WELLCARE HEALTH PLANS, INC.
Form 10-Q
October 30, 2018

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549
FORM 10-Q
(Mark One)
ý QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the quarterly period ended September 30, 2018
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)

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 Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ý No o

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

As of October 29, 2018, there were 49,991,867 shares of the registrant's common stock, par value $0.01 per share, outstanding.

WELLCARE HEALTH PLANS, INC.

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Part I — FINANCIAL INFORMATION

Item 1. Financial Statements.

WELLCARE HEALTH PLANS, INC.
CONDENSED CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME
(Unaudited) (In millions, except per share and share data)

	For the Three Months Ended September 30,		For the Nine Months Ended September 30,	
	2018	2017	2018	2017
Revenues:				
Premium	4,988.8	4,390.9	14,227.7	12,631.5
Products and services	34.6	—	34.6	—
Investment and other income	34.7	12.0	81.0	30.6
Total revenues	5,058.1	4,402.9	14,343.3	12,662.1
Expenses:				
Medical benefits	4,195.0	3,740.7	12,023.0	10,938.3
Costs of products and services	33.5	—	33.5	—
Selling, general and administrative	433.2	372.3	1,167.0	1,040.2
ACA industry fee	86.5	—	247.0	—
Medicaid premium taxes	31.5	29.5	94.2	90.6
Depreciation and amortization	46.2	31.4	117.1	84.6
Interest	23.6	17.1	57.8	51.4
Total expenses	4,849.5	4,191.0	13,739.6	12,205.1
Income from operations	208.6	211.9	603.7	457.0
Loss on extinguishment of debt	—	—	—	26.1
Income before income taxes and equity in losses of unconsolidated subsidiaries	208.6	211.9	603.7	430.9
Equity in earnings (losses) of unconsolidated subsidiaries	6.6	23.2	(0.1)	22.1
Income before income taxes	215.2	235.1	603.6	453.0
Income tax expense	84.6	63.5	219.7	140.0
Net income	$130.6	$ 171.6	$383.9	$ 313.0
Other comprehensive income (loss):				
Change in net unrealized gains and losses on available-for-sale securities, before tax	(1.1)	0.4	(11.4)	1.7
Income tax expense (benefit) related to other comprehensive income	(0.3)	0.2	(2.7)	0.6
Other comprehensive (loss) income, net of tax	(0.8)	0.2	(8.7)	1.1
Comprehensive income	$129.8	$ 171.8	$375.2	$ 314.1
Earnings per common share:				
Basic	$2.74	$ 3.86	$8.40	$ 7.04
Diluted	$2.70	$ 3.82	$8.29	$ 6.97
Weighted average common shares outstanding:				
Basic	47,712,714	44,509,692	45,692,804	44,458,096

Diluted	48,384,427	44,969,033	46,287,614	44,909,916

See notes to unaudited condensed consolidated financial statements.

WELLCARE HEALTH PLANS, INC.
CONDENSED CONSOLIDATED BALANCE SHEETS
(Unaudited) (In millions, except share data)

	September 30, 2018	December 31, 2017
Assets		
Current Assets:		
Cash and cash equivalents	$ 4,306.6	$ 4,198.6
Short-term investments	1,034.4	469.5
Premiums receivable, net	969.6	453.4
Pharmacy rebates receivable, net	494.6	335.0
Funds receivable for the benefit of members	268.1	27.5
Prepaid expenses and other current assets, net	608.9	335.2
Total current assets	7,682.2	5,819.2
Property, equipment and capitalized software, net	384.1	319.5
Goodwill	1,753.5	660.7
Other intangible assets, net	1,326.6	367.9
Long-term investments	844.4	766.2
Restricted cash, cash equivalents and investments	234.8	211.0
Other assets	17.8	4.9
Assets of discontinued operations	215.1	215.2
Total Assets	$ 12,458.5	$ 8,364.6
Liabilities and Stockholders' Equity		
Current Liabilities:		
Medical benefits payable	$ 2,901.4	$ 2,146.3
Unearned premiums	20.8	65.9
Accounts payable and accrued expenses	868.8	788.1
Funds payable for the benefit of members	1,569.2	1,075.9
Other payables to government partners	444.2	367.0
Total current liabilities	5,804.4	4,443.2
Deferred income tax liability, net	117.2	93.4
Long-term debt, net	2,125.4	1,182.4
Other liabilities	34.0	13.7
Liabilities of discontinued operations	215.1	215.2
Total Liabilities	8,296.1	5,947.9
Commitments and contingencies (see Note 13)	—	—
Stockholders' Equity:		
Preferred stock, $0.01 par value (20,000,000 authorized, no shares issued or outstanding)	—	—
Common stock, $0.01 par value (100,000,000 authorized, 49,979,666 and 44,522,988 shares issued and outstanding at September 30, 2018 and December 31, 2017, respectively)	0.5	0.4
Paid-in capital	1,961.9	591.5
Retained earnings	2,211.4	1,827.5
Accumulated other comprehensive loss	(11.4)	(2.7)

Total Stockholders' Equity	4,162.4	2,416.7
Total Liabilities and Stockholders' Equity	$ 12,458.5	$ 8,364.6

See notes to unaudited condensed consolidated financial statements.

WELLCARE HEALTH PLANS, INC.
CONDENSED CONSOLIDATED STATEMENTS OF CHANGES IN STOCKHOLDERS' EQUITY
(Unaudited) (In millions, except share data)

	Common Stock		Paid in Capital	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	Total Stockholders' Equity
	Shares	Amount				
Balance at January 1, 2018	44,522,988	$ 0.4	$591.5	$1,827.5	$ (2.7)	$ 2,416.7
Issuance of common stock, net of issuance costs	5,207,547	0.1	1,342.2	—	—	1,342.3
Common stock issued for vested stock-based compensation awards	356,491	—	—	—	—	—
Repurchase and retirement of shares to satisfy tax withholding requirements	(107,360)	—	(23.3)	—	—	(23.3)
Stock-based compensation expense, net of forfeitures	—	—	51.5	—	—	51.5
Comprehensive income	—	—	—	383.9	(8.7)	375.2
Balance at September 30, 2018	49,979,666	$ 0.5	$1,961.9	$2,211.4	$ (11.4)	$ 4,162.4
Balance at January 1, 2017	44,293,881	$ 0.4	$546.9	$1,453.8	$ (1.0)	$ 2,000.1
Common stock issued for vested stock-based compensation awards	315,391	—	—	—	—	—
Repurchase and retirement of shares to satisfy tax withholding requirements	(96,795)	—	(13.6)	—	—	(13.6)
Stock-based compensation expense, net of forfeitures	—	—	32.8	—	—	32.8
Comprehensive income	—	—	—	313.0	1.1	314.1
Balance at September 30, 2017	44,512,477	$ 0.4	$566.1	$1,766.8	$ 0.1	$ 2,333.4

See notes to unaudited condensed consolidated financial statements.

WELLCARE HEALTH PLANS, INC.
CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS
(Unaudited, in millions)

	For the Nine Months Ended September 30,	
	2018	2017
Cash flows from operating activities:		
Net income	$383.9	$313.0
Adjustments to reconcile net income to cash flows from operating activities:		
Depreciation and amortization	117.1	84.6
Loss on extinguishment of debt	—	26.1
Stock-based compensation expense	51.5	32.8
Deferred taxes, net	(9.8)	(39.0)
Other, net	13.1	13.4
Changes in operating accounts, net of effects from acquisitions:		
Premiums receivable, net	(144.1)	58.4
Pharmacy rebates receivable, net	(138.7)	(52.7)
Medical benefits payable	227.1	258.8
Unearned premiums	(74.7)	574.4
Other payables to government partners	64.8	36.6
Accrued liabilities and other, net	(292.2)	(60.9)
Net cash provided by operating activities	198.0	1,245.5
Cash flows from investing activities:		
Acquisitions and acquisition-related settlements, net of cash acquired	(2,035.7)	(728.5)
Purchases of investments	(1,322.6)	(1,062.2)
Proceeds from sales and maturities of investments	822.8	324.1
Additions to property, equipment and capitalized software, net	(87.5)	(92.6)
Net cash used in investing activities	(2,623.0)	(1,559.2)
Cash flows from financing activities:		
Proceeds from issuance of debt, net of financing costs paid	739.0	1,182.2
Borrowings on Revolving Credit Facility, net of financing costs paid	221.3	—
Payments on debt	(25.0)	(1,026.1)
Proceeds from issuance of common stock, net of issuance fees paid	1,342.3	—
Repurchase and retirement of shares to satisfy employee tax withholding requirements	(23.3)	(13.6)
Funds received for the benefit of members, net	250.8	978.0
Other, net	29.5	13.4
Net cash provided by financing activities	2,534.6	1,133.9
Increase in cash, cash equivalents and restricted cash and cash equivalents	109.6	820.2
Balance at beginning of period [(1)]	4,263.0	4,121.3
Balance at end of period [(1)]	$4,372.6	$4,941.5
SUPPLEMENTAL DISCLOSURES OF CASH FLOW INFORMATION:		
Cash paid for taxes, net of refunds	$174.6	$149.5
Cash paid for interest	$65.5	$56.3

SUPPLEMENTAL DISCLOSURES OF NON-CASH TRANSACTIONS:		
Non-cash additions to property, equipment, and capitalized software	$3.7	$11.3

(1) Beginning and ending cash, cash equivalents and restricted cash and cash equivalents balances have been retrospectively adjusted to reflect the adoption of ASU 2016-18, "Statement of Cash Flows (Topic 230): Restricted Cash" effective January 1, 2018. See Note 1 - Organization, Basis of Presentation and Significant Accounting Policies for further discussion.

See notes to unaudited condensed consolidated financial statements.

WELLCARE HEALTH PLANS, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(Unaudited) (In millions, except member, per share and share data)

1. ORGANIZATION, BASIS OF PRESENTATION AND SIGNIFICANT ACCOUNTING POLICIES

WellCare Health Plans, Inc. (the "Company," "we," "us," or "our") focuses primarily on providing government-sponsored managed care services to families, children, seniors and individuals with complex medical needs primarily through Medicaid, Medicare Advantage ("MA") and Medicare Prescription Drug Plans ("PDP"), as well as individuals in the Health Insurance Marketplace. As of September 30, 2018, we served approximately 5.5 million members nationwide. 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.

As of September 30, 2018, we operated Medicaid health plans, including states where we receive Medicaid premium revenues associated with dually eligible special needs plans, in Arizona, Florida, Georgia, Hawaii, Illinois, Kentucky, Michigan, Missouri, Nebraska, New Jersey, New York, South Carolina and Texas.

In addition, as of September 30, 2018, we also operated MA coordinated care plans ("CCPs") in Arizona, Arkansas, California, Connecticut, Florida, Georgia, Hawaii, Illinois, Indiana, Kentucky, Louisiana, Maine, Michigan, Mississippi, New Jersey, New York, North Carolina, Ohio, South Carolina, Tennessee and Texas. We also offered stand-alone Medicare PDPs in 50 states and the District of Columbia.

In September 2018, we completed the acquisition of Meridian Health Plan of Michigan, Inc., Meridian Health Plan of Illinois, Inc., and MeridianRx, a pharmacy benefit manager ("PBM") (collectively, “Meridian”). As a result of the acquisition, we expanded our Medicaid portfolio through the addition of Michigan, where Meridian has the leading market position; expanded our Medicaid presence in Illinois; and acquired an integrated PBM platform. Meridian also serves MA members in Illinois, Indiana, Michigan, and Ohio, as well as Health Insurance Marketplace members in Michigan.

Basis of Presentation

The accompanying unaudited condensed consolidated balance sheets and statements of comprehensive income, changes in stockholder's equity, and cash flows include our accounts and the accounts of our subsidiaries over which we have control or are the primary beneficiary. We eliminated all intercompany accounts and transactions.

The accompanying unaudited condensed consolidated interim financial statements have been prepared in accordance with generally accepted accounting principles in the United States of America ("GAAP"). Accordingly, certain financial information and footnote disclosures normally included in financial statements prepared in accordance with GAAP, but that are not required for interim reporting purposes, have been condensed or omitted. The accompanying unaudited condensed consolidated interim financial statements should be read in conjunction with the consolidated financial statements and notes thereto, for the fiscal year ended December 31, 2017, included in our Annual Report on Form 10-K ("2017 Form 10-K"), which was filed with the U.S. Securities and Exchange Commission ("SEC") in February 2018. Results for the interim periods presented are not necessarily indicative of results that may be expected for the entire year or any other interim period.

In the opinion of management, the unaudited condensed consolidated interim financial statements reflect all normal recurring adjustments that we consider necessary for the fair presentation of our financial position, results of operations and cash flows for the interim periods presented. In accordance with GAAP, we make certain estimates and assumptions that affect the amounts reported in the condensed consolidated interim financial statements and accompanying notes. We base these estimates, including assumptions as to the annualized tax rate, on our knowledge of current events and anticipated future events and evaluate and update our assumptions and estimates on an ongoing basis; however, actual results may differ from our estimates. We evaluated all material events subsequent to the date of these condensed consolidated interim financial statements. Certain reclassifications were made to 2017 financial information to conform to the 2018 presentation.

As previously discussed, we acquired an integrated PBM platform in connection with the Meridian acquisition. The external revenues and costs for our PBM business are reported within "Products and Services" and "Cost of Products and Services", respectively, on the statements of comprehensive income. Products and services revenues from our PBM consist of the prescription price (ingredient cost plus dispensing fee) negotiated with the retail pharmacies with which we have contracted, plus any associated administrative fees. This revenue is recognized when the claim is processed. We have the contractual obligation to pay network pharmacies for benefits provided to participating members and, therefore, act as principal in the arrangement and reflect the total prescription price as revenue, on a gross basis, in accordance with applicable accounting guidance. Costs of products and services is recognized at the time prescriptions are dispensed by pharmacies in the PBM's network to eligible members and consists primarily of ingredient costs and dispensing fees paid to retail pharmacies with which we have contracted. The overall results of our PBM business are immaterial.

Unconsolidated Subsidiaries

In April 2017, in connection with the acquisition of Universal American Corp. (“Universal American”), we acquired a wholly-owned subsidiary, which works with physicians and other health care professionals to operate Accountable Care Organizations ("ACOs") under the Medicare Shared Saving Program ("MSSP") and Next Generation ACO Models. ACOs were established by the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (the "ACA") to reward integrated, efficient care and allow providers to share in any savings they achieve as a result of improved quality and operational efficiency.

These ACOs are generally formed as limited liability companies. The ACOs are considered variable interest entities ("VIEs") under GAAP as these entities do not have sufficient equity to finance their own operations without additional financial support. We own a majority interest in our ACOs; however, we share the power to direct the activities that most significantly affect the ACOs with health care providers that are minority owners in the ACOs. This power is shared pursuant to the structure of the management committee of each of the ACOs. Accordingly, we have determined that we are not the primary beneficiary of the ACOs; therefore, we cannot consolidate their results. We perform an ongoing qualitative assessment of our variable interests in VIEs to determine whether we have a controlling financial interest and would therefore be considered the primary beneficiary of the VIE.

We account for our participation in the ACOs using the equity method. Gains and losses are immaterial and are reported on the face of our condensed consolidated statements of comprehensive income as equity in earnings (losses) of unconsolidated subsidiaries.

Significant Accounting Policies

Below is a discussion of our significant accounting policies, which affected the comparability of our consolidated results of operations, financial condition or cash flows for the periods presented. Refer to Note 2 - Summary of Significant Accounting Policies to the Consolidated Financial Statements included in our 2017 Form 10-K for a complete discussion of all of our significant accounting policies.

Premium Receivables and Unearned Premiums

We record premiums earned but not received as premiums receivable and record premiums received in advance of the period of service as unearned premiums in our condensed consolidated balance sheets. A complete discussion of premiums receivable and unearned premiums is included in Note 2 - Summary of Significant Accounting Policies to the Consolidated Financial Statements included in our 2017 Form 10-K. The premium receivable balance at September 30, 2018 is primarily related to Medicaid contracts with our state partners of approximately $771.8 million, as well as net risk-adjusted premiums receivable under our MA and PDP contracts of approximately $181.3 million.

Medicaid Risk-Adjusted Premiums and Retroactive Rate Changes

As discussed further in Note 2 - Summary of Significant Accounting Policies to the Consolidated Financial Statements included in our 2017 Form 10-K, Medicaid premium rate changes are recognized in the period the change becomes effective, when the effect of the change in the rate is reasonably estimable and collection is assured. In some instances, our Medicaid premiums are subject to risk score adjustments based on the health profile of our membership. Generally, the risk score is determined by the state agency's analysis of encounter submissions of processed claims

data to determine the acuity of our membership relative to the entire state's Medicaid membership. The frequency of when states adjust premiums varies, but is usually done quarterly or semi-annually on a retrospective basis. We recognize periodic changes to risk-adjusted premiums as revenue when the amounts are determinable and collection is reasonably assured. As of September 30, 2018, our condensed consolidated balance sheet included a net receivable from our Medicaid state partners of $17.9 million related to retroactive rate

changes and risk score adjustments, compared with a net payable to our Medicaid state partners of $50.7 million as of December 31, 2017.

Medicare Part D Settlements

We receive certain Part D prospective subsidy payments from the Centers for Medicare & Medicaid Services ("CMS") for our MA and PDP members as a fixed monthly per member amount, based on the estimated costs of providing prescription drug benefits over the plan year, as reflected in our bids. A discussion of the subsidy components under Part D is included in Note 2 - Summary of Significant Accounting Policies to the Consolidated Financial Statements included in our 2017 Form 10-K. CMS will fully reimburse these subsidies, or recoup overpaid subsidies made during the plan year, as part of its annual settlement process that typically occurs in the fourth quarter of the subsequent year 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 (payable) for the benefit of members in the condensed consolidated balance sheets. As of September 30, 2018, our condensed consolidated balance sheet includes CMS Part D payables for the 2018, 2017 and 2016 plan years, and a net receivable relating to the 2015 plan year. As of December 31, 2017, our condensed consolidated balance sheet included CMS Part D payables primarily related to the 2017 and 2016 plan years, as well as a net receivable relating to the 2015 plan year. The 2017 net payable is expected to be settled during the fourth quarter of 2018.

ACA Industry Fee

The ACA imposed certain new taxes and fees, including an annual premium-based health insurance industry assessment (the "ACA industry fee") on health insurers, which began in 2014. 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, which also eliminated the associated Medicaid ACA industry fee reimbursements from our state government partners for 2017. Accordingly, we did not incur ACA industry fee expense nor recognize any Medicaid ACA industry fee reimbursement revenue for the three and nine months ended September 30, 2017. During September 2018, we remitted a total of $388.5 million to the Internal Revenue Service ("IRS") for our portion of the ACA Industry fee assessed for 2018, including $66.5 million remitted for the recently acquired Meridian business. We incurred $86.5 million and $247.0 million of such amortization as ACA industry fee expense for the three and nine months ended September 30, 2018, respectively. Additionally, we recognized $71.5 million and $199.0 million of Medicaid ACA industry fee reimbursement revenue for the three and nine months ended September 30, 2018, respectively.

