have an effective shelf registration statement on Form S-3 filed with the SEC under which we may offer from time to time an indeterminate amount of any combination of debt securities, common and preferred stock and warrants. The registration statement allows us to seek additional financing, subject to the SEC's rules and regulations relating to eligibility to use Form S-3. Debt financing, if available, may involve restrictive covenants.

The issuance of additional shares of our common stock or other equity securities, including sales of shares in connection with any future acquisitions, could be substantially dilutive to our stockholders. These sales may have a harmful effect on prevailing market prices for our common stock and our ability to raise additional capital in the financial markets at a time and price favorable to us. Holders of shares of our common stock have no preemptive rights that entitle them to purchase a pro rata share of any offering of shares of any class or series and, therefore, such

sales or offerings could result in increased dilution to our stockholders. Our certificate of incorporation provides that we have authority to issue 100,000,000 shares of common stock and 20,000,000 shares of preferred stock.

Risks Related to Information Technology

If we or our vendors are unable to maintain effective and secure management information systems and applications, successfully update or expand processing capability or develop new capabilities to meet our business needs and regulatory requirements, we could experience operational disruptions and other materially adverse consequences to our business and results of operations.

Our business depends on effective and secure information systems, applications and operations. The information gathered, processed and stored by our management information systems and our vendors' management information systems assists us in, among other things, marketing and sales, membership tracking, billing, claims processing, medical management, medical care cost and utilization trending, reinsurance, financial and management accounting, reporting, and planning and analysis. These

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systems also support our customer service functions, provider and member administrative functions and support tracking and extensive analysis of medical expenses and outcome data. These systems remain subject to unexpected interruptions resulting from occurrences such as hardware failures or increased demand. There can be no assurance that such interruptions will not occur in the future, and any such interruptions could have a material adverse effect on our business and results of operations. Moreover, operating and other issues can lead to data problems that affect the performance of important functions, including, but not limited to, claims payment, customer service and financial reporting.

There can also be no assurance that our or our vendors' process of maintaining and improving existing systems, developing new systems to support our operations, complying with contractual and regulatory requirements and improving service levels will not be delayed or that system issues will not arise in the future. Our and our vendors' information systems and applications require continual maintenance, upgrading and enhancement to meet our operational needs and regulatory requirements. If we or our vendors are unable to maintain or expand our systems, we could suffer from, among other things, operational disruptions, such as the inability to pay claims or to make claims payments on a timely basis, loss of members, difficulty in attracting new members, regulatory problems, difficulty in improving quality, increases in administrative expenses and write-offs of our expenditures in unsuccessful capital investments.

Additionally, events outside our control, including terrorism or acts of nature such as hurricanes, earthquakes, or fires, could significantly impair our or our vendors' information systems, applications and critical business functions. To help ensure continued operations in the event that our primary operations are rendered inoperable, we have a disaster recovery plan to recover critical business functionality within stated timelines. Our plan may not operate effectively during or following an actual attack or natural disaster and our operations and critical business functions could be disrupted or compromised, which could have a material adverse effect on our business and our results of operations.

Cybersecurity attacks also could significantly impair our or our vendors’ information systems, or compromise our or our vendors’ data security. Despite our and our vendors efforts to secure information systems, we could be subject to cybersecurity incidents that bypass our security measures, impact the integrity, availability or privacy of personal health information or other data subject to privacy laws or disrupt our information systems, devices or business, including our ability to provide various health care services. As cyber threats continue to evolve from malicious persons and groups, new vulnerabilities and advanced new attacks against information systems, we may be required to expend significant additional resources to continue to modify or enhance our protective measures or to investigate and remediate any cybersecurity vulnerabilities. Cybersecurity attacks could result in (i) harm to our members, associates and providers; (ii) business interruptions and delays; (iii) the loss, misappropriation, corruption or unauthorized access of data; (iv) litigation and potential liability under privacy, security and consumer protection laws or other applicable laws; (v) reputational damage and (vi) federal and state governmental inquiries, any of which could have a material, adverse effect on our financial position and results of operations and harm our business reputation.

In addition, we and our vendors are subject to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as amended by the Health Information Technology for Economic and Clinical Health Act (the “HITECH Act”), as well as numerous other privacy and security laws and regulations at the federal and state levels. Given the complexity and the evolving regulations related to data security and privacy, our or our vendors' ongoing ability to comply with such requirements is uncertain, which may expose us to the criminal and increased civil penalties provided under such laws and may require us to incur significant costs in order to seek to comply with such requirements, as well as subject us to significant penalties and reputational damage if we are unable to comply, which could have a material adverse effect on our business and our results of operations.

Item 1B. Unresolved Staff Comments.

None.

Item 2. Properties.