While the ACA industry fee is being assessed in 2018, the continuing spending resolution passed into law in January 2018 provides for an additional one-year moratorium for the ACA industry fee in 2019.

Recently Adopted Accounting Standards

In May 2017, the Financial Accounting Standards Board ("FASB") issued Accounting Standards Update ("ASU") 2017-09, "Compensation-Stock Compensation (Topic 718) - Scope of Modification Accounting". This guidance addresses which changes to the terms or conditions of a share-based payment award require an entity to apply modification accounting pursuant to Topic 718. An entity should account for the effects of a modification unless (a) the fair value of the modified award is the same as the fair value of the original award, (b) the vesting conditions of the modified award are the same as the vesting conditions of the original award and (c) the classification of the modified award as an equity instrument or a liability instrument is the same as the classification of the original award immediately before the original award is modified. The amendments in this guidance should be applied prospectively for public business entities effective for annual periods beginning after December 15, 2017, including interim periods within those annual periods. We adopted this guidance prospectively on January 1, 2018. The adoption of this guidance did not have a material effect on our consolidated results of operations, financial condition or cash flows for the three and nine months ended September 30, 2018.

In January 2017, the FASB issued ASU 2017-04, "Intangibles—Goodwill and Other (Topic 350): Simplifying the Test for Goodwill Impairment". This update eliminates the requirement to calculate the implied fair value of goodwill to measure a goodwill impairment charge. As a result, an entity should perform its annual goodwill impairment test by comparing the fair value of a reporting unit with its carrying amount and should recognize an impairment charge for the amount by which the carrying amount exceeds the reporting unit's fair value; however, the loss recognized should

not exceed the total amount of goodwill allocated to that reporting unit. We adopted this guidance prospectively on January 1, 2018. The adoption of this guidance did not have a material effect on our consolidated results of operations, financial condition or cash flows for the three and nine months ended September 30, 2018.

In January 2017, the FASB issued ASU 2017-01, “Business Combinations (Topic 805): Clarifying the Definition of a Business”. The amendments in this update provide guidance to assist entities with evaluating when a group of transferred assets

and activities (collectively referred to as a "set") is a business. This new guidance provides for a "screen", which requires a determination that when substantially all of the fair value of the gross assets acquired (or disposed of) is concentrated in a single identifiable asset or a group of similar identifiable assets, the set is not a business. If the screen's threshold is not met, a set cannot be considered a business unless it includes an input and a substantive process that together significantly contribute to the ability to create output, eliminating the evaluation of whether a market participant could replace missing elements. This guidance is effective for prospective business combinations for public entities for interim and annual periods beginning after December 15, 2017. We adopted this guidance prospectively on January 1, 2018. The adoption of this guidance did not have a material effect on our consolidated results of operations, financial condition or cash flows for the three and nine months ended September 30, 2018.

In November 2016, the FASB issued ASU 2016-18, “Statement of Cash Flows (Topic 230) Restricted Cash; a consensus of the FASB Emerging Issues Task Force”. This update requires entities to reconcile, on the statement of cash flows, changes in the total of cash, cash equivalents, and amounts generally described as restricted cash or restricted cash equivalents. We adopted this guidance retrospectively on January 1, 2018. The adoption of this guidance did not have a material effect on our consolidated results of operations, financial condition or cash flows for the three and nine months ended September 30, 2018 and 2017, respectively. The following table provides a reconciliation of cash, cash equivalents and restricted cash and cash equivalents as reported within the condensed consolidated balance sheets to the total of the same such amounts shown within the condensed consolidated statements of cash flows:

	As of September 30, 2018	December 31, 2017
Cash and cash equivalents	$4,306.6	$ 4,198.6
Restricted cash and cash equivalents [1]	66.0	64.4
Total cash, cash equivalents, and restricted cash and cash equivalents	$4,372.6	$ 4,263.0

(1) Restricted cash and cash equivalents consist of restricted cash and restricted money market funds and are included in Restricted cash, cash equivalents and investments within noncurrent assets of our condensed consolidated balance sheets. Refer to Note 6 - Restricted Cash, Cash Equivalents and Investments for further detail.

In August 2016, the FASB issued ASU 2016-15, "Statement of Cash Flows Classification of Certain Cash Receipts and Cash Payments (Topic 230)". This update targets eight specific areas to clarify how certain cash receipts and cash payments are presented and classified in the statement of cash flows. This guidance is effective for public entities for interim and annual periods beginning after December 15, 2017, with early adoption permitted. We adopted this guidance on January 1, 2018. The adoption of this guidance did not have a material effect on our consolidated results of operations, financial condition or cash flows for the three and nine months ended September 30, 2018.

In January 2016, the FASB issued ASU 2016-01, "Financial Instrument - Overall (Subtopic 825-10): Recognition and Measurement of Financial Assets and Financial Liabilities." ASU 2016-01 requires entities to measure equity securities that are not consolidated or accounted for under the equity method at fair value through net income. This amendment also simplifies the impairment test of equity investments without readily determinable fair values. In February 2018, the FASB issued ASU 2018-03, "Technical Corrections and Improvements to Financial Instruments - Overall (Subtopic 825-10): Recognition and Measurement of Financial Assets and Financial Liabilities," which clarifies that an entity that uses the measurement alternative for equity securities without readily determinable fair values can change its measurement approach to fair value. This guidance is effective for public companies for fiscal years beginning after December 15, 2017, including interim periods within those fiscal years. We adopted this guidance prospectively on January 1, 2018. The adoption of this guidance did not have a material effect on our consolidated results of operations, financial condition or cash flows for the three and nine months ended September 30, 2018.

In May 2014, the FASB issued ASU 2014-09, "Revenue from Contracts with Customers (Topic 606)". ASU 2014-09 supersedes existing revenue recognition standards with a single model unless those contracts are within the scope of other standards (e.g., an insurance entity’s insurance contracts). The revenue recognition principle in ASU 2014-09 requires that an entity recognize revenue to depict the transfer of goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. In addition, new and enhanced disclosures are required. We adopted this guidance on January 1, 2018 using the modified retrospective approach. Given that substantially all of our revenues are derived from insurance contracts accounted for in accordance with ASC 944, Financial Services-Insurance, which are specifically excluded from the scope of ASU 2014-09, the adoption of this guidance did not have a material effect on

our consolidated results of operations, financial condition or cash flows for the three and nine months ended September 30, 2018.

Accounting Standards Pending Adoption

In August 2018, the FASB issued ASU 2018-15, "Intangibles-Goodwill and Other-Internal-Use Software: Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement that is a Service Contract", which requires implementation costs incurred by customers in cloud computing arrangements (i.e., hosting arrangements) to be capitalized under the same premises of authoritative guidance for internal-use software, and deferred over the noncancellable term of the cloud computing arrangements plus any option renewal periods that are reasonably certain to be exercised by the customer or for which the exercise is controlled by the service provider. The guidance is effective for interim and annual periods beginning after December 15, 2019. Early adoption is permitted. We are currently assessing the effect this guidance will have on our consolidated results of operations, financial condition or cash flows.

In February 2018, the FASB issued ASU 2018-02 "Income Statement – Reporting Comprehensive Income (Topic 220): Reclassification of Certain Tax Effects from Accumulated Other Comprehensive Income", which allows entities to reclassify stranded tax effects resulting from the Tax Cuts and Jobs Act of 2017 from accumulated other comprehensive income to retained earnings. The guidance is effective for interim and annual periods beginning after December 15, 2018. Early adoption is permitted. We are currently assessing the effect this guidance will have on our consolidated results of operations, financial condition or cash flows.

In March 2017, the FASB issued ASU 2017-08, "Receivables – Nonrefundable Fees and Other Costs (Subtopic 310-20): Premium Amortization on Purchased Callable Debt Securities". This update shortens the amortization period for the premium on certain purchased callable debt securities to the earliest call date. Currently, entities generally amortize the premium as a yield adjustment over the contractual life of the security. The new guidance does not change the accounting for purchased callable debt securities held at a discount. This guidance is effective for interim and annual periods beginning after December 15, 2018. Early adoption is permitted. We are currently assessing the effect this guidance will have on our consolidated results of operations, financial condition or cash flows.

In June 2016, the FASB issued ASU 2016-13, "Financial Instruments – Credit Losses (Topic 326): Measurement of Credit Losses on Financial Instruments," which requires entities to use a current expected credit loss model, which is a new impairment model based on expected losses rather than incurred losses. Under this model, an entity would recognize an impairment allowance equal to its current estimate of all contractual cash flows that the entity does not expect to collect from financial assets measured at amortized cost. The entity's estimate would consider relevant information about past events, current conditions, and reasonable and supportable forecasts, which will result in recognition of lifetime expected credit losses upon loan origination. ASU 2016-13 is effective for interim and annual reporting periods beginning after December 15, 2019, with early adoption permitted for annual reporting periods beginning after December 15, 2018. We are currently assessing the effect this guidance will have on our consolidated results of operations, financial condition or cash flows.

In February 2016, the FASB issued ASU 2016-02, "Leases (Topic 842)", which for operating leases, requires a lessee to recognize a right-of-use asset and a lease liability, initially measured at the present value of the lease payments in its balance sheet. This standard also requires a lessee to recognize a single lease cost, calculated so that the cost of the lease is allocated over the lease term, on a generally straight-line basis. Additionally, in July 2018, the FASB issued ASU No. 2018-10, "Codification Improvements to Topic 842, Leases" and ASU 2018-11, "Leases (Topic 842), Targeted Improvements". ASU 2018-10 provides certain amendments that affect narrow aspects of the guidance issued in ASU 2016-02. ASU 2018-11 provides an additional transition method option to adopt the new lease standard. Under the new transition method, a lessee would initially apply the new lease requirements in the period of adoption and recognize a cumulative-effect adjustment to the opening balance of retained earnings in the period of adoption without adjustment to the financial statements for periods prior to adoption. This guidance is effective for

public companies for fiscal years beginning after December 15, 2018, including interim periods within those fiscal years. Early adoption is permitted. We plan to elect the practical expedients permitted within the new standard, which among other things, allows us to carryforward the historical lease classification. In addition, we will also elect the new transition method and apply the new lease requirements in the period of adoption without adjustment to the financial statement for periods prior to adoption. We do not expect the adoption of this guidance to have a material effect on our consolidated results of operations or cash flows. The effect of ASU 2016-02 and related amendments on our consolidated financial position will be based on leases outstanding at the time of adoption.

2. ACQUISITIONS

Meridian Acquisition

On September 1, 2018 (the "Effective Date"), we acquired Meridian for an estimated purchase price of approximately $2.5 billion in cash, subject to certain purchase price adjustments, as described in the purchase agreement. The Meridian acquisition was funded through a combination of cash on hand, $225.0 million drawn on our revolving credit facility, net proceeds of $739.0 million from the August 2018 issuance of $750.0 million aggregate principal amount of 5.375% of Senior Notes due 2026 ("2026 Notes") and net proceeds of approximately $1.3 billion from an issuance of 5,207,547 shares of our common stock (after deducting underwriting discounts, commissions and offering expenses of approximately $37.7 million).

As a result of the Meridian acquisition, we expanded our Medicaid portfolio through the addition of Michigan, where Meridian has the leading market position; expanded our Medicaid presence in Illinois; and acquired an integrated PBM platform. Meridian also serves MA members in Illinois, Indiana, Michigan, and Ohio, as well as Health Insurance Marketplace members in Michigan.
The following table summarizes the estimated fair values of major classes of assets acquired and liabilities assumed at the Effective Date, based on our valuation assumptions, reconciled to the total consideration transferred.

Assets	(in millions)
Cash, cash equivalents and restricted cash	$484.4
Investments, including restricted investments	180.4
Premiums receivable, net	379.6
Other current assets	196.5
Property, equipment and capitalized software, net	49.3
Goodwill	1,086.5
Other intangible assets, net	1,000.0
Fair value of total assets acquired	$3,376.7
Liabilities	
Medical benefits payable	$528.0
ACA Fee liability	66.5
Other liabilities	262.1
Fair value of liabilities assumed	856.6
Fair value of net assets acquired	$2,520.1

The fair value results from judgments about future events, which reflect certain uncertainties and rely on estimates and assumptions. The judgments used to determine the fair value assigned to each class of assets acquired and liabilities assumed, as well as intangible asset lives, can materially affect our operating results. As of the Effective Date, the expected fair value of all current assets and liabilities approximated their historical cost. We have not yet completed our evaluation and determination of certain assets acquired and liabilities assumed, primarily (i) the final valuation of intangible assets related to memberships and trade names, (ii) the final assessment and valuation of certain other assets acquired and liabilities assumed, including premiums receivable, property, equipment and capitalized software, medical benefits payable and other liabilities and (iii) the final assessment and valuation of certain income tax amounts. Therefore, the final fair values of the assets acquired and liabilities assumed may vary significantly from our preliminary estimates.

Identifiable intangible assets acquired

Under the Hart-Scott-Rodino Antitrust Improvements Act and other relevant laws and regulations, there were significant limitations on our ability to obtain specific information about Meridian's intangible assets prior to completion of the acquisition in September 2018. At this time, we do not have sufficient information as to the amount, timing and risk of cash flows of all of Meridian's identifiable intangible assets to determine their fair value. Some of the more significant assumptions inherent in the development of intangible asset values, from the perspective of a market participant, include: the amount and timing of

projected future cash flows (including revenue and profitability); the discount rate selected to measure the risks inherent in the future cash flows; and the assessment of the asset’s life cycle and the competitive trends impacting the asset.

Therefore, using publicly available information, such as historical revenues, Meridian's cost structure, industry information for comparable intangible assets and certain other high-level assumptions, the estimated fair value of identifiable intangible assets and their weighted-average useful lives have been estimated at $1.0 billion and 11 years, respectively. These preliminary estimates of fair value and weighted-average useful life may be different from the final acquisition accounting, and the difference could have a material impact on the condensed consolidated financial statements.

The identifiable intangible assets resulting from our acquisitions typically include membership, provider networks, broker networks, trademarks, state contracts, and licenses. The fair value of certain identifiable intangible assets is determined primarily using variations of the “income approach,” which is based on the present value of the future after-tax cash flows attributable to each identified intangible asset. Other valuation methods, including the market approach and cost approach, are also considered in estimating the fair value. We amortize other intangible assets over their estimated useful lives ranging from approximately one to 15 years. The recorded other intangible assets related to the acquisition are not deductible for tax purposes.

We recorded $1.1 billion for the valuation of goodwill for the excess of the purchase price over the estimated fair value of the net assets acquired. The assignment of goodwill to our respective segments has not been completed at this time. The recorded goodwill related to the acquisition is deductible for tax purposes.

The Meridian acquisition included taxable and nontaxable components resulting in differences in amounts recognized for GAAP and tax purposes. In both taxable and nontaxable business combinations, the amounts assigned to the individual assets acquired and liabilities assumed for financial statement purposes are often different from the amounts assigned or carried forward for tax purposes. We recorded a $38.1 million deferred tax liability based on the estimated bases differences of $156.0 million.

Condensed Consolidated Statements of Comprehensive Income

We included the results of Meridian's operations since the Effective Date in our condensed consolidated financial statements. The amount of total revenues attributable to Meridian included in our condensed consolidated statement of comprehensive income for the three and nine months ended September 30, 2018 was $416.4 million. Total pre-tax net losses in our condensed consolidated statement of comprehensive income for the three and nine months ended September 30, 2018 was $15.2 million and $23.7 million, respectively, including transaction and integration-related costs discussed below.

We incurred transaction and integration-related costs of $12.5 million and $21.0 million during the three and nine months ended September 30, 2018, respectively, related to the acquisition of Meridian. These costs include severance payments to former executives, advisory, legal and other professional fees that are reflected in selling, general and administrative ("SG&A") expense in our condensed consolidated statement of comprehensive income.

Universal American Acquisition

On April 28, 2017, we acquired all of the issued and outstanding shares of Universal American. The transaction was valued at approximately $770.0 million, including the cash purchase price of $10.00 per outstanding share ("Per Share Merger Consideration") of Universal American's common stock, the assumption of $145.3 million fair value of Universal American's convertible debt, the cash settlement of Universal American's $40.0 million par value of Series A Mandatorily Redeemable Preferred Shares (the "Preferred Shares") and the cash settlement of outstanding vested

and unvested stock-based compensation awards.

The fair value of the consideration transferred in the Universal American acquisition consisted of the following:

(in millions)	
Number of shares of Universal American common stock outstanding on April 28, 2017 (57.1 million) multiplied by the Per Share Merger Consideration	$570.8
Assumed debt[(a)]	145.3
Repurchase of Preferred Shares[(b)]	41.0
Stock-based award cash consideration[(c)]	12.9
Total consideration transferred	$770.0

(a) Following the consummation of the Universal American transaction, all of the holders of Universal American's 4.00% convertible senior notes (the "Convertible Notes") elected to convert their notes into the right to receive cash equal to the par value of the notes plus a make whole premium. We paid the noteholders the amounts due and all of the Convertible Notes were redeemed in the second quarter of 2017.

The fair value of the Convertible Notes was determined based on quoted market prices; therefore, have been classified within Level 1 of the fair value hierarchy. Refer to Note 3 - Acquisitions to the consolidated financial statements included in our 2017 Form 10-K for further discussion of the repurchase of the Convertible Notes.

(b) We redeemed an aggregate of $40.0 million of Universal American's Preferred Shares, which became redeemable by the holders on April 28, 2017, due to certain change in control provisions for the Preferred Shares. We redeemed the Preferred Shares for $41.0 million, which includes the $40.0 million par value of the Preferred Shares and $1.0 million of accrued dividends. Refer to Note 3 - Acquisitions to the consolidated financial statements included in our 2017 Form 10-K for further discussion of the redemption of the Preferred Shares.

(c) Pursuant to the terms of the Universal American acquisition, outstanding vested and unvested stock-based compensation awards as of April 28, 2017 converted to the right to receive cash. We estimated the fair value of these awards on April 28, 2017 and attributed that fair value to pre-acquisition and post-acquisition services in accordance with GAAP. Accordingly, $12.9 million of the fair value of these awards was attributed to pre-acquisition services and is included in the estimated consideration transferred, and approximately $20.0 million has been, or will be, included in our post-acquisition financial statements as compensation costs and reflected as a selling, general and administrative expense in our condensed consolidated statements of comprehensive income.

The final allocation of the purchase price to assets acquired and liabilities assumed at the acquisition date included total tangible net assets of $189.8 million, primarily comprised of cash and cash equivalents, investments, premiums receivable and medical benefits payable.