Our principal administrative, sales and marketing facilities are located at our leased corporate headquarters in Tampa, Florida. Our corporate headquarters is used in all of our lines of business. As of December 31, 2017, we also leased office space for the administration of our health plans in Arizona, Arkansas, California, Connecticut, Florida, Georgia, Hawaii, Illinois, Kentucky, Louisiana, Missouri, Mississippi, Nebraska, New Jersey, New York, North Carolina, South Carolina, Tennessee, Texas, Washington D.C. and Wisconsin. These properties are all in good condition and are well maintained. We believe these facilities are suitable and provide the appropriate level of capacity for our current operations. Upon expiration of the terms of the leases, we believe we could renew these leases on acceptable terms, or find suitable space elsewhere.

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Item 3. Legal Proceedings.

We are involved in legal actions in the normal course of our business, including, without limitation, protests and appeals related to Medicaid procurements, wage and hour claims and other employment claims, claims for indemnification under purchase agreements, vendor disputes and provider disputes regarding payment of claims. Some of these actions seek monetary damages, including claims for liquidated or punitive damages, which are not covered by insurance. We accrue for contingent liabilities related to these matters if a loss is deemed probable and is estimable. The actual outcome of these matters may differ materially from our current estimates and therefore could have a material adverse effect on our results of operations, financial position, and 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

Our common stock is listed on the New York Stock Exchange under the symbol "WCG." The following table sets forth the high and low closing sales prices of our common stock, as reported on the New York Stock Exchange, for each of the periods indicated:

	High	Low
2017		
First Quarter ended March 31, 2017	$146.04	$136.63
Second Quarter ended June 30, 2017	$183.60	$140.32
Third Quarter ended September 30, 2017	$183.87	$164.15
Fourth Quarter ended December 31, 2017	$212.99	$167.68
2016		
First Quarter ended March 31, 2016	$94.47	$70.06
Second Quarter ended June 30, 2016	$108.99	$88.00
Third Quarter ended September 30, 2016	$117.42	$104.23
Fourth Quarter ended December 31, 2016	$141.40	$113.51

The last reported sale price of our common stock on the New York Stock Exchange on February 13, 2018 was $194.33. As of February 13, 2018, we had approximately 15 holders of record of our common stock.

Dividends

We have never paid cash dividends on our common stock. We currently intend to retain any future earnings to fund our business, and we do not anticipate paying any cash dividends in the foreseeable future.

Our ability to pay dividends is partially dependent on, among other things, our receipt of cash dividends from our regulated subsidiaries. The ability of our regulated subsidiaries to pay dividends to us is limited by the state departments of insurance in the states in which we operate or may operate, as well as requirements of the government-sponsored health programs in which we participate. In addition, our current credit agreement and indenture have certain restrictions on our ability to pay dividends. Any future determination to pay dividends will be at the discretion of our board and will depend upon, among other factors, our results of operations, financial condition, capital requirements and contractual restrictions. For more information regarding restrictions on the ability of our regulated subsidiaries to pay dividends to us, please see Item 7 – Management's Discussion and Analysis of Financial Condition and Results of Operations – Regulatory Capital and Dividend Restrictions.

Unregistered Issuances of Equity Securities

None.

Issuer Purchases of Equity Securities

We do not have a stock repurchase program. Additionally, for the majority of restricted stock units granted, the number of shares issued on the date the units vest is net of shares withheld to meet applicable tax withholding requirements. Although these withheld shares are not issued or considered common stock repurchases under a stock

repurchase program, they are treated as common stock repurchases in our financial statements as they reduce the number of shares that would have been issued upon vesting.

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Performance Graph

The following graph compares the cumulative total stockholder return on our common stock for the period from December 31, 2012 to December 31, 2017 with the cumulative total return on the stocks included in the Standard & Poor's 500 Stock Index ("S&P 500") and the custom composite index over the same period. The Custom Composite Index includes the stock of Aetna Inc., Anthem Inc., Centene Corp., Cigna Corp., Humana Inc., Molina Healthcare, Inc., and UnitedHealth Group Inc. The graph assumes an investment of $100 made in our common stock, the S&P 500 and the custom composite index on December 31, 2012. The graph also assumes the reinvestment of dividends and is weighted according to the respective company's stock market capitalization at the beginning of each of the periods indicated. We did not pay any dividends on our common stock during the period reflected in the graph. Further, our common stock price performance shown below should not be viewed as being indicative of future performance.

	12/31/2012	12/31/2013	12/31/2014	12/31/2015	12/31/2016	12/31/2017
WellCare Health Plans, Inc.	$ 100	$ 145	$ 169	$ 161	$ 282	$ 413
S&P 500 Index	$ 100	$ 132	$ 151	$ 153	$ 171	$ 208
Custom Composite Index (7 stocks)	$ 100	$ 148	$ 200	$ 243	$ 290	$ 417