In addition, we recorded $298.2 million for the final valuation of identified intangible assets, primarily associated with acquired membership, tradenames and Universal American's provider networks. We valued the acquired membership and tradename intangible assets using an income approach (discounted future cash flow analysis) based on our consideration of historical financial results and expected industry and market trends. We discounted the future cash flows by a weighted-average cost of capital based on an analysis of the cost of capital for comparable companies within our industry. We valued the acquired provider network using a cost approach, which utilizes cost assumptions applicable at the valuation date to determine the cost of constructing a similar asset. Our other intangible assets include acquired operating licenses, certain non-compete agreements and acquired technology, which were valued using a combination of income and cost approaches. We amortize the intangible assets over the period we expect these assets to contribute directly or indirectly to our future cash flows on a straight-line basis, which approximates the expected pattern of economic consumption over their estimated useful lives. The weighted average amortization period for these intangible assets is 10.5 years.

We recorded $282.0 million for the valuation of goodwill, assigned to our Medicare Health Plans reportable segment, for the excess of the purchase price over the estimated fair value of the net assets acquired. The recorded goodwill and other intangible assets related to the acquisition are not deductible for tax purposes.

Condensed Consolidated Statement of Comprehensive Income

We included the results of Universal American's operations after the acquisition in our condensed consolidated financial statements. The amount of premium revenue attributable to Universal American included in our condensed consolidated statement of comprehensive income, for the three and nine months ended September 30, 2018, was $378.6 million and $1.2 billion, respectively. Additionally, our condensed consolidated statement of comprehensive income for the three and nine months ended September 30, 2018 included pretax income of $21.8 million and $53.5 million, respectively, attributable to Universal American's operations, which includes transaction and integration-related costs of $0.6 million and $4.5 million, respectively, related to the ongoing integration of the operations. These costs include severance payments, and advisory, legal and other professional fees that are reflected in SG&A expense in our condensed consolidated statement of comprehensive income.

During the three and nine months ended September 30, 2017, the amount of revenue attributable to Universal American included in our condensed consolidated statements of comprehensive income was $355.4 million and $590.5 million, respectively. Pretax net income (loss) attributable to Universal American included in our condensed consolidated statements of comprehensive income for the three and nine months ended September 30, 2017 was $23.9 million and $(7.8) million, respectively. These results include transaction and integration-related costs of approximately $6.6 million and $33.3 million incurred during the three and nine months ended September 30, 2017, respectively. These costs include severance payments, and advisory, legal and other professional fees that are reflected in SG&A expense in our condensed consolidated statement of comprehensive income.

Goodwill

A summary of changes in our goodwill by reportable segment is as follows for the nine months ended September 30, 2018:

	Medicaid Health Plans	Medicare Health Plans	Not assigned[1]	Total
Balance as of December 31, 2017	$ 274.7	$ 386.0	$ —	$660.7
Acquisitions[1]	—	—	1,086.5	1,086.5
Acquisition related adjustments	—	6.3	—	6.3
Balance as of September 30, 2018 [1]	$ 274.7	$ 392.3	$ 1,086.5	$1,753.5

(1) Goodwill related to our September 1, 2018 Meridian acquisition is considered preliminary, pending the final allocation of the applicable purchase price. The assignment of goodwill to our respective segments has not been completed at this time.

Unaudited Pro Forma Financial Information

The results of operations and financial condition for our 2018 and 2017 acquisitions have been included in our condensed consolidated financial statements since the respective acquisition dates. The unaudited pro forma financial information presented below reflects our 2018 acquisition of Meridian and 2017 acquisitions, including Universal American, assuming the acquisitions occurred as of January 1, 2017.

These pro forma results are based on estimates and assumptions and do not reflect any anticipated synergies, efficiencies or other cost savings that we expect to realize from the acquisitions. The following unaudited pro forma results have been prepared for comparative purposes only and do not purport to be indicative of the results of operations that would have occurred had the acquisitions actually consummated at January 1, 2017, or project the future results of the combined company.

	Pro Forma - Unaudited			
	Three Months ended September 30,		Nine Months Ended September 30,	
(in millions, except per share data)	2018	2017	2018	2017
Total revenues	$5,869.8	$ 5,284.6	$17,337.8	$ 15,399.8
Net income	$106.9	$ 164.2	$355.2	$ 305.8
Earnings per common share:				
Basic	$2.14	$ 3.30	$7.12	$ 6.16
Diluted	$2.11	$ 3.27	$7.03	$ 6.10

Weighted average common shares outstanding:				
Basic	49,976,864	49,717,239	49,949,219	47,665,643
Diluted	50,648,578	50,176,580	50,514,031	50,117,463

The pro forma results presented in the schedule above include adjustments related to the following purchase accounting and other acquisition-related costs:

- Elimination of historical intangible asset amortization expense and addition of amortization expense based on the current preliminary values of identified intangible assets;
- Elimination of interest expense associated with retired obligations and addition of interest expense based on debt incurred to finance the Meridian transaction;
- Elimination of results for Meridian operations not acquired;
- Elimination of transaction and integration-related costs;
- Elimination of Universal American discontinued operations;
- Include 5,207,547 shares of our common stock issued to finance the Meridian transaction;
- Adjustments to align the acquisitions to our accounting policies; and
- Tax effects of the adjustments noted above.

Pending Acquisition

In September 2018, we entered into an asset purchase agreement with Aetna Inc. ("Aetna") to acquire Aetna's entire standalone Medicare Part D prescription drug plan business ("Aetna Part D business"), which Aetna plans to divest as part of CVS Health Corporation's proposed acquisition of Aetna ("CVS Health Transaction"). The closing of the acquisition is subject to the closing of the CVS Health Transaction and other customary closing conditions. The Aetna Part D business had an aggregate of approximately 2.2 million members as of June 30, 2018. Per the terms of the agreements, Aetna will provide administrative services to, and retain financial risk of, the Aetna Part D business through 2019.

3. SEGMENT REPORTING

On a regular basis, we evaluate discrete financial information and assess the performance of our three reportable segments Medicaid Health Plans, Medicare Health Plans and Medicare PDPs, to determine the most appropriate use and allocation of Company resources. In addition, the Corporate and Other category includes businesses that are not individually reportable because they do not meet the quantitative thresholds required by generally accepted accounting principles.

We allocate premium revenue, medical benefits expense, Medicaid premium taxes, the ACA industry fee incurred in 2018 and goodwill to our reportable segments. We do not allocate to our reportable segments any other assets and liabilities, investment and other income, selling, general and administrative expenses, depreciation and amortization, or interest expense. The Company's decision-makers primarily use premium revenue, medical benefits expense and gross margin to evaluate the performance of our reportable segments.

Our Corporate and Other category includes net investment and other income, SG&A expenses, depreciation, amortization and interest. Also included in this category are results for operating segments that are not individually reportable because they do not meet the quantitative thresholds required by generally accepted accounting principles.

Medicaid Health Plans

Our Medicaid Health Plans segment includes plans for beneficiaries of Temporary Assistance for Needy Families ("TANF"), Supplemental Security Income ("SSI"), Aged Blind and Disabled ("ABD") and other state-based programs that are not part of the Medicaid program, such as Children's Health Insurance Program ("CHIP") and Long-Term Services and Supports ("LTSS") programs. TANF generally provides assistance to low-income families with children. ABD and SSI generally provide assistance to low-income aged, blind or disabled individuals. CHIP provides assistance to qualifying families who are not eligible for Medicaid because their income exceeds the applicable income thresholds. The LTSS program is 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.

Our Medicaid operations in Kentucky and Florida individually account for 10% or more of our consolidated premium revenue. Those states and the respective Medicaid premium revenue as a percentage of total consolidated premium revenue are as follows:

	For the Three Months Ended September 30,		For the Nine Months Ended September 30,	
	2018	2017	2018	2017
Kentucky	13%	15%	14%	15%
Florida	13%	15%	13%	15%

In July 2018, we received a Notice of Intent to Award a five-year contract from the Florida Department of Health to provide statewide-managed care services to more than 60,000 children with medically complex conditions through the Children's Medical Services Managed Care Plan ("CMS Plan") intended to begin on January 1, 2019. Additionally, in April 2018, we received a Notice of Agency Decision from the Florida Agency for Health Care Administration (“AHCA”) that it intends to award our subsidiary, Staywell, a new five-year contract to provide managed care services to Medicaid-eligible beneficiaries, including Managed Medical Assistance and Long-Term Care beneficiaries in 10 of 11 regions. As part of the Medicaid Managed Care program, we expect to provide statewide managed care services to beneficiaries in the Serious Mental Illness Specialty Plan, which currently has more than 75,000 beneficiaries statewide. The new statewide Medicaid Managed Care program is expected to begin implementation on December 1, 2018. These contract awards are subject to the outcome of a protest and appeal process.

Medicare Health Plans

Medicare is a federal program that provides eligible persons age 65 and over and some disabled persons with a variety of hospital, medical and prescription drug benefits. MA is Medicare's managed care alternative to the original Medicare program, which provides individuals standard Medicare benefits directly through CMS. Our MA CCPs generally require members to seek health care services and select a primary care physician from a network of health care providers. In addition, we offer coverage of prescription drug benefits under the Medicare Part D program as a component of most of our MA plans.

Medicare PDPs

We offer stand-alone Medicare Part D coverage to Medicare-eligible beneficiaries in our Medicare PDPs segment. The Medicare Part D prescription drug benefit is supported by risk sharing with the federal government through risk corridors designed to limit the losses and gains of the participating drug plans and by reinsurance for catastrophic drug costs. The government subsidy is based on the national weighted average monthly bid for this coverage, adjusted for risk factor payments. Additional subsidies are provided for dually-eligible beneficiaries and specified low-income beneficiaries. The Part D program offers national in-network prescription drug coverage that is subject to limitations in certain circumstances.

Summary of Financial Information

Reportable operating segments are defined as components of an enterprise for which discrete financial information is available and evaluated on a regular basis by the enterprise's decision-makers to determine how resources should be allocated to an individual segment and to assess performance of those segments. Accordingly, we have three reportable segments: Medicaid Health Plans, Medicare Health Plans and Medicare PDPs.

A summary of financial information for our reportable segments through the gross margin level and reconciliation to income from operations is presented in the table below.

	Medicaid Health Plan	Medicare Health Plan	Medicare PDP	Corporate & Other	Consolidated
For the Three Months Ended September 30, 2018	(in millions)				
Premium	$3,223.3	$1,582.0	$ 182.3	$ 1.2	$ 4,988.8
Products and services	—	—	—	34.6	34.6
Total premium and products and services revenues	3,223.3	1,582.0	182.3	35.8	5,023.4
Medical benefits	2,738.1	1,340.8	115.1	1.0	4,195.0
Costs of products and services	—	—	—	33.5	33.5
ACA industry fee	54.4	27.5	4.6	—	86.5
Medicaid premium taxes	31.5	—	—	—	31.5
Total gross margin expenses	2,824.0	1,368.3	119.7	34.5	4,346.5
Gross margin [1]	399.3	213.7	62.6	1.3	676.9
Investment and other income	—	—	—	34.7	34.7
Other expenses [2]	—	—	—	(503.0)	(503.0)
Income from operations	$399.3	$213.7	$ 62.6	$(467.0)	$ 208.6
For the Three Months Ended September 30, 2017					
Premium	$2,722.7	$1,466.3	$ 201.9	$—	$ 4,390.9
Products and services	—	—	—	—	—
Total premium and products and services revenues	2,722.7	1,466.3	201.9	—	4,390.9
Medical benefits	2,341.7	1,256.3	142.7	—	3,740.7
Costs of products and services	—	—	—	—	—
ACA industry fee	—	—	—	—	—
Medicaid premium taxes	29.5	—	—	—	29.5
Total gross margin expenses	2,371.2	1,256.3	142.7	—	3,770.2
Gross margin [1]	351.5	210.0	59.2	—	620.7
Investment and other income	—	—	—	12.0	12.0
Other expenses [2]	—	—	—	(420.8)	(420.8)
Income from operations	$351.5	$210.0	$ 59.2	$(408.8)	$ 211.9

	Medicaid Health Plan	Medicare Health Plan	Medicare PDP	Corporate & Other	Consolidated
For the Nine Months Ended September 30, 2018	(in millions)				
Premium	$8,899.4	$4,684.9	$ 642.2	$1.2	$ 14,227.7
Products and services	—	—	—	34.6	34.6
Total premium and products and services revenues	8,899.4	4,684.9	642.2	35.8	14,262.3
Medical benefits	7,601.1	3,929.8	491.1	1.0	12,023.0
Costs of products and services	—	—	—	33.5	33.5
ACA industry fee	151.5	81.8	13.7	—	247.0
Medicaid premium taxes	94.2	—	—	—	94.2
Total gross margin expenses	7,846.8	4,011.6	504.8	34.5	12,397.7
Gross margin [1]	1,052.6	673.3	137.4	1.3	1,864.6
Investment and other income	—	—	—	81.0	81.0
Other expenses [2]	—	—	—	(1,341.9)	(1,341.9)
Income from operations	$1,052.6	$673.3	$ 137.4	$(1,259.6)	$ 603.7
For the Nine Months Ended September 30, 2017					
Premium	$8,058.3	$3,877.6	$ 695.6	$—	$ 12,631.5
Products and services	—	—	—	—	—
Total premium and products and services revenues	8,058.3	3,877.6	695.6	—	12,631.5
Medical benefits	7,039.2	3,301.4	597.7	—	10,938.3
Costs of products and services	—	—	—	—	—
ACA industry fee	—	—	—	—	—
Medicaid premium taxes	90.6	—	—	—	90.6
Total gross margin expenses	7,129.8	3,301.4	597.7	—	11,028.9
Gross margin [1]	928.5	576.2	97.9	—	1,602.6
Investment and other income	—	—	—	30.6	30.6
Other expenses [2]	—	—	—	(1,176.2)	(1,176.2)
Income from operations	$928.5	$576.2	$ 97.9	$(1,145.6)	$ 457.0

(1) Effective July 1, 2018, the Company redefined gross margin as total revenues less investment and other income, medical expenses, cost of products and services, the ACA industry fee expense, and Medicaid premium tax expense. Accordingly, results for the three and nine months ended September 30, 2017 were adjusted to include Medicaid premium taxes, which decreased gross margin by $29.5 million and $90.6 million, respectively.

(2) Effective July 1, 2018, other expenses include SG&A expenses, depreciation, amortization and interest. Accordingly, results for the three and nine months ended September 30, 2017 were adjusted to exclude Medicaid premium taxes, which decreased other expenses by $29.5 million and $90.6 million, respectively.

4. EQUITY AND EARNINGS PER SHARE

Issuance of Common Stock

In August 2018, we completed a public offering of our common stock and issued 5,207,547 shares of our common stock, at an offering price of $265.00 per share. The net proceeds from the offering were approximately $1.3 billion, after deducting underwriting discounts and offering costs of approximately $37.7 million. We used the net proceeds to fund the acquisition of Meridian.

Earnings per Common Share

We compute basic earnings per common share on the basis of the weighted-average number of unrestricted common shares outstanding. We compute diluted earnings per common share on the basis of the weighted-average number of unrestricted common shares outstanding plus the dilutive effect of our stock-based compensation awards using the treasury stock method.

The calculation of the weighted-average common shares outstanding — diluted is as follows:

	For the Three Months Ended September 30,		For the Nine Months Ended September 30,	
	2018	2017	2018	2017
Weighted-average common shares outstanding — basic	47,712,712	44,509,692	45,692,804	44,458,096
Dilutive effect of outstanding stock-based compensation awards	671,715	459,341	594,812	451,820
Weighted-average common shares outstanding — diluted	48,384,427	44,969,033	46,287,616	44,909,916
Anti-dilutive stock-based compensation awards excluded from computation	136,428	147,141	184,964	51,475

5. INVESTMENTS

The Company considers all of its investments as available-for-sale securities. Excluding restricted cash, cash equivalents and investments, the amortized cost, gross unrealized gains or losses and estimated fair value of short-term and long-term investments by security type are summarized in the following tables.

	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
September 30, 2018				
Asset-backed securities	$ 127.3	$ —	$ (0.6)	$ 126.7
Corporate debt securities	941.0	0.3	(9.4)	931.9
Municipal securities	266.0	0.1	(3.2)	262.9
Residential mortgage-backed securities	36.7	—	(0.5)	36.2
Short-term time deposits	341.6	—	—	341.6
Government and agency obligations	98.3	—	(1.0)	97.3
Other securities	82.3	—	(0.1)	82.2
Total	$ 1,893.2	$ 0.4	$ (14.9)	$ 1,878.8
December 31, 2017				
Asset-backed securities	$ 88.9	$ —	$ (0.2)	$ 88.7
Corporate debt securities	400.6	0.7	(1.2)	400.1
Municipal securities	223.7	1.0	(1.9)	222.8
Residential mortgage-backed securities	11.2	—	—	11.2
Short-term time deposits	300.4	—	—	300.4
Government and agency obligations	148.7	—	(1.2)	147.5
Other securities	65.2	—	(0.2)	65.0
Total	$ 1,238.7	$ 1.7	$ (4.7)	$ 1,235.7

Contractual maturities of available-for-sale securities at September 30, 2018 are as follows:

	Total	Within 1 Year	1 Through 5 Years	5 Through 10 Years	Thereafter
Asset-backed securities	$126.7	$51.1	$ 71.6	$ 1.2	$ 2.8
Corporate debt securities	931.9	525.6	319.8	75.8	10.7
Municipal securities	262.9	12.6	146.4	79.5	24.4
Residential mortgage-backed securities	36.2	—	0.4	0.3	35.5
Short-term time deposits	341.6	341.6	—	—	—
Government and agency obligations	97.3	53.7	39.3	4.3	—
Other securities	82.2	49.8	—	3.0	29.4
Total	$1,878.8	$1,034.4	$ 577.5	$ 164.1	$ 102.8

Actual maturities may differ from contractual maturities due to the exercise of pre-payment options.

We sold available-for-sale investments totaling $252.4 million and $141.9 million during the three months ended September 30, 2018 and 2017, respectively, and $471.2 million and $224.8 million during the nine months ended

September 30, 2018 and 2017, respectively. Realized gains and losses resulting from sales and redemptions of our available-for-sale investments were immaterial for all periods presented. Additionally, we did not realize any other-than-temporary impairment during any of these periods.

6. RESTRICTED CASH, CASH EQUIVALENTS AND INVESTMENTS

As a condition for licensure, we are required to maintain certain funds on deposit or pledged to various state agencies. Certain of our state contracts require the issuance of surety bonds. We classify restricted cash, cash equivalents and investments as long-term regardless of the contractual maturity date of the securities held, due to the nature of the states' requirements. The amortized cost, gross unrealized gains, gross unrealized losses and fair value of our restricted cash, cash equivalents and investment securities are as follows:

	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
September 30, 2018				
Cash	$ 4.9	$ —	$ —	$ 4.9
Money market funds	61.1	—	—	61.1
U.S. government securities and other	169.6	—	(0.8)	168.8
Total	$ 235.6	$ —	$ (0.8)	$ 234.8
December 31, 2017				
Cash	$ 5.7	$ —	$ —	$ 5.7
Money market funds	58.7	—	—	58.7
U.S. government securities and other	147.4	—	(0.8)	146.6
Total	$ 211.8	$ —	$ (0.8)	$ 211.0

Realized gains and losses on sales and redemptions of our restricted cash, cash equivalents and investments were not material for all periods presented.

7. STOCK-BASED COMPENSATION

Our Compensation Committee awards certain equity-based compensation under our stock plans, including restricted stock units ("RSUs"), performance stock units ("PSUs") and, through 2015, market stock units ("MSUs"). Compensation expense related to our stock-based compensation awards was $21.4 million and $9.3 million for the three months ended September 30, 2018 and 2017, respectively, and $51.5 million and $32.8 million for the nine months ended September 30, 2018 and 2017, respectively. As of September 30, 2018, there was $91.0 million of unrecognized compensation cost related to unvested stock-based compensation arrangements that is expected to be recognized over a weighted-average period of 1.9 years. The unrecognized compensation cost for certain of our PSUs, which are subject to variable accounting, was determined based on our closing common stock price of $320.49 as of September 28, 2018 and amounted to approximately $33.3 million of the total unrecognized compensation cost. Due to the nature of the accounting for these awards, future compensation cost will fluctuate based on changes in our common stock price.

A summary of RSU, PSU and MSU award activity, at target, for the nine months ended September 30, 2018, is presented in the table below. For our PSUs and MSUs, shares attained over target upon vesting are reflected as awards granted during the period, while shares canceled due to vesting below target are reflected as awards forfeited during the period.

	RSUs	PSUs	MSUs	Total
Outstanding as of January 1, 2018	274,643	552,618	45,230	872,491
Granted	121,902	256,679	45,075	423,656
Vested	(128,210)	(154,055)	(90,150)	(372,415)
Forfeited	(15,251)	(33,361)	(155)	(48,767)
Outstanding as of September 30, 2018	253,084	621,881	—	874,965

The weighted-average grant-date fair value of all equity awards granted during the nine months ended September 30, 2018 was $199.39.

Refer to Note 2 - Summary of Significant Accounting Policies and Note 15 - Stock-based Compensation to the Consolidated Financial Statements included in our 2017 Form 10-K for additional information regarding our equity-compensation awards and related compensation cost measurement.

8. DEBT

The following table summarizes our outstanding debt obligations and their classification in the accompanying condensed consolidated balance sheets (in millions):

	September 30, 2018	December 31, 2017
Long-term debt, net:		
5.25% Senior Notes, due April 1, 2025	$1,200.0	$1,200.0
5.375% Senior Notes, due August 15, 2026	750.0	—
Revolving Credit Facility	200.0	—
Debt issuance costs	(24.6)	(17.6)
Total long-term debt, net	$2,125.4	$1,182.4

5.375% Senior Notes due 2026

On August 13, 2018, we completed the offering and sale of 5.375% unsecured senior notes due 2026 in the aggregate principal amount of $750.0 million (the “2026 Notes”). The aggregate net proceeds from the issuance of the 2026 Notes were $739.0 million, which were used to fund a portion of the cash consideration for our acquisition of Meridian.

The 2026 Notes will mature on August 15, 2026, and bear interest at a rate of 5.375% per annum, payable semi-annually on February 15 and August 15 of each year, commencing on February 15, 2019.

The 2026 Notes were issued under an indenture, dated as of August 13, 2018 (the "Indenture"), between the Company and The Bank of New York Mellon Trust Company, N.A., as trustee. The Indenture contains covenants that, among other things, limit our ability and the ability of our subsidiaries under certain circumstances to:

- incur additional indebtedness and issue preferred stock;
- pay dividends or make other distributions;
- make other restricted payments and investments;
- sell assets, including capital stock of restricted subsidiaries;
- create certain liens;
- incur restrictions on the ability of restricted subsidiaries to pay dividends or make other payments, and in the case of our subsidiaries, guarantee indebtedness;
- engage in transactions with affiliates; and
- create unrestricted subsidiaries.

In addition, the Indenture requires that for the Company to merge, consolidate or sell all or substantially all of its assets, (i) either the Company must be the surviving entity, or the surviving entity or purchaser must be a U.S. entity; (ii) the surviving entity or purchaser must assume all the obligations of the Company under the notes and the indenture; (iii) no default or event of default (as defined under the Indenture) exits and (iv) the surviving entity, after giving pro forma effect to the transaction, (x) may incur at least $1.00 of additional indebtedness pursuant to the fixed charge coverage ratio or (y) have a fixed charge coverage ratio that is no worse than the fixed charge coverage ratio of the Company without giving pro forma effect to the transactions.

Ranking and Optional Redemption

The 2026 Notes are senior obligations of our company and rank equally in right of payment with all of our other existing and future unsecured and unsubordinated indebtedness. In addition, the 2026 Notes will be structurally subordinated to all indebtedness and other liabilities of our subsidiaries (unless our subsidiaries become guarantors of the 2026 Notes).

At any time prior to August 15, 2021, we may, on any one or more occasions redeem up to 40% of the aggregate principal amount of 2026 Notes at a redemption price equal to 105.375% of the principal amount of the 2026 Notes redeemed, plus accrued and unpaid interest, if any, with the net cash proceeds of an equity offering by the Company; provided that:

(1) at least 50% of the aggregate principal amount of the 2026 Notes issued under the Indenture (including any additional 2026 Notes, but excluding 2026 Notes held by the Company or its subsidiaries) remains outstanding immediately after the occurrence of such redemption, unless all such 2026 Notes are redeemed substantially concurrently with the redemption of 2026 Notes; and

(2) the redemption occurs within 180 days of the date of the closing of such equity offering.

At any time prior to August 15, 2021, we may on any one or more occasions redeem all or a part of the 2026 Notes, at a redemption price equal to 100% of the principal amount of the 2026 Notes redeemed, plus the Applicable Premium, as defined in the Indenture.

Except pursuant to the preceding two paragraphs, the 2026 Notes will not be redeemable at our option prior to August 15, 2021.

On or after August 15, 2021, we may on any one or more occasions redeem all or a part of the 2026 Notes, at the redemption prices (expressed as percentages of principal amount) set forth below, plus accrued and unpaid interest, if any, on the 2026 Notes redeemed, to, but not including, the applicable date of redemption, if redeemed during the twelve-month period beginning on August 15 of the years indicated below, subject to the rights of holders of 2026 Notes on the relevant record date to receive interest due on the relevant interest payment date:

Period	Redemption Price
2021	104.031%
2022	102.688%
2023	101.344%
2024 and thereafter	100.000%

The 2026 Notes are classified as long-term debt in our condensed consolidated balance sheet at September 30, 2018 based on their August 2026 maturity date.

5.25% Senior Notes due 2025

On March 22, 2017, we completed the offering and sale of 5.25% unsecured senior notes due 2025 in the aggregate principal amount of $1,200.0 million (the “2025 Notes”). The aggregate net proceeds from the issuance of the 2025 Notes were $1,182.2 million, with a portion of the net proceeds from the offering used to repay the $100.0 million outstanding under our credit agreement dated January 8, 2016 (the "Credit Agreement", discussed further below) and to redeem the full $900.0 million aggregate principal amount of our 5.75% unsecured senior notes (the "2020 Notes") on April 7, 2017, which is discussed further below. The remaining net proceeds from the offering of the 2025 Notes were used for general corporate purposes, including organic growth and working capital.

The 2025 Notes are classified as long-term debt in our condensed consolidated balance sheet at September 30, 2018, based on their April 2025 maturity date. Refer to Note 10 - Debt to the consolidated financial statements included in our 2017 Form 10-K for additional information regarding these 2025 Notes, including applicable covenants.

5.75% Senior Notes due 2020

In November 2013, we issued $600.0 million in aggregate principal amount of our 2020 Notes. In June 2015, we issued an additional $300.0 million aggregate principal amount of our 2020 Notes pursuant to a reopening of our existing series of such notes. The offering was completed at an issue price of 104.50%, plus accrued interest.

On April 7, 2017, we redeemed the full $900.0 million in aggregate principal amount outstanding of our 2020 Notes at a redemption price of 102.875% of the principal amount, plus accrued and unpaid interest. Our obligations under the related base indenture and supplemental indenture, each dated as of November 14, 2013, by and among us and The Bank of New York Trust Company, N.A., as trustee, were satisfied and discharged on April 7, 2017. In connection with the redemption of the 2020 Notes, we incurred a one-time loss on extinguishment of debt related to the redemption premium, the write-off of associated deferred financing costs and the write-off of the unamortized portion of associated premiums paid on the 2020 Notes. The loss on extinguishment of debt was reflected in our consolidated statements of comprehensive income upon redemption.

Revolving Credit Facility

In January 2016, we entered into the Credit Agreement, which provides for a senior unsecured revolving loan facility (the "Revolving Credit Facility"), which had an initial aggregate principal amount at any time outstanding not to exceed $850.0 million. On March 22, 2017, we increased the aggregate principal amount available under our Credit Agreement from $850.0 million to $1.0 billion.

On July 23, 2018, we entered into an amended and restated Credit Agreement (“Amended and Restated Credit Agreement”) which increased the aggregate principle amount available under our Revolving Credit Facility from $1.0 billion to $1.3 billion. Additionally, in July 2018, we extended the maturity date under the Revolving Credit Facility from January 2021 to July 2023 and decreased the applicable margins for borrowings under the Revolving Credit Facility to a range of (A) 0.375% to 1.00% per annum for ABR Loans (as defined in the Amended and Restated Credit Agreement) and (B) 1.375% to 2.00% per annum for Eurodollar Loans (as defined in the Amended and Restated Credit Agreement), in each case depending on our ratio of total debt to consolidated EBITDA, as calculated in accordance with the Amended and Restated Credit Agreement. The Amended and Restated Credit Agreement also includes an accordion feature which allows the Company to increase the total commitments under the revolving credit

facility by up to an additional $500 million, subject to certain conditions.

Unutilized commitments under the Amended and Restated Credit Agreement are subject to a fee of 0.20% to 0.30% depending upon our ratio of total debt to consolidated EBITDA, as calculated in accordance with the Amended and Restated Credit Agreement.

The Amended and Restated Credit Agreement includes negative and financial covenants that limit certain of our and our subsidiaries' activities, including (i) restrictions on our and our subsidiaries' ability to incur additional indebtedness; and (ii) financial covenants that require (a) the ratio of total debt to consolidated EBITDA not to exceed a maximum and (b) a minimum interest expense and principal payment coverage ratio.

The Amended and Restated Credit Agreement also contains customary representations and warranties that must be accurate in order for us to borrow under the Revolving Credit Facility. In addition, the Amended and Restated Credit Agreement contains customary events of default. If an event of default occurs and is continuing, we may be required immediately to repay all amounts outstanding under the Amended and Restated Credit Agreement. Lenders holding greater than 50% of the loans and commitments under the Amended and Restated Credit Agreement may elect to accelerate the maturity of the loans.

In August 2018, $225.0 million was drawn on our Revolving Credit Facility to partially fund the Meridian acquisition, of which $25.0 million was repaid during September 2018. As of September 30, 2018, $200.0 million was outstanding under the Revolving Credit Facility, and was classified as long-term in accordance with the contractual terms of the Amended and Restated Credit Agreement.

As of September 30, 2018, and the date of this filing, we were in compliance with all covenants under the 2026 Notes, the 2025 Notes and the Amended and Restated Credit Agreement.

9. FAIR VALUE MEASUREMENTS

Our condensed consolidated balance sheets include the following financial instruments: cash and cash equivalents, investments, receivables, accounts payable, medical benefits payable, long-term debt, including any current portion of long-term debt, and other liabilities. We consider the carrying amounts of cash and cash equivalents, receivables, other current assets and current liabilities to approximate their fair value due to the short period of time between the origination of these instruments and the expected realization or payment. Certain assets and liabilities are measured at fair value on a recurring basis and are disclosed below. These assets and liabilities are classified into one of three levels of a hierarchy defined by GAAP. For a description of the methods and assumptions that are used to estimate the fair value and determine the fair value hierarchy classification of each class of financial instrument, see the consolidated financial statements and notes thereto included in our 2017 Form 10-K.

Recurring Fair Value Measurements

Assets and liabilities measured at fair value on a recurring basis at September 30, 2018 are as follows:

	Carrying Value	Fair Value Measurements Using Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Investments:				
Asset-backed securities	$126.7	$—	$ 126.7	$ —
Corporate debt securities	931.9	—	931.9	—
Municipal securities	262.9	—	262.9	—
Residential mortgage-backed securities	36.2	—	36.2	—
Short-term time deposits	341.6	—	341.6	—
Government and agency obligations	97.3	97.3	—	—

Other securities	82.2	49.8	32.4	—	
Total investments	$1,878.8	$147.1	$ 1,731.7	$	—
Restricted cash, cash equivalents and investments:					
Cash	$4.9	$4.9	$ —	$	—
Money market funds	61.1	61.1	—	—	
U.S. government securities and other	168.8	168.6	0.2	—	
Total restricted cash, cash equivalents and investments	$234.8	$234.6	$ 0.2	$	—

Assets and liabilities measured at fair value on a recurring basis at December 31, 2017 are as follows:

	Carrying Value	Fair Value Measurements Using Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Investments:				
Asset-backed securities	$88.7	$—	$ 88.7	$ —
Corporate debt securities	400.1	—	400.1	—
Municipal securities	222.8	—	210.5	12.3
Residential mortgage-backed securities	11.2	—	11.2	—
Short-term time deposits	300.4	—	300.4	—
Government and agency obligations	147.5	147.5	—	—
Other securities	65.0	52.8	12.2	—
Total Investments	$1,235.7	$200.3	$ 1,023.1	$ 12.3
Restricted cash, cash equivalents and investments:				
Cash	$5.7	$5.7	$ —	$ —
Money market funds	58.7	58.7	—	—
U.S. government securities and other	146.6	146.4	0.2	—
Total restricted cash, cash equivalents and investments	$211.0	$210.8	$ 0.2	$ —

The following table presents the carrying value and fair value of our long-term debt outstanding as of September 30, 2018 and December 31, 2017:

	Carrying Value	Fair Value Measurements Using Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Long-term debt - September 30, 2018	2,125.4	1,985.8	200.0	—
Long-term debt - December 31, 2017	1,182.4	1,274.3	—	—

The fair value of our 2026 Notes and 2025 Notes were determined based on quoted market prices; therefore, would be classified within Level 1 of the fair value hierarchy. The fair value of obligations outstanding under our Revolving Credit Facility as of September 30, 2018, approximated carrying value and would be classified within Level 2 of the

fair value hierarchy. There were no borrowings outstanding under our Revolving Credit Facility as of December 31, 2017.

During June 2018, we sold the remaining auction rate securities in our portfolio. The sale resulted in a loss of $1.2 million that was included within investment and other income in the condensed consolidated statements of comprehensive income for the nine months ended September 30, 2018. There was no activity recorded during the three months ended September 30, 2018. The following table presents the changes in the fair value of our Level 3 auction rate securities for the nine months ended September 30, 2018 and the three and nine months ended September 30, 2017.

	For the Three Months Ended September 30,	For the Nine Months Ended September 30,	
	2017	2018	2017
Balance at beginning of period	$ 12.3	$12.3	$12.4
Realized gains (losses) in earnings	—	(1.2)	—
Changes in unrealized gains (losses) in other comprehensive income	—	1.4	
Purchases, sales and redemptions	—	(12.5)	(0.1)
Net transfers in or (out) of Level 3	—	—	—
Balance at end of period	$ 12.3	$—	$12.3

10. MEDICAL BENEFITS PAYABLE

A reconciliation of the beginning and ending balances of medical benefits payable, by segment, is as follows:

	For the nine months ended September 30, 2018				
	Medicaid Health Plans	Medicare Health Plans	Medicare PDPs	Corporate and other [2]	Consolidated
Beginning balance [1]	$1,373.2	$722.5	$ 50.6	$ —	$ 2,146.3
Acquisitions	478.2	47.1	—	2.7	528.0
Medical benefits incurred related to:					
Current year	7,803.2	4,051.6	560.4	1.0	12,416.2
Prior years	(202.1)	(121.8)	(69.3)	—	(393.2)
Total	7,601.1	3,929.8	491.1	1.0	12,023.0
Medical benefits paid related to:					
Current year	(6,562.2)	(3,382.3)	(502.9)	(0.8)	(10,448.2)
Prior years	(889.3)	(488.3)	30.0	(0.1)	(1,347.7)
Total	(7,451.5)	(3,870.6)	(472.9)	(0.9)	(11,795.9)
Ending balance [1]	$2,001.0	$828.8	$ 68.8	$ 2.8	$ 2,901.4

(1) The Medicaid Health Plans and Consolidated beginning and ending balances for 2018 include a premium deficiency reserve for our Illinois Medicaid programs ("Illinois PDR"), which amounted to $20.6 million and $45.6 million at September 30, 2018 and December 31, 2017, respectively. See Note 2 - Summary of Significant Accounting Policies in our 2017 Form 10-K for further discussion.
(2) The Corporate and Other category includes operating segments that are not individually reportable because they do not meet the quantitative thresholds required by generally accepted accounting principles.

	For the nine months ended September 30, 2017				
	Medicaid Health Plans	Medicare Health Plans	Medicare PDPs	Corporate and other [2]	Consolidated
Beginning balance	$1,135.8	$510.0	$ 44.7	$ —	$ 1,690.5
Acquisitions	—	128.1	—	—	128.1
Medical benefits incurred related to:					
Current year	7,229.9	3,397.4	662.7	—	11,290.0
Prior years	(190.7)	(96.0)	(65.0)	—	(351.7)
Total	7,039.2	3,301.4	597.7	—	10,938.3
					—
Medical benefits paid related to:					
Current year	(6,104.3)	(2,905.4)	(633.7)	—	(9,643.4)
Prior years	(749.6)	(308.6)	21.5	—	(1,036.7)
Total	(6,853.9)	(3,214.0)	(612.2)	—	(10,680.1)
Ending balance	$1,321.1	$725.5	$ 30.2	$ —	$ 2,076.8

We recognize the cost of medical benefits in the period in which services are provided, including an estimate of the cost of medical benefits incurred but not reported ("IBNR"). Medical benefits expense includes direct medical expenses and certain medically-related administrative costs. We evaluate our estimates of medical benefits payable as we obtain more complete claims information and medical expense trend data over time. We record differences between actual experience and estimates used to establish the liability, which we refer to as favorable and unfavorable prior year reserve developments, as increases or decreases to medical benefits expense in the period we identify the differences.

Our consolidated medical benefits payable developed favorably by approximately $393.2 million and $351.7 million for the nine months ended September 30, 2018 and 2017, respectively. The release of the provision for moderately adverse conditions included in our prior year estimates was substantially offset by the provision for moderately adverse conditions established for claims incurred in the current year. Accordingly, the favorable development in our estimate of medical benefits payable related to claims incurred in prior years does not directly correspond to a decrease in medical benefits expense recognized during the period in which the favorable development is recognized.

Excluding the prior year development related to the release of the provision for moderately adverse conditions, our estimates of consolidated medical benefits payable developed favorably by approximately $215.2 million and $205.0 million for the nine months ended September 30, 2018 and 2017, respectively. Such amounts are net of the development relating to refunds due to government customers with minimum loss ratio provisions. The net favorable development recognized in both 2018 and 2017 was primarily in our Medicaid Health Plans segment and, to the lesser extent, in our Medicare Health Plans segment. The net favorable development resulted primarily due to a number of operational and clinical initiatives planned and executed, throughout both 2016 and 2017, that contributed to lower than expected pharmacy and medical trends, and actual claim submission time being faster than we originally assumed (i.e., our completion factors were higher than we originally assumed) in establishing our medical benefits payable in the prior years. This development does not directly correspond to an increase in our current year operating results as these reductions were offset by estimated current period medical benefits expense when we established our estimate of the current year medical benefits payable. Both completion factor and medical trend assumptions are influenced by utilization levels, unit costs, mix of business, provider reimbursement levels, processing system conversions and changes, claim inventory levels, claim processing patterns, our ability and practices to manage medical and pharmaceutical costs, claim submission patterns and operational changes resulting from business combinations, among others. Our actual costs were ultimately less than expected.

Our Meridian acquisition in September 2018 and our Universal American acquisition in April 2017 resulted in an increase to medical benefits payable as of the respective acquisition dates. See Note 2- Acquisitions, for additional information on the Meridian and Universal American acquisitions.

11. INCOME TAXES

Our effective income tax rate on pre-tax income was 39.3% and 36.4% for the three and nine months ended September 30, 2018, respectively, compared with 27.0% and 30.9% for the three and nine months ended September 30, 2017, respectively. The increases in our effective rate was primarily driven by the expiration of the 2017 ACA industry fee moratorium and reestablishment of the ACA industry fee for 2018, which is nondeductible for tax purposes, an increase in the company’s state tax rate resulting from the Meridian acquisition and increased apportionment to states with higher tax rates, and the recognition of certain previously unrecognized tax benefits during the three and nine months ended September 30, 2017. This increase was partially offset by the federal income tax rate decrease resulting from the enactment of the Tax Cuts and Jobs Act of 2017 (“TCJA”) (discussed in Note 14 - Income Taxes to the consolidated financial statements in the 2017 Form 10-K). There were no significant changes to unrecognized tax benefits for the three and nine months ended September 30, 2018. Our unrecognized tax benefits are not expected to change significantly during the next 12 months.

The TCJA was enacted on December 22, 2017. The TCJA, in part, reduced the U.S. federal statutory corporate income tax rate from 35% to 21% effective January 1, 2018. Staff Accounting Bulletin No. 118 allows filers one year subsequent to the end of the tax year to finalize the valuation of deferred tax assets and liabilities. At September 30, 2018, we had not completed our accounting for the tax effects resulting from enactment of TCJA with respect to valuation of our deferred tax assets and liabilities. We will continue to make and refine our calculations as additional analysis is completed.

12. DISCONTINUED OPERATIONS

On August 3, 2016, our subsidiary, Universal American, completed the sale of its Traditional Insurance business prior to our acquisition of Universal American. This was accomplished by selling two life insurance subsidiaries, while retaining ownership of a third life insurance subsidiary, American Progressive Life & Health Insurance of New York ("Progressive"). The sale of the Traditional Insurance business underwritten by Progressive was accomplished through a 100% quota-share reinsurance treaty with a wholly-owned subsidiary of Nassau Re, that, when considered in combination with other reinsurance transactions previously entered into, resulted in the reinsurance of all of the Traditional Insurance policies that were underwritten by Progressive. Accordingly, the discontinued Traditional Insurance business did not materially affect our condensed consolidated statements of comprehensive income for any of the periods presented.

In accordance with ASC 360-10, Property, Plant and Equipment and ASC 205-20, Presentation of Financial Statements—Discontinued Operations, the Traditional Insurance business has been reported in discontinued operations in this Form 10-Q.

The following table summarizes the total assets and liabilities of our discontinued operations:

	September 30, 2018	December 31, 2017
	(in millions)	
Assets		
Cash and cash equivalents	$1.9	$ 1.3
Investments	43.3	46.5
Reinsurance recoverables	169.4	166.9
Other assets	0.5	0.5
Total Assets	$215.1	$ 215.2
Liabilities		
Reserves and other policy liabilities	$149.4	$ 148.6
Other liabilities	65.7	66.6
Total liabilities	$215.1	$ 215.2

Progressive's traditional insurance products are reinsured under quota share coinsurance treaties with unaffiliated insurers, while the life insurance risks are reinsured under either quota share coinsurance or yearly-renewable term treaties with unaffiliated insurers. Under quota share coinsurance treaties, we pay the reinsurer an agreed upon percentage of all premiums and the reinsurer reimburses us that same percentage of any losses. In addition, the reinsurer pays us certain allowances to cover commissions, the cost of administering the policies and premium taxes. Under yearly-renewable term treaties, the reinsurer receives premiums at an agreed upon rate for its share of the risk on a yearly-renewable term basis. We also use excess of loss reinsurance agreements for certain policies whereby we limit our loss in excess of specified thresholds.

We evaluate the financial condition of our Traditional Insurance reinsurers and monitor concentrations of credit risk to minimize our exposure to significant losses from reinsurer insolvencies. We are obligated to pay claims in the event that a reinsurer to whom we have ceded an insured claim fails to meet its obligations under the reinsurance agreement. We are not aware of any instances where any of our reinsurers have been unable to pay any policy claims on any reinsured business.

13. COMMITMENTS AND CONTINGENCIES

Indemnification Obligations

Under Delaware law, our charter and bylaws and certain indemnification agreements to which we are a party, we are obligated 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, including the matters discussed in this note. The indemnification agreements for our directors and executive officers with respect to events occurring prior to May 2009 require us to indemnify an indemnitee to the fullest extent permitted by law if the indemnitee was or is or becomes a party to or a witness or other participant in any proceeding by reason of any event or occurrence related to the indemnitee's status as a director, officer, associate, agent or fiduciary of the Company or any of our subsidiaries. The indemnification agreements require us to indemnify an indemnitee against all expenses, including attorney's fees, judgments, fines, settlement amounts and interest and other charges, and any taxes as a result of the receipt of payments under the indemnification agreement. We will not indemnify the indemnitee if not permitted under applicable law. We are required to advance all expenses incurred by the indemnitee. We are entitled to reimbursement by an indemnitee of expenses advanced if the indemnitee is not permitted to be reimbursed under applicable law after a final judicial determination is made and all rights of appeal have been exhausted or lapsed.

We amended and restated our indemnification agreements in May 2009. The revised agreements apply to our officers and directors with respect to events occurring after that time. Pursuant to the 2009 indemnification agreements, we will indemnify the indemnitee against all expenses, including attorney's fees, judgments, penalties, fines, settlement amounts and any taxes imposed as a result of payments made under the indemnification agreement incurred in connection with any proceedings that relate to the indemnitee's status as a director, officer or associate of the Company or any of our subsidiaries or any other enterprise that the indemnitee was serving at our request. We will also indemnify for expenses incurred by an indemnitee if the indemnitee, by reason of his or her corporate status, is a witness in any proceeding. Further, we are required to indemnify for expenses incurred by an indemnitee in defense of a proceeding to the extent the indemnitee has been successful on the merits or otherwise. Finally, if the indemnitee is involved in certain proceedings as a result of the indemnitee's corporate status, we are required to advance the indemnitee's reasonable expenses incurred in connection with such proceeding, subject to the requirement that the indemnitee repay the expenses if it is ultimately determined that the indemnitee is not entitled to be indemnified. We are not obligated to indemnify an indemnitee for losses incurred in connection with any proceeding if a determination has not been made by the Board of Directors, a committee of disinterested directors or independent legal counsel in the specific case that the indemnitee has satisfied any standards of conduct required as a condition to indemnification under Section 145 of the Delaware General Corporation Law.

Pursuant to our obligations, we have advanced legal fees and related expenses to three former officers and two additional associates who were criminally indicted in connection with the government investigations of the Company that commenced in 2007 related to federal criminal health care fraud charges including conspiracy to defraud the United States, false statements relating to health care matters, and health care fraud in connection with their defense of criminal charges. In June 2013, the jury in the federal criminal trial reached guilty verdicts on multiple charges for the four individuals that were tried in 2013. In May 2014, the individuals were sentenced and our request for restitution was denied. All four individuals filed notices of appeal and the government filed notices of cross appeal on three of the four individuals, which the government has subsequently voluntarily dismissed. The appellate court affirmed the convictions in August 2016. Mr. Farha filed a petition for a writ of certiorari to the United States Supreme Court in January 2017. In April 2017, the United States Supreme Court declined to hear the appeal by Mr. Farha. The fifth individual, Mr. Bereday, entered a guilty plea in June 2017 in connection with the federal criminal charges, which was accepted by the court in July 2017. Mr. Bereday was sentenced in November 2017.

We have also previously advanced legal fees and related expenses to these five individuals regarding: a dispute in Delaware Chancery Court related to whether we were legally obligated to advance fees or indemnify certain of these individuals; the class actions titled Eastwood Enterprises, L.L.C. v. Farha, et al. and Hutton v. WellCare Health Plans, Inc. et al. filed in federal court; six stockholder derivative actions filed in federal and state courts between October 2007 and January 2008; an investigation by the United States Securities & Exchange Commission (the "Commission"); an action by the Commission filed in January 2012 against three of the five individuals, Messrs. Farha, Behrens and Bereday, and a qui tam action against Messrs. Farha, Behrens and Bereday in federal court. We settled the class actions in May 2011. In 2010, we settled the stockholder derivative actions and we were realigned as the plaintiff to pursue our claims against Messrs. Farha, Behrens and Bereday. Pursuant to the settlement agreements described below, Messrs. Farha, Behrens and Bereday were dismissed from the federal court and state derivative actions. Pursuant to the settlement agreement with Mr. Bereday described below, Mr. Bereday was dismissed from the fee advancement case in Delaware Chancery Court. The Commission action was closed in May 2018. The qui tam action is currently stayed and the stay is subject to being lifted at any time.

In April 2017, the Commission and Mr. Farha entered into a consent judgment to pay $12.5 million to the Commission and $7.5 million to us. In April 2017, the Commission and Mr. Behrens also entered into a consent judgment to pay $4.5 million to the Commission and $1.5 million to us. In May 2018, the Commission and Mr. Bereday entered into a consent judgment to pay $4.5 million to the Commission and the case was closed.
In addition, we have advanced a portion of the legal fees and related expenses to Mr. Farha in connection with lawsuits he filed in Delaware and Florida state court to have certain restrictions lifted on WellCare stock purportedly awarded to him during his employment with us. The Delaware and Florida state court matters have been dismissed.

In September 2016, we entered into a settlement agreement with Mr. Farha pursuant to which he paid us $7.5 million, as referenced in the April 2017 consent judgment with the Commission, and we agreed that we would not seek to recover additional legal fees previously advanced related to these matters, and that our obligation to continue advancing fees would be limited to no more than an additional $7.5 million.

We also have advanced a portion of the legal fees and related expenses to Mr. Behrens in connection with his lawsuit in Delaware state court to have certain restrictions lifted on WellCare stock purportedly awarded to him during his employment with WellCare, which the court dismissed. In October 2016, we also entered into a settlement agreement with Mr. Behrens pursuant to which he paid us $1.5 million, as referenced in the April 2017 consent judgment with the Commission, and we agreed that we would not seek to recover additional legal fees previously advanced in connection with these matters, and that our obligation to continue advancing fees would be limited to no more than an additional $1.5 million.

In June 2017, we entered into a settlement agreement with Mr. Bereday that became effective in July 2017, pursuant to which we agreed that we would not seek to recover legal fees previously advanced in connection with these matters, and that our obligation to continue advancing fees would be limited to no more than an additional $2.5 million.

In connection with these matters, we have advanced to the five individuals cumulative legal fees and related expenses of approximately $237.0 million from the inception of the investigations through September 30, 2018. We incurred $0.1 million and $0.8 million of these fees and related expenses during the three and nine months ended September 30, 2018, respectively, compared with $1.2 million and $6.7 million, respectively, for the same periods in 2017. These fees are not inclusive of the amounts recovered from Mr. Farha and Mr. Behrens discussed above. We expense these costs as incurred and classify the costs as selling, general and administrative expense incurred in connection with the investigations and related matters.

We have exhausted our insurance policies related to reimbursement of our advancement of fees related to these matters. We are unable to estimate the total amount of these costs or a range of possible loss. Accordingly, we continue to expense these costs as incurred.

Other Lawsuits and Claims

Based on the nature of our business, we are subject to regulatory reviews or other investigations by various state insurance and health care regulatory authorities and other state and federal regulatory authorities. These authorities regularly scrutinize the business practices of health insurance and benefits companies and their reviews focus on numerous facets of our business, including claims payment practices, provider contracting, competitive practices, commission payments, privacy issues and utilization management practices, among others. Some of these reviews have historically resulted in fines imposed on us and some have required changes to our business practices. We continue to be subject to such reviews, which may result in additional fines and/or sanctions being imposed, premium refunds or additional changes in our business practices.

Separate and apart from the legal matters described above, we are also involved in other legal actions in the normal course of our business, including, without limitation, protests and appeals related to Medicaid procurement awards, 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 review relevant information with respect to these litigation matters and we update our estimates of reasonably possible losses and related disclosures. We accrue an estimate for contingent liabilities, including attorney's fees related to these matters, if a loss is probable and estimable. Currently, we do not expect that the resolution of any of these currently pending actions, either individually or in the aggregate, will differ materially from our current estimates or have a material adverse effect on our results of operations, financial condition and cash flows. However, the outcome of any legal actions cannot be predicted, and therefore actual results may differ from those estimates.

Item 2. Management's Discussion and Analysis of Financial Condition and Results of Operations.

Forward-Looking Statements

Statements contained in this Form 10-Q for the quarterly period ended September 30, 2018 ("2018 Form 10-Q"), 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, and the status of pending acquisitions, including our acquisition of Aetna's Part D business (as defined herein), 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 this Item of this 2018 Form 10-Q 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. Please refer to the Risk Factors in Part I, Item 1A of our Annual Report on Form 10-K for the year ended December 31, 2017 ("2017 Form 10-K") and in Part II, Item 1A of this 2018 Form 10-Q. 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, our ability to meet the requirements of readiness reviews, competition, changes in health care practices, changes in the demographics of our members, changes in the eligibility for participation in government programs, and changes to eligibility certification requirements, 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, the ability to complete the acquisition of Aetna's Part D business (as defined herein) in a timely manner or at all (which may adversely affect our business and the price of our common stock), the failure to satisfy the conditions to the consummation of the acquisition (including the closing of CVS Health’s acquisition of Aetna and other customary closing conditions), our ability to effectively identify, execute and integrate acquisitions and performance of our acquisitions once acquired, including the ability to achieve expected synergies of the Meridian acquisition within the expected time frames or at all, the ability to achieve accretion to WellCare’s earnings, revenues or other benefits expected, disruption to business relationships, operating results, and business generally of WellCare and/or Meridian and the ability to retain Meridian employees, our ability to address operational challenges relating to the integration of Meridian with our existing business. 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 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.

OVERVIEW

Introduction

WellCare Health Plans, Inc. (the "Company," "we," "us," or "our") focuses primarily on providing government-sponsored managed care services to families, children, seniors and individuals with complex medical needs primarily through Medicaid, Medicare Advantage ("MA") and Medicare Prescription Drug Plans ("PDP"), as well as individuals in the Health Insurance Marketplace. As of September 30, 2018, we served approximately 5.5 million members nationwide. As of September 30, 2018, we operated Medicaid health plans, including states where we receive Medicaid premium revenues associated with dually eligible special needs plans, in Arizona, Florida, Georgia, Hawaii, Illinois, Kentucky, Michigan, Missouri, Nebraska, New Jersey, New York, South Carolina and Texas.

As of September 30, 2018, we also operated MA coordinated care plans ("CCPs") in Arizona, Arkansas, California, Connecticut, Florida, Georgia, Hawaii, Illinois, Indiana, Kentucky, Louisiana, Maine, Michigan, Mississippi, New Jersey, New York, North Carolina, Ohio, South Carolina, Tennessee and Texas, as well as stand-alone Medicare prescription drug plans ("PDP") in 50 states and the District of Columbia.

In September 2018, we completed the acquisition of Meridian Health Plan of Michigan, Inc., Meridian Health Plan of Illinois, Inc., and MeridianRx, a pharmacy benefit manager ("PBM") (collectively, “Meridian”). As a result of the acquisition, we expanded our Medicaid portfolio through the addition of Michigan, where Meridian has the leading market position; expanded our Medicaid presence in Illinois; and acquired an integrated PBM platform. Meridian also serves MA members in Illinois, Indiana, Michigan, and Ohio, as well as Health Insurance Marketplace members in

Michigan.

Summary of Consolidated Financial Results

Summarized below are the key highlights for the three and nine months ended September 30, 2018. For additional information, refer to "Results of Operations" below, which discusses both consolidated and segment results.

Membership at September 30, 2018 increased by 1.2 million, or 26.6%, compared with September 30, 2017. The increase was primarily driven by our September 2018 acquisition of Meridian as well as organic growth in our Medicare Health Plans segment, partially offset by decreased membership in our PDP segment resulting from our 2018 bid positioning.

Premiums increased 13.6% for the three months ended September 30, 2018 compared with the same period in 2017, reflecting our September 2018 acquisition of Meridian, the assignment of additional members in our Illinois Medicaid health plan, organic growth in our Medicare Health Plans segment and the expiration of the 2017 ACA industry fee moratorium (discussed in Key Development and Accomplishments below), which reestablished the associated Medicaid ACA industry fee reimbursements from our state government partners for 2018. Premiums increased 12.6% for the nine months ended September 30, 2018 compared with the same period in 2017, as a result of the items noted above as well as the acquisition of Universal American in April 2017 and our participation in the Missouri Medicaid program expansion, effective May 1, 2017. These increases were partially offset by the previously discussed membership declines in our PDP segment.

Net Income decreased $41.0 million for the three months ended September 30, 2018 compared with the same period in 2017, primarily reflecting the effect of the recognition of certain previously unrecognized tax benefits during the three months ended September 30, 2017, the expiration of the 2017 ACA industry fee moratorium and reestablishment of the ACA industry fee for 2018, which is nondeductible for tax purposes, and incremental retroactive revenue related to Florida. These decreases were partially offset by continued improvement in operational execution across all three of our segments and the effect of the Tax Cuts and Jobs Act of 2017 ("TCJA") which reduced the U.S. federal statutory corporate income tax rate for 2018 (discussed in Note 11 - Income Taxes to the condensed consolidated financial statements of this 2018 Form 10-Q). Net income increased $70.9 million for the nine months ended September 30, 2018 compared with the same period in 2017, reflecting continued improvement in operational execution, and increased investment income.

Key Developments and Accomplishments

Presented below are key developments and accomplishments relating to progress on our business strategy that have affected, or are expected to affect, our results:

- In September 2018, we entered into an asset purchase agreement with Aetna Inc. ("Aetna") to acquire Aetna's entire standalone Medicare Part D prescription drug plan business ("Aetna Part D business"), which Aetna plans to divest as part of CVS Health Corporation's proposed acquisition of Aetna ("CVS Health Transaction"). The closing of the acquisition is subject to the closing of the CVS Health Transaction and other customary closing conditions. The Aetna Part D business had an aggregate of approximately 2.2 million members as of June 30, 2018. Per the terms of the agreements, Aetna will provide administrative services to, and retain financial risk of, the Aetna Part D business through 2019.

- In September 2018, we completed the acquisition of Meridian for approximately $2.5 billion in cash. As a result of this transaction, we expanded our Medicaid portfolio through the addition of Michigan, where Meridian has the leading market position; expanded our Medicaid presence in Illinois; and acquired an integrated PBM platform. Meridian also serves MA members in Illinois, Indiana, Michigan and Ohio, as well as Health Insurance Marketplace members in Michigan.

- In August 2018, we completed a public offering and issuance of 5,207,547 shares of our common stock, at an offering price of $265.00 per share. The net proceeds from the offering were approximately $1.3 billion, after deducting underwriting discounts and offering costs of $37.7 million. We used the net proceeds to fund the acquisition of Meridian.

- In August 2018, we completed the offering and sale of 5.375% unsecured senior notes due 2026 in the aggregate principal amount of $750.0 million (the “2026 Notes"). The aggregate net proceeds from the issuance of the 2026 Notes were $739.0 million, which were used to fund a portion of the cash consideration for our acquisition of Meridian.

- In July 2018, we entered into an amended and restated Credit Agreement (“Amended and Restated Credit Agreement”) which increased the aggregate principle amount available under our Revolving Credit Facility from $1.0 billion to $1.3 billion. Additionally, we extended the maturity date under the Revolving Credit Facility from January 2021 to July 2023.

- In July 2018, we received a Notice of Intent to Award a contract from the Florida Department of Health to provide statewide-managed care services to more than 60,000 children with medically complex conditions through the Children's Medical Services Managed Care Plan ("CMS Plan") and the proposed five-year contract award is intended to begin on January 1, 2019. Additionally, in April 2018, we received a Notice of Agency Decision from the Florida

Agency for Health Care Administration (“AHCA”) that it intends to award our subsidiary, Staywell, a new five-year contract to provide managed care services to Medicaid-eligible beneficiaries, including Managed Medical Assistance and Long-Term Care beneficiaries in 10 of 11 regions. As part of the Medicaid Managed Care program, we expect to provide statewide managed care services to beneficiaries in the Serious Mental Illness Specialty Plan, which currently has more than 75,000 beneficiaries statewide. The new statewide Medicaid Managed Care program is expected to begin implementation on December 1, 2018. These contract awards are subject to the outcome of a protest and appeal process.

- In March 2018, we announced that our Arizona subsidiary, Care1st Health Plan Arizona, Inc., was selected to enter into a contract with the Arizona Health Care Cost Containment System ("AHCCCS") to coordinate the provision of physical and behavioral healthcare services in the Central and North geographic service areas ("GSAs"). Under the new program, health plans were eligible to be awarded two of the three GSAs. Services under the new contract began on October 1, 2018. The initial term of the contract with AHCCCS is three years. The parties may extend the term upon mutual consent for up to two additional two-year terms.

- Effective January 1, 2017, the Consolidated Appropriations Act, 2016 provided for a one-year moratorium on the ACA industry fee, which also eliminated the associated Medicaid ACA industry fee reimbursements from our state government partners. This 2017 moratorium expired effective January 1, 2018. Accordingly, we incurred $86.5 million and $247.0 million of ACA industry fee expense for the three and nine months ended September 30, 2018, respectively, compared with no expense for the same periods in 2017. Additionally, we recognized $71.5 million and $199.0 million in Medicaid ACA industry fee reimbursement revenue during the three and nine months ended September 30, 2018, respectively, compared with no reimbursement recognized for the same periods in 2017.

Political and Regulatory Developments

Our 2019 PDP bids resulted in one of our basic plans being below the benchmarks in 21 of the 34 CMS regions, and within the de minimis range in 10 other regions, compared with our 2018 bids, in which we were below the benchmarks in 25 of the 34 CMS regions, and within the de minimis range in five other regions.

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. 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.

In October 2018, CMS announced 2019 MA and PDP Star Ratings. Four of our 25 active MA contracts, serving certain members in California, Florida, Texas and New York/Maine, received an overall rating of 4.0 stars or higher and served approximately 41.2% of our total September 30, 2018 MA membership. Excluding members from our two dual demonstration MA contracts, which are not subject to star ratings, these four contracts served approximately 42.3% of our total September 30, 2018 MA membership.

Additionally, five of our MA contracts received an overall rating of 3.5 stars, including contracts serving certain members in Arizona, Connecticut, Kentucky, North Carolina, New York and Texas; while, eight of our MA contracts received an overall rating of 3.0 stars, serving members in 11 states, and eight of our MA contracts have not been scored due to size, are too new to be rated or not subject to star ratings.

Our MA plan serving Hawaii and Louisiana received an overall score of 3.0 stars, and for its Part D operations for 2018 and 2019 received a score of 2.5 stars and, as a result, could be subject to termination by CMS if the score does not improve for 2020.

RESULTS OF OPERATIONS

Condensed Consolidated Financial Results

The following tables set forth condensed consolidated statements of operations data, as well as other key data used in our results of operations discussion for the three and nine months ended September 30, 2018, compared with the same periods in 2017.

	For the Three Months Ended September 30,		Percentage	For the Nine Months Ended September 30,		Percentage
	2018	2017	Change	2018	2017	Change
Revenues:	(Dollars in millions)			(Dollars in millions)		
Premium	$4,988.8	$4,390.9	13.6%	$14,227.7	$12,631.5	12.6%
Products and services	34.6	—	100.0%	34.6	—	100.0%
Investment and other income	34.7	12.0	189.2%	81.0	30.6	164.7%
Total revenues	5,058.1	4,402.9	14.9%	14,343.3	12,662.1	13.3%
Expenses:						
Medical benefits	4,195.0	3,740.7	12.1%	12,023.0	10,938.3	9.9%
Costs of products and services	33.5	—	100.0%	33.5	—	100.0%
Selling, general and administrative	433.2	372.3	16.4%	1,167.0	1,040.2	12.2%
ACA industry fee	86.5	—	100.0%	247.0	—	100.0%
Medicaid premium taxes	31.5	29.5	6.8%	94.2	90.6	4.0%
Depreciation and amortization	46.2	31.4	47.1%	117.1	84.6	38.4%
Interest	23.6	17.1	38.0%	57.8	51.4	12.5%
Total expenses	4,849.5	4,191.0	15.7%	13,739.6	12,205.1	12.6%
Income from operations	208.6	211.9	(1.6)%	603.7	457.0	32.1%
Loss on extinguishment of debt	—	—	—%	—	26.1	(100.0)%
Income before income taxes and equity in losses of unconsolidated subsidiaries	208.6	211.9	(1.6)%	603.7	430.9	40.1%
Equity in earnings (losses) of unconsolidated subsidiaries	6.6	23.2	(71.6)%	(0.1)	22.1	NM
Income before income taxes	215.2	235.1	(8.5)%	603.6	453.0	33.2%
Income tax expense	84.6	63.5	33.2%	219.7	140.0	56.9%
Net income	$130.6	$171.6	(23.9)%	$383.9	$313.0	22.7%
Effective tax rate	39.3 %	27.0 %	12.3%	36.4 %	30.9 %	5.5%

NM - Not meaningful

Membership

In the following tables, 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 September 30, 2018 and 2017, respectively.

State	September 30, 2018 Medicaid Health Plans[1]	Medicare Health Plans[1]	Medicare PDPs	Total Membership	Percentage of Total
Illinois	862,000	27,000	34,000	923,000	16.8%
Florida	735,000	96,000	29,000	860,000	15.6%
Michigan	512,000	19,000	44,000	575,000	10.4%
Georgia	502,000	50,000	15,000	567,000	10.3%
Kentucky	448,000	13,000	22,000	483,000	8.8%
New York	152,000	89,000	52,000	293,000	5.3%
Missouri	265,000	—	16,000	281,000	5.1%
Other states	427,000	250,000	844,000	1,521,000	27.6%
Health Insurance Marketplace[2]	—	—	—	5,000	0.1%
Total	3,903,000	544,000	1,056,000	5,508,000	100.0%

State	September 30, 2017 Medicaid Health Plans[1]	Medicare Health Plans[1]	Medicare PDPs	Total Membership	Percentage of Total
Illinois	139,000	18,000	36,000	193,000	4.4%
Florida	757,000	101,000	30,000	888,000	20.4%
Georgia	498,000	46,000	20,000	564,000	13.0%
Kentucky	446,000	9,000	23,000	478,000	11.0%
New York	144,000	89,000	57,000	290,000	6.7%
Missouri	291,000	—	17,000	308,000	7.1%
Other states	441,000	229,000	958,000	1,628,000	37.4%
Total	2,716,000	492,000	1,141,000	4,349,000	100.0%

(1) 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 68,000 and 52,000 of our Medicaid and Medicare membership as of September 30, 2018 and 2017, respectively.
(2) Health Insurance Marketplace, included in our Corporate and Other category as it does not meet the quantification thresholds required by generally accepted accounting principles and therefore not individually reportable, includes members from Michigan. Total Michigan membership is 582,000 members.

As of September 30, 2018, membership increased approximately 1.2 million members, or 26.6%, compared with September 30, 2017. Membership discussion by segment follows:

- Medicaid Health Plans. Membership increased by 1.2 million or 43.7% year-over-year to 3.9 million members as of September 30, 2018. The increase was primarily driven by the acquisition of Meridian, as well as organic membership growth primarily in our Illinois Medicaid health plan as a result of a new contract with HFS to administer the Health Choice Illinois Medicaid managed care program statewide, effective January 1, 2018. These increases were partially offset by net eligibility decreases in certain of our Medicaid markets.

- Medicare Health Plans. Membership as of September 30, 2018 increased by 52,000 year-over-year, or 10.6%, to 544,000 members. The increase is partially a result of the acquisition of Meridian which expanded our membership through the addition of Michigan, Indiana and Ohio, as well as deepened our presence in Illinois. Additionally, the increase reflects our 2018 bid positioning and organic growth.

- Medicare PDPs. Membership as of September 30, 2018 decreased 85,000 year-over-year, or 7.4%, to 1.1 million members. The decrease was primarily the result of our 2018 bid positioning. Our 2018 PDP bids resulted in one of our basic plans being below CMS 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.

Premium Revenue

Premium revenue increased by approximately $597.9 million, or 13.6%, for the three months ended September 30, 2018, compared with the same period in 2017, reflecting our September 2018 acquisition of Meridian, the assignment of additional members in our Illinois Medicaid health plan, organic growth in our Medicare Health Plans segment and the expiration of the 2017 ACA industry fee moratorium, which reestablished the associated Medicaid ACA industry fee reimbursements from our state government partners for 2018. Premiums increased $1.6 billion, or 12.6%, for the nine months ended September 30, 2018 compared with the same period in 2017, as a result of the items noted above, as well as reflecting the acquisition of Universal American in April 2017 and our participation in the Missouri Medicaid program expansion, effective May 1, 2017. These increases were partially offset by the previously discussed membership declines in our PDP segment.

Medical Benefits Expense

Medical benefits expense increased by approximately $454.3 million, or 12.1%, for the three months ended September 30, 2018, compared with the same period in 2017, primarily driven by the 2018 acquisition of Meridian, the assignment of additional members in our Illinois Medicaid health plan and organic growth in our Medicare Health Plans segment. Medical benefits expense increased $1.1 billion, or 9.9%, for the nine months ended September 30, 2018 compared with the same period in 2017, as a result of the items noted above, as well as the acquisition of Universal American in April 2017, and our participation in the Missouri Medicaid program expansion, effective May 1, 2017. The increases were partially offset by the previously discussed membership declines in our PDP segment and the favorable result of continued performance in clinical and pharmacy execution.

Selling, General and Administrative ("SG&A") Expense

SG&A expense under GAAP includes aggregate costs related to previously disclosed government investigations and related litigation and resolution costs ("investigation costs"). Refer to Note 13 - Commitments and Contingencies within the condensed consolidated financial statements included in this 2018 Form 10-Q for additional discussion of these investigation costs. For the three and nine months ended September 30, 2018 and 2017, SG&A expense also included certain transaction and integrations-related costs associated with our 2018 acquisition of Meridian and 2017 acquisition of Universal American ("transaction and integration costs"). These costs include severance payments, advisory, legal and other professional fees that are reflected in SG&A expense in our condensed consolidated statements of comprehensive income. Although the above items may recur, we believe that by providing non-GAAP measurements exclusive of these items, we facilitate period-over-period comparisons and provide additional clarity about events and trends affecting our core operating performance, as well as providing comparability to competitor results. The investigation costs are related to a discrete incident, which we do not expect to re-occur. The transaction and integration costs are related to specific 2017 and 2018 events, which do not reflect the underlying ongoing performance of our business. The non-GAAP financial measures should be considered in addition to, but not as a substitute for, or superior to, financial measures prepared in accordance with GAAP. Below is a reconciliation of these non-GAAP measures with the most directly comparable financial measure calculated in accordance with GAAP.

The reconciliation of SG&A expense, including and excluding such costs, is as follows:

	For the Three Months Ended September 30,		For the Nine Months Ended September 30,	
	2018	2017	2018	2017
	(Dollars in millions)			
SG&A expense (GAAP)	$433.2	$372.3	$1,167.0	$1,040.2
Adjustments:				
Investigation costs	(0.1)	(0.9)	(0.3)	(7.2)
Transaction and integration costs	(13.1)	(6.6)	(25.5)	(33.3)
Adjusted SG&A expense (non-GAAP)	$420.0	$364.8	$1,141.2	$999.7
SG&A ratio (GAAP) [1] [3]	8.6%	8.5%	8.1%	8.2%
Adjusted SG&A ratio (non-GAAP) [2] [3]	8.5%	8.3%	8.1%	8.0%

(1) SG&A expense, as a percentage of total revenues.
(2) Adjusted SG&A expense, as a percentage of total revenues, excluding Medicaid premium tax reimbursement and Medicaid ACA industry fee reimbursements.
(3) Effective July 1, 2018, the Company redefined our SG&A ratio (GAAP) to be a percentage of total revenues. Adjusted SG&A ratio was redefined to be a percentage of total revenues excluding Medicaid premium tax reimbursement and Medicaid ACA industry fee reimbursement. Accordingly, results for the three and nine months ended September 30, 2017 were adjusted to conform to this presentation, which decreased our SG&A ratio (GAAP) by 0.0% for each period and our Adjusted SG&A ratio for the three and nine months ended September 30, 2017 by 0.1% and 0.0%, respectively.

Our SG&A expense for the three and nine months ended September 30, 2018, increased approximately $60.9 million and $126.8 million, respectively, compared with the same periods in 2017. The increases were primarily the result of our 2018 acquisition of Meridian, staffing and infrastructure costs to support organic growth, our 2017 acquisition of Universal American and variable long-term management incentive compensation. Our SG&A ratio for the three and nine months ended September 30, 2018 is consistent with the same period in 2017.

Our Adjusted SG&A expense for the three and nine months ended September 30, 2018, increased approximately $55.2 million and $141.5 million, respectively, compared with the same periods in 2017. Our Adjusted SG&A ratio increased by 20 basis points and 10 basis points for the three and nine months ended September 30, 2018, respectively, compared with the same period in 2017. These increases were primarily the result of staffing and infrastructure costs to support organic growth, our 2018 acquisition of Meridian, our 2017 acquisition of Universal American and variable short-term and long-term management incentive compensation.

Income Tax Expense

Our effective income tax rates were 39.3% and 36.4% for the three and nine months ended September 30, 2018, respectively, compared with 27.0% and 30.9% for the same periods in 2017, respectively. The increase in our effective rates were primarily driven by the effect of the recognition of certain previously unrecognized tax benefits during the three and nine months ended September 30, 2017, as well as the effect of the nondeductible ACA industry fee incurred in 2018 as a result of the expiration of the 2017 ACA industry fee moratorium. These increases were partially offset by the federal income tax rate decrease associated with the TCJA.

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Segment Reporting

Reportable operating segments are defined as components of an enterprise for which discrete financial information is available and evaluated on a regular basis by the enterprise's decision-makers to determine how resources should be allocated to an individual segment and to assess performance of those segments. Accordingly, we have three reportable segments: Medicaid Health Plans, Medicare Health Plans and Medicare PDPs.

Segment Financial Performance Measures

Our primary measurements of profitability for our reportable operating segments are premium revenue, gross margin and medical benefits ratio ("MBR"). Gross margin is defined as total revenues less investment and other income, medical benefits expense, costs of products and services, ACA industry fee expense and Medicaid premium tax expense. MBR measures the ratio of medical benefits expense to premium revenue. Our Adjusted MBR (non-GAAP) measures the ratio of medical benefits expense to premium revenue, excluding Medicaid premium taxes reimbursement and Medicaid ACA industry fee reimbursement.

We use gross margin, MBR and, where applicable, Adjusted MBR to monitor our management of medical benefits and medical benefits expense. These metrics are utilized to make various business decisions, including which health care plans to offer, which geographic areas to enter or exit and which health care providers to include in our networks.

For further information regarding premium revenues and medical benefits expense, please refer to "Premium Revenue Recognition and Premiums Receivable," and "Medical Benefits Expense and Medical Benefits Payable" in Part II – Item 7 – Management's Discussion and Analysis of Financial Condition and Results of Operations, under "Critical Accounting Estimates" in our 2017 Form 10-K.

Reconciling Segment Results

The following table reconciles our reportable segment results to income from operations, as reported in accordance with GAAP.

	For the Three Months Ended September 30,		Percentage		For the Nine Months Ended September 30,		Percentage	
	2018	2017	Change		2018	2017	Change	
	(Dollars in millions)				(Dollars in millions)			
Gross Margin [1]								
Medicaid Health Plans	$399.3	$351.5	13.6	%	$1,052.6	$928.5	13.4	%
Medicare Health Plans	213.7	210.0	1.8	%	673.3	576.2	16.9	%
Medicare PDPs	62.6	59.2	5.7	%	137.4	97.9	40.3	%
Corporate and Other [2]	1.3	—	100.0	%	1.3	—	100.0	%
Total gross margin	676.9	620.7	9.1	%	1,864.6	1,602.6	16.3	%
Investment and other income	34.7	12.0	189.2	%	81.0	30.6	164.7	%
Other expenses [3]	(503.0)	(420.8)	19.5	%	(1,341.9)	(1,176.2)	14.1	%
Income from operations	$208.6	$211.9	(1.6)	%	$603.7	$457.0	32.1	%

[1] Effective July 1, 2018, the Company redefined gross margin as total revenues less investment and other income, medical benefits expense, costs of products and services, the ACA industry fee expense, and Medicaid premium tax expense. Accordingly, results for the three and nine months ended September 30, 2017 were adjusted to include

Medicaid premium taxes, which decreased gross margin by $29.5 million and $90.6 million, respectively.
(2) Corporate and other category includes businesses that are not individually reportable because they do not meet the quantitative thresholds required by generally accepted accounting principles.
(3) Effective July 1, 2018, other expenses include SG&A expenses, depreciation, amortization and interest. Accordingly, results for the three and nine months ended September 30, 2017 were adjusted to exclude Medicaid premium taxes, which decreased other expenses by $29.5 million and $90.6 million, respectively.

Medicaid Health Plans

Our Medicaid Health Plans segment includes plans for beneficiaries of Temporary Assistance for Needy Families ("TANF"), Supplemental Security Income ("SSI"), Aged Blind and Disabled ("ABD") and other state-based programs that are not part of the Medicaid program, such as Children's Health Insurance Program ("CHIP") and the Long-Term Services and Supports ("LTSS") program.

Medicaid Health Plans Results of Operations

The following table sets forth the summarized results of operations and other relevant performance measures for our Medicaid Health Plans segment for the three and nine months ended September 30, 2018 and 2017:

	For the Three Months Ended September 30,		Percentage Change	For the Nine Months Ended September 30,		Percentage Change
	2018	2017		2018	2017	
	(Dollars in millions)			(Dollars in millions)		
Premium revenue [1]	$3,120.3	$2,693.2	15.9 %	$8,606.2	$7,967.7	8.0 %
Medicaid premium tax reimbursement [1]	31.5	29.5	6.8 %	94.2	90.6	4.0 %
Medicaid ACA industry fee reimbursement [1]	71.5	—	100.0 %	199.0	—	100.0 %
Total premiums	3,223.3	2,722.7	18.4 %	8,899.4	8,058.3	10.4 %
Medical benefits expense	2,738.1	2,341.7	16.9 %	7,601.1	7,039.2	8.0 %
ACA industry fee	54.4	—	100.0 %	151.5	—	100.0 %
Medicaid premium tax	31.5	29.5	6.8 %	94.2	90.6	4.0 %
Gross margin[2]	$399.3	$351.5	13.6 %	$1,052.6	$928.5	13.4 %
Medicaid Health Plans MBR [1]	84.9 %	86.0 %	(1.1)%	85.4 %	87.4 %	(2.0)%
Effect of:						
Medicaid premium taxes	0.9 %	0.9 %		0.9 %	0.9 %	
Medicaid ACA industry fee reimbursement	2.0 %	— %		2.0 %	— %	
Medicaid Health Plans Adjusted MBR [1]	87.8 %	86.9 %	0.9 %	88.3 %	88.3 %	— %
Medicaid membership at end of period:	3,903,000	2,716,000	43.7 %			

[1] For GAAP reporting purposes, Medicaid premium tax reimbursement and Medicaid ACA industry fee reimbursement are included in premium revenue to measure our MBR. Our Medicaid Health Plans Adjusted MBR measures the ratio of our medical benefits expense to premium revenue, excluding Medicaid premium tax reimbursement and Medicaid ACA industry fee reimbursement revenue. Because reimbursements for Medicaid premium tax and the ACA industry fee are both included in the premium rates or reimbursement established in certain of our Medicaid contracts and also recognized separately as a component of expense, we exclude these reimbursements from premium revenue when calculating key ratios as we believe that these components are not indicative of operating performance.

[2] Effective July 1, 2018, the Company redefined gross margin as total revenues less investment and other income, medical benefit expense, costs of products and services, the ACA industry fee expense, and Medicaid premium tax expense. Accordingly, results for the three and nine months ended September 30, 2017 were adjusted to include Medicaid premium taxes, which decreased gross margin by $29.5 million and $90.6 million, respectively.

Medicaid total premiums increased $500.6 million, or 18.4%, for the three months ended September 30, 2018 compared with the same period in 2017, primarily driven by our September 2018 acquisition of Meridian, the expiration of the 2017 ACA industry fee moratorium, which reestablished the associated Medicaid ACA industry fee reimbursements from our state government partners in 2018, the assignment of additional members in our Illinois Medicaid health plan, effective January 1, 2018, and net premium rate increases in certain of our Medicaid markets. The increases were partially offset by net eligibility decreases in certain of our Medicaid markets and incremental retroactive revenue related to Florida during the three months ended September 30, 2017. Medicaid total premiums increased $841.1 million, or 10.4%, for the nine months ended September 30, 2018 compared with the same period in 2017, as a result of the items noted above as well as our previously discussed Missouri Medicaid program expansion, partially offset by average lower membership in our Georgia health plan due to the introduction of a fourth managed care organization in the State, effective July 1, 2017.

Excluding Medicaid premium taxes and the Medicaid ACA industry fee reimbursements, Medicaid premium revenue for the three months ended September 30, 2018 increased $427.1 million, or 15.9%, compared with the same period in 2017, primarily driven by our September 2018 acquisition of Meridian, the assignment of additional members in our Illinois Medicaid health plan, effective January 1, 2018, and net premium rate increases in certain of our Medicaid markets. The increases were partially offset by net eligibility decreases in certain of our Medicaid markets. Excluding Medicaid premium taxes and the Medicaid ACA industry fee reimbursements, Medicaid premium revenue increased $638.5 million, or 8.0%, for the nine months ended September 30, 2018 compared with the same period in 2017, as a result of the items noted above as well as our previously discussed Missouri Medicaid program expansion, partially offset by average lower membership in our Georgia health plan due to the introduction of a fourth managed care organization in the State, effective July 1, 2017.

Medical benefits expense for the three and nine months ended September 30, 2018 increased $396.4 million, or 16.9%, and $561.9 million, or 8.0%, respectively, compared with the same periods in 2017, primarily resulting from the Meridian acquisition and the new members in our Illinois Medicaid health plan, effective January 1, 2018, partially offset by the previously discussed lower average membership in our Georgia health plan, eligibility decreases in certain of our Medicaid markets and the favorable result of continued performance in clinical and pharmacy execution.

Our Medicaid Health Plans segment MBR decreased 110 and 200 basis points, respectively, for the three and nine months ended September 30, 2018, compared with the same periods in 2017. The decreases are primarily a result of the expiration of the 2017 ACA industry fee moratorium, which reestablished the associated Medicaid ACA industry fee reimbursements from our state government partners for 2018, net premium rate increases in certain of our Medicaid markets and the favorable result of continued performance in clinical and pharmacy execution.

Excluding the effect of Medicaid premium taxes and Medicaid ACA industry fee reimbursements, our Medicaid Health Plans Adjusted MBR for the three months ended September 30, 2018 increased by 90 basis points compared with the same period in 2017. The increase was primarily a result of our acquisition of Meridian and incremental retroactive revenue related to Florida during the three months ended September 30, 2017. These increases were partially offset by net premium rate increases in certain of our Medicaid markets and the favorable result of continued performance in clinical and pharmacy execution. Our Medicaid Health Plans Adjusted MBR for the nine months ended September 30, 2018 was consistent with the same period in 2017.

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 provided through our MA plans. Our MA plans are comprised of coordinated care plans ("CCPs"), which are primarily administered through HMOs and generally require members to seek health care services and select a primary care physician from a network of health care providers. Certain MA CCPs are administered through preferred provider organizations ("PPO") and private-fee-for-service ("PFFS"). In addition, we offer Medicare Part D coverage, which provides prescription drug benefits, as a component of most of our MA plans.

Medicare Health Plans Results of Operations

The following table sets forth the summarized results of operations and other relevant performance measures for our Medicare Health Plans segment for the three and nine months ended September 30, 2018 and 2017:

	For the Three Months Ended September 30,		For the Nine Months Ended September 30,	
		Percentage		Percentage

	2018	2017	Change	2018	2017	Change
Medicare Health Plans:	(Dollars in millions)			(Dollars in millions)		
Premium revenue	$1,582.0	$1,466.3	7.9 %	$4,684.9	$3,877.6	20.8 %
Medical benefits expense	1,340.8	1,256.3	6.7 %	3,929.8	3,301.4	19.0 %
ACA industry fee	27.5	—	— %	81.8	—	— %
Gross margin	$213.7	$210.0	1.8 %	$673.3	$576.2	16.9 %
MBR	84.8 %	85.7 %	(0.9)%	83.9 %	85.1 %	(1.2)%
Membership	544,000	492,000	10.6 %			

Medicare Health Plans premium revenue for the three and nine months ended September 30, 2018 increased $115.7 million, or 7.9%, and $807.3 million, or 20.8%, respectively, compared with the same periods in 2017, primarily driven by our 2018 bid strategy, organic growth and the acquisition of Meridian. Medicare Health Plans premium revenue for the nine months ended September 30, 2018 further increased due to our acquisition of Universal American, effective April 28, 2017.

Medical benefits expense for the three and nine months ended September 30, 2018 increased $84.5 million, or 6.7%, and $628.4 million, or 19.0%, respectively, compared with the same periods in 2017, primarily driven by organic growth and the acquisition of Meridian. Medicare Health Plans medical benefits expense for the nine months ended September 30, 2018 further increased due to our acquisition of Universal American, effective April 28, 2017. The Medicare Health Plans segment MBR decreased by 90 and 120 basis points for the three and nine months ended September 30, 2018, respectively, compared with the same periods in 2017. The decreases primarily resulted from our 2018 bid positioning and the favorable result of continued performance in clinical and pharmacy execution.

Medicare PDPs

We have contracted with CMS to serve as a plan sponsor offering stand-alone Medicare Part D PDPs to Medicare eligible beneficiaries through our Medicare PDPs segment. 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 Medicare PDPs' MBR is generally lower in the second half of the year as compared with the first half. In addition, the level and mix of members who are auto assigned to us and those who actively choose our PDPs will affect the segment MBR pattern across periods.

Medicare PDPs Results of Operations

The following table sets forth the summarized results of operations and other relevant performance measures for our Medicare PDPs segment for the three and nine months ended September 30, 2018 and 2017:

	For the Three Months Ended September 30,		Percentage	For the Nine Months Ended September 30,		Percentage
	2018	2017	Change	2018	2017	Change
Medicare PDPs:	(Dollars in millions)			(Dollars in millions)		
Premium revenue	$182.3	$201.9	(9.7)%	$642.2	$695.6	(7.7)%
Medical benefits expense	115.1	142.7	(19.3)%	491.1	597.7	(17.8)%
ACA industry fee	4.6	—	100.0 %	13.7	—	100.0 %
Gross margin	$62.6	$59.2	5.7 %	$137.4	$97.9	40.3 %
MBR	63.1 %	70.7 %	(7.6)%	76.5 %	85.9 %	(9.4)%
Membership	1,056,000	1,141,000	(7.4)%			

As noted in the table above, Medicare PDPs premium revenue, medical benefits expense and MBR for the three and nine months ended September 30, 2018 decreased compared with the same periods in 2017. The decreases were primarily a result of our 2018 bid positioning and continued performance in pharmacy execution.

BUSINESS TRENDS AND INFLATION

Health care expenditures have grown consistently for many years, and we expect overall health care costs to continue to grow in the future due to inflation, evolving medical technology, pharmaceutical advancement, regulatory

requirements, demographic trends in the U.S. population, and national interest in health and wellbeing. We use various strategies to mitigate the negative effects of health care cost inflation. Specifically, our health plans try to control medical and hospital costs through our state savings initiatives and contracts with independent providers of health care services. Through these contracted care providers, our health plans emphasize preventive health care and appropriate use of specialty and hospital services. Additionally, our contracts with states require actuarially sound premiums that include health care cost trend. While we currently believe our strategies to mitigate health care cost inflation will continue to be successful, competitive pressures, new health care and pharmaceutical product introductions, demands from health care providers and customers, applicable health care reform regulations, an increase in the expected rate of inflation for health care costs, or other factors may adversely affect our ability to control health care costs.

OUTLOOK

Medicaid Health Plans - We expect premium revenue (GAAP) for our Medicaid Health Plans segment to be in the range of $12.7 billion to $12.9 billion for 2018, compared with $10.7 billion for 2017. We expect premium revenue for our Medicaid Health Plans, excluding $125.0 million to $130.0 million in Medicaid premium taxes and $280.0 million to $285.0 million in Medicaid ACA industry fee reimbursements, to be in the range of $12.3 billion to $12.45 billion for 2018, compared with $10.6 billion reported for 2017, excluding $119.8 million in Medicaid premium taxes.

The Medicaid Health Plans MBR (GAAP) is expected to be in the range of 85.6% to 85.9% for 2018, compared with 87.8% for 2017. The Medicaid Health Plans Adjusted MBR is expected to be in the range of 88.4% to 88.8%, consistent with 88.8% reported in 2017.

Medicare Health Plans - We expect premium revenue for our Medicare Health Plans segment to be in the range of $6.25 billion to $6.35 billion for 2018, compared with $5.3 billion reported for 2017. Medicare Health Plans MBR is expected to be in the range of 84.1% to 84.7% for 2018, compared with 86.0% in 2017, reflecting our 2018 bid strategy.

Medicare PDPs - We expect premium revenue for our Medicare PDPs segment to be in the range of $825.0 million to $875.0 million for 2018, compared with $913.8 million for 2017. Medicare PDPs MBR is expected to be in the range of 75.0% to 76.5% for 2018, compared with 82.4% for 2017 due to our bid positioning for the 2018 plan year.

Consolidated SG&A - Our consolidated SG&A ratio (GAAP) is not estimable as we currently are not able to project future amounts associated with investigation costs as well as the transaction and integration costs, as defined earlier. We expect that our consolidated Adjusted SG&A ratio (non-GAAP) for 2018, which excludes the effect of investigation costs as well as transaction and integration costs, will be approximately 8.35% to 8.45%, compared with 8.5% for 2017, resulting from improved operating leverage associated with organic growth and continued synergies from our 2016 and 2017 acquisitions.

Income Taxes - Our consolidated effective income tax rate (GAAP) is not estimable as we currently are not able to project future amounts associated with investigation costs as well as the transaction and integration costs, as defined earlier. However, we expect our effective income tax rate to be affected by the 2018 reinstatement of the ACA industry fee that was subject to a one-year moratorium in 2017, which is nondeductible for tax purposes, and has the effect of increasing our income tax rate in 2018. This increase will be offset by the reduction in the federal income tax rate for corporations from 35% to 21% effective on January 1, 2018 as part of the TCJA.

LIQUIDITY AND CAPITAL RESOURCES

Each of our existing and anticipated sources of cash is affected by operational and financial risks that influence the overall amount of cash generated and the capital available to us. Additionally, we operate as a holding company in a highly regulated industry. The parent and other non-regulated companies ("non-regulated subsidiaries") are dependent upon dividends and management fees from our regulated subsidiaries, most of which are subject to regulatory restrictions. For a further discussion of risks that can affect our liquidity, see Part I – Item 1A – "Risk Factors" included in our 2017 Form 10-K and in Part II – Item 1A – "Risk Factors" of this 2018 Form 10-Q.

Liquidity

The Company maintains liquidity at two levels: the regulated subsidiary level and the non-regulated subsidiary level.

Regulated subsidiaries

Our regulated subsidiaries' primary liquidity requirements include:

- payment of medical claims and other health care services;
- payment of certain Part D benefits paid for members on behalf of CMS;
- SG&A costs directly incurred or paid through a management services agreement to one of our non-regulated administrative and management services subsidiaries; and
- federal tax payments to the parent company under an intercompany tax sharing agreement.

Our regulated subsidiaries meet their liquidity needs by:

- generating cash flows from operating activities, mainly from premium revenue;
- receipts of prospective subsidy payments and related final settlements from CMS to reimburse us for certain Part D benefits paid for members on behalf of CMS;
- cash flows from investing activities, including investment income and sales of investments; and
- capital contributions received from our non-regulated subsidiaries.

We refer collectively to the cash, cash equivalents and investment balances maintained by our regulated subsidiaries as "regulated cash and investments." Our regulated subsidiaries generally receive premiums in advance of payments of claims for medical and other health care services; however, regulated cash and investments can fluctuate significantly in a particular period depending on the timing of receipts for premiums from our government partners. Our unrestricted regulated cash and investments were $5.7 billion as of September 30, 2018, an approximate $900 million increase from $4.8 billion at December 31, 2017, due primarily to cash and investments acquired with the Meridian acquisition, earnings from operations and contributions received from the parent and non-regulated subsidiaries, partially offset by the ACA industry fee payment remitted to the IRS in September 2018 and dividends paid to the unregulated subsidiaries.

Our regulated subsidiaries are each subject to applicable state regulations that, among other things, require the maintenance of minimum levels of capital and surplus. We continue to maintain significant levels of aggregate excess statutory capital and surplus in our regulated subsidiaries. See further discussion under Regulatory Capital and Dividend Restrictions below.

Parent and Non-Regulated Subsidiaries

Liquidity requirements at the non-regulated parent and subsidiary level generally consist of:

- payment of administrative costs not directly incurred by our regulated operations, including, but not limited to, staffing costs, business development, rent, branding and certain information technology services;
- capital contributions paid to our regulated subsidiaries;
- capital expenditures;
- debt service; and
- federal and state tax payments.

Our non-regulated parent and subsidiaries normally meet their liquidity requirements by:

- management fees earned by our non-regulated administrator subsidiary under management services agreements;
- dividends received from our regulated subsidiaries;
- collecting federal and state tax payments from the regulated subsidiaries;
- proceeds from issuance of debt and equity securities; and
- cash flows from investing activities, including investment income and sales of investments.

Unregulated cash, cash equivalents and investments totaled approximately $462.6 million as of September 30, 2018, a decrease of approximately $154.4 million from $617.0 million as of December 31, 2017. The decrease is primarily due to capital contributions to our regulated subsidiaries, the semi-annual interest payment for our 2025 Notes and cash on hand used to partially fund the Meridian acquisition, partially offset by cash acquired in the Meridian acquisition and dividends from certain of our regulated subsidiaries.

Medicare Part D Funding and Settlements

Funding may be provided to certain regulated subsidiaries from our unregulated subsidiaries to cover any shortfall resulting from the amount of Part D benefits paid for members on behalf of CMS that exceeds the prospective subsidy payments that these regulated subsidiaries receive from CMS. We receive certain Part D prospective subsidy payments from CMS for our MA and PDP members as a fixed monthly per member amount, based on the estimated costs of providing prescription drug benefits over the plan year, as reflected in our bids. A discussion of the subsidy components under Part D is included in Note 2 - Summary of Significant Accounting Policies to the Consolidated Financial Statements included in our 2017 Form 10-K. The benefits include the catastrophic reinsurance, premium and cost sharing for low income Part D members, for which CMS will fully reimburse these subsidies, or recoup overpaid subsidies made during the plan year, as part of its annual settlement process that occurs in the fourth quarter of the subsequent year.

Cash Flow Activities

Our cash flows are summarized as follows:

	For the Nine Months Ended September 30,	
	2018	2017
	(In millions)	
Net cash provided by operating activities	$198.0	$1,245.5
Net cash used in investing activities	(2,623.0)	(1,559.2)
Net cash provided by financing activities	2,534.6	1,133.9
Increase in cash, cash equivalents and restricted cash and cash equivalents	$109.6	$820.2

Cash Flows from Operating Activities

We generally receive premiums in advance of payments of claims for health care services; however, cash flows related to our operations can fluctuate significantly in a particular period depending on the timing of premium receipts from our government partners.

Net cash provided by operating activities for the nine months ended September 30, 2018 was $198.0 million, compared with $1.2 billion for the same period in 2017. The decrease primarily reflects the $538.8 million advance

receipt of October CMS Medicare premiums in September 2017 and the $388.5 million ACA industry fee payment remitted to the IRS in September 2018, partially offset by the reestablishment of the associated Medicaid ACA industry fee reimbursements from our state government partners for 2018 and cash flows from operations. The ACA industry fee and associated reimbursements were eliminated in 2017 through a one-year moratorium, which was not extended for 2018.

Cash Flows from Investing Activities

Net cash used in investing activities for the nine months ended September 30, 2018 was $2.6 billion, compared with $1.6 billion for the same period in 2017. The increase was primarily due to the September 2018 acquisition of Meridian,

partially offset by the Universal American acquisition, in April 2017, and higher sales of investments during the nine months ended September 30, 2018.

Cash Flows from Financing Activities

Cash flows from financing activities are primarily affected by debt-related activity, as well as net funds received or paid for the benefit of members of our MA and PDP plans. Cash provided by financing activities for the nine months ended September 30, 2018 was $2.5 billion, compared with approximately $1.1 billion for the same period in 2017, primarily driven by the following:

- Net proceeds of approximately $1.3 billion from an issuance of 5,207,547 shares of our common stock, after deducting underwriting discounts and offering costs;

- Net proceeds of $935.3 million resulting from debt transactions executed during the nine months ended September 30, 2018, including net proceeds of $739.0 million from the issuance of our 2026 Notes in August 2018 and net borrowings on our Revolving Credit Facility of $196.3 million during the third quarter of 2018, both transactions are net of issuance costs.

- Net funds received for the benefit of members was approximately $250.8 million for the nine months ended September 30, 2018, compared with $978.0 million during the same period in 2017. These funds represent the net amounts of subsidies we received from CMS in connection with the low-income cost sharing, catastrophic reinsurance and coverage gap discount components of the Medicare Part D program related to the government's portion of financial responsibility, net of the amounts we paid for related prescription drug benefits, described above in "Medicare Part D Funding and Settlements." The decrease was primarily the result of our 2018 bid positioning, resulting in lower payments received for 2018 net subsidies, as well as the advance receipt of October 2017 CMS Medicare subsidy payments in September 2017.

Capital Resources

Debt

5.375% Senior Notes due 2026

On August 13, 2018, we completed the offering and sale of 5.375% unsecured senior notes due 2026 in the aggregate principal amount of $750.0 million (the “2026 Notes”). The aggregate net proceeds from the issuance of the 2026 Notes were $739.0 million, with the net proceeds from the offering being used to fund a portion of the cash consideration for our acquisition of Meridian.

The 2026 Notes will mature on August 15, 2026, and bear interest at a rate of 5.375% per annum, payable semi-annually on February 15 and August 15 of each year, commencing on February 15, 2019.

The 2026 Notes were issued under an indenture, dated as of August 13, 2018 (the “2026 Indenture”), between the Company and The Bank of New York Mellon Trust Company, N.A., as trustee. The 2026 Indenture under which the notes were issued contains covenants that, among other things, limit our ability and the ability of our subsidiaries under certain circumstances to:

- incur additional indebtedness and issue preferred stock;
- pay dividends or make other distributions;
- make other restricted payments and investments;

- sell assets, including capital stock of restricted subsidiaries;
- create certain liens;
- incur restrictions on the ability of restricted subsidiaries to pay dividends or make other payments, and in the case of our subsidiaries, guarantee indebtedness;
- engage in transactions with affiliates; and
- create unrestricted subsidiaries.

In addition, the 2026 Indenture requires that for the Company to merge, consolidate or sell all or substantially all of its assets, (i) either the Company must be the surviving entity, or the surviving entity or purchaser must be a U.S. entity; (ii) the

surviving entity or purchaser must assume all the obligations of the Company under the 2026 Notes and the 2026 Indenture; (iii) no default or event of default (as defined under the Indenture) exits and (iv) the surviving entity, after giving pro forma effect to the transaction, (x) may incur at least $1.00 of additional indebtedness pursuant to the fixed charge coverage ratio or (y) have a fixed charge coverage ratio that is no worse than the fixed charge coverage ratio of the Company without giving pro forma effect to the transactions.

5.25% Senior Notes due 2025

On March 22, 2017, we completed the offering and sale of our 2025 Notes in the aggregate principal amount of $1,200.0 million, resulting in aggregate net proceeds of $1,182.2 million. A portion of the net proceeds from the offering were used to repay the $100.0 million outstanding under our Credit Agreement, and to redeem the full $900.0 million aggregate principal amount of our 2020 Notes. The remaining net proceeds from the offering of the 2025 Notes were used for general corporate purposes, including organic growth and working capital.

The 2025 Notes were issued under an indenture, dated as of March 22, 2017 (the "Base Indenture"), as supplemented by the First Supplemental Indenture, dated as of March 22, 2017 (the "First Supplemental Indenture" and, together with the Base Indenture, the "2025 Indenture"), each between the Company and The Bank of New York Mellon Trust Company, N.A. (“BNY Mellon”), as trustee. The 2025 Indenture under which the notes were issued contains covenants that, among other things, limit our ability and the ability of our subsidiaries under certain circumstances to:

- incur additional indebtedness and issue preferred stock;
- pay dividends or make other distributions;
- make other restricted payments and investments;
- sell assets, including capital stock of restricted subsidiaries;
- create certain liens;
- incur restrictions on the ability of restricted subsidiaries to pay dividends or make other payments, and in the case of our subsidiaries, guarantee indebtedness;
- engage in transactions with affiliates; and
- create unrestricted subsidiaries.

In addition, the 2025 Indenture requires that for the Company to merge, consolidate or sell all or substantially all of its assets: (i) either the Company must be the surviving entity, or the surviving entity or purchaser must be a U.S. entity; (ii) the surviving entity or purchaser must assume all the obligations of the Company under the 2025 Notes and the 2025 Indenture; (iii) no default or event of default (as defined under the indenture) exists; and (iv) the surviving entity, after giving pro forma effect to the transaction, (x) may incur at least $1.00 of additional indebtedness pursuant to the fixed charge coverage ratio or (y) have a fixed charge coverage ratio that is no worse than the fixed charge coverage ratio of the Company without giving pro forma effect to the transactions.

5.75% Senior Notes due 2020

In November 2013, we issued $600.0 million in aggregate principal amount of our 2020 Notes. In June 2015, we issued an additional $300.0 million of 2020 Notes, pursuant to a reopening of such notes. Refer to Note 10 - Debt to the Consolidated Financial Statements included in our 2017 Form 10-K for additional information regarding these 2020 Notes.

In April 2017, we redeemed the full $900.0 million in aggregate principal amount outstanding of our 2020 Notes at a redemption price of 102.875% of the principal amount, plus accrued and unpaid interest. In connection with the redemption of the 2020 Notes, we incurred a one-time loss on extinguishment of debt of approximately $25.9 million related to the redemption premium, the write-off of associated deferred financing costs and the write-off of the

unamortized portion of associated premiums paid on the 2020 Notes. The loss on extinguishment of debt was reflected in our results of operations for the nine months ended September 30, 2017.

Credit Agreement

On July 23, 2018, we entered into an amended and restated credit agreement (the “Amended and Restated Credit Agreement”) with JPMorgan Chase Bank, N.A., as administrative agent, and the other lenders party thereto. The Amended and Restated Credit Agreement, among other things, modified the terms of our senior unsecured revolving loan facility (the "Revolving Credit Facility") to (i) increase the total commitments under the Revolving Credit Facility from $1.0 billion to $1.3 billion and (ii) extend the maturity date under the Revolving Credit Facility from January 2021 to July 2023.

Unutilized commitments under the Amended and Restated Credit Agreement are subject to a fee of 0.20% to 0.30% depending upon our ratio of total debt to consolidated EBITDA, as calculated in accordance with the Amended and Restated Credit Agreement.

Revolving Credit Loans designated by us at the time of borrowing as “ABR Loans” that are outstanding under the Credit Agreement bear interest at a rate per annum equal to (i) the greatest of (a) the Prime Rate (as defined in the Credit Agreement) in effect on such day; (b) the Federal Reserve Bank of New York Rate (as defined in the Credit Agreement) in effect on such day plus 1/2 of 1%; and (c) the Adjusted LIBO Rate (as defined in the Credit Agreement) for a one-month interest period on such day plus 1%; plus (ii) the Applicable Rate. Revolving Credit Loans designated by us at the time of borrowing as “Eurodollar Loans” that are outstanding under the Credit Agreement bear interest at a rate per annum equal to the Adjusted LIBO Rate (as defined in the Credit Agreement) for the interest period in effect for such borrowing plus the Applicable Rate. Pursuant to the Amended and Restated Credit Agreement, the “Applicable Rate” decreased to a range of (A) 0.375% to 1.00% per annum for ABR Loans and (B) 1.375% to 2.00% per annum for Eurodollar Loans, in each case depending on our ratio of total debt to consolidated earnings before interest, taxes, depreciation and amortization ("EBITDA"), as calculated in accordance with the Amended and Restated Credit Agreement. The Amended and Restated Credit Agreement includes negative and financial covenants that limit certain of our and our subsidiaries’ activities, including (i) restrictions on our and our subsidiaries’ ability to incur additional indebtedness; and (ii) financial covenants that require (a) the ratio of total debt to consolidated EBITDA not to exceed a maximum and (b) a minimum interest expense and principal payment coverage ratio.

The Amended and Restated Credit Agreement also contains customary representations and warranties that must be accurate in order for us to borrow under the revolving credit facility. In addition, the Amended and Restated Credit Agreement contains customary events of default. If an event of default occurs and is continuing, we may be required immediately to repay all amounts outstanding under the Amended and Restated Credit Agreement. Lenders holding greater than 50% of the loans and commitments under the Amended and Restated Credit Agreement may elect to accelerate the maturity of the loans.

In January 2016, we initially entered into the credit agreement, which at the time, had an initial aggregate principal amount at any time outstanding not to exceed $850.0 million. In 2017, we increased the amount available under our Credit Agreement from $850.0 million to $1.0 billion. In March 2017, we also repaid the $100.0 million outstanding under our Revolving Credit Facility.

As of September 30, 2018 $200.0 million was outstanding under our Revolving Credit Facility. Additionally, we were in compliance with all covenants under the 2026 Notes, the 2025 Notes and the Amended and Restated Credit Agreement as of September 30, 2018.

Initiatives to Increase Our Unregulated Cash

We may pursue alternatives to raise additional unregulated cash. Some of these initiatives may include, but are not limited to, obtaining dividends from certain of our regulated subsidiaries, provided sufficient capital in excess of regulatory requirements exists in these subsidiaries, and/or accessing the debt and equity capital markets. However, we cannot provide any assurances that we will obtain applicable state regulatory approvals for additional dividends to our non-regulated subsidiaries by our regulated subsidiaries or be successful in accessing the capital markets if we determine to do so. We believe that we have sufficient capital, or sufficient access to capital, including through the Amended and Restated Revolving Credit Facility, to meet our capital needs for at least the next twelve months.
Regulatory Capital and Dividend Restrictions

Each of our HMO and insurance subsidiaries must maintain a minimum amount of statutory capital determined by statute or regulation. Such statutes, regulations and capital requirements also restrict the timing, payment and amount of dividends and other distributions, loans or advances that may be paid to us as the sole stockholder. To the extent our HMO and insurance subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. Based upon current statutes and regulations, the minimum capital and surplus requirement, or net assets, for these subsidiaries was approximately $1.6 billion and $1.2 billion at September 30, 2018 and December 31, 2017, respectively. Our HMO and insurance subsidiaries were in compliance with these minimum capital requirements.

Under applicable regulatory requirements at September 30, 2018, the amount of dividends that may be paid through the remainder of 2018 by our HMO and insurance subsidiaries without prior approval by regulatory authorities is approximately $30.7 million in the aggregate. We received $210.6 million in dividends from our regulated subsidiaries during the nine-month period ended September 30, 2018, $165.0 million of which required prior regulatory approval.

For additional information on regulatory requirements, see Note 17 – Regulatory Capital and Dividend Restrictions to the Consolidated Financial Statements included in our 2017 Form 10-K.

CRITICAL ACCOUNTING ESTIMATES

There have been no material changes in our critical accounting estimates during the nine months ended September 30, 2018 from those previously disclosed in Part II – Item 7 – Management's Discussion and Analysis of Financial Condition and Results of Operations, Critical Accounting Estimates in our 2017 Form 10-K.

Item 3. Quantitative and Qualitative Disclosures About Market Risk.

Investment Return Market Risk

As of September 30, 2018, we had cash and cash equivalents of $4.3 billion, short-term investments classified as current assets of $1.0 billion, long-term investments of $844.4 million and restricted investments on deposit for licensure of $234.8 million. The short-term investments classified as current assets consist of highly liquid securities with maturities between three and twelve months that are considered available for sale. Restricted assets consist of cash and cash equivalents and U.S. Treasury instruments deposited or pledged to state agencies in accordance with state rules and regulations. These restricted assets are classified as long term regardless of the contractual maturity date due to the nature of the states' requirements. The investments classified as long term are subject to interest rate risk and will decrease in value if market rates increase. Because of their contractual maturity dates, however, we would not expect the value of these investments to decline significantly as a result of a sudden change in market interest rates. Assuming a hypothetical and immediate 1% increase in market rates at September 30, 2018, the fair value of our fixed income investments would decrease by approximately $28.4 million. Similarly, a 1% decrease in market interest rates at September 30, 2018 would increase the fair value of our investments by approximately $28.4 million.

Item 4. Controls and Procedures.

Evaluation of Disclosure Controls and Procedures

Our management carried out an evaluation required by Rule 13a-15 under the Exchange Act, under the leadership and with the participation of our Chief Executive Officer ("CEO") and Chief Financial Officer ("CFO"), of the effectiveness of our disclosure controls and procedures as defined in Rule 13a-15 under the Exchange Act ("Disclosure Controls"). Based on the evaluation, our CEO and CFO concluded that our Disclosure Controls were effective as of the end of the period covered by this 2018 Form 10-Q.

Changes in Internal Control over Financial Reporting

On September 1, 2018, we acquired Meridian Health Plan of Michigan, Inc., Meridian Health Plan of Illinois, Inc. and MeridianRx, a pharmacy benefit manager (collectively "Meridian"). Refer to Note 2 - Acquisitions of this 2018 Form 10-Q for further discussion of the acquisition. We are currently in the process of integrating the internal controls and procedures of Meridian into our internal controls over financial reporting. Changes to certain processes, information technology systems and other components of internal control over financial reporting (as defined in Rule 13a - 15(f) promulgated under the Securities and Exchange Act of 1934) resulting from the acquisition of Meridian may occur and will be evaluated by management as such integration activities are implemented. As provided under the Sarbanes-Oxley Act of 2002 and the applicable rules and regulations of the Securities and Exchange Commission, we intend to include the internal controls and procedures of Meridian in our annual assessment of the effectiveness of our internal control over financial reporting for our 2019 fiscal year.

Excluding the Meridian acquisition, there has not been any change in our internal control over financial reporting (as defined in Rule 13a-15(f) of the Exchange Act) identified in connection with the evaluation required by Rule 13a-15(d) under the Exchange Act during the quarter ended September 30, 2018 that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

Part II – OTHER INFORMATION

Item 1. Legal Proceedings.

For information regarding legal proceedings, see Note 13 – Commitments and Contingencies to the condensed consolidated financial statements of this Form 10-Q.

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 parts of the ACA, or any modification thereof. 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 minimum MLR and other provisions.

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, 2017 or to date in 2018.

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 certain 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.

In addition, five states, including Nebraska, are currently challenging the requirement that the ACA industry fee be included in the determination of actuarially sound rates. If this challenge is upheld, the states in which we provide Medicaid services may not be required to reimburse us for the ACA industry fee, which may have a material adverse effect on 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 in how federal matching funds for the state Medicaid programs will continue, including for 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 business and membership has grown substantially due to acquisitions, such as that of Universal American Corp. ("Universal American") in April 2017, the acquisition of Caidan Management Company, LLC, MeridianRx, LLC and Caidan Holding Company ("Meridian") in September 2018, 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. For example, we completed our acquisition of Universal American in April 2017 and our acquisition of Meridian in September 2018 and our acquisition of the entire stand-alone Medicare Part D prescription drug plan business of Aetna Inc. (the “Aetna Part D business") is expected to close by the end of 2018. Once an attractive acquisition target is identified, we may not be successful in bidding against competitors. 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.

Even if we are successful in bidding against competitors, we may not be able to complete an acquisition or completion may be delayed. We may not be able to obtain regulatory approval from federal and state agencies required to complete the acquisition. We also may not be able to comply with the regulatory requirements or conditions 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. Depending on the transaction size, we also may not be able to obtain appropriate financing. For instance, completion of the acquisition of the Aetna Part D business is subject to a number of conditions, including, among others, the completion of CVS Health Corporation's proposed acquisition of Aetna Inc. ("Aetna") and other customary closing conditions, which make the completion and timing of the completion of the acquisition of the Aetna Part D business uncertain. In addition, we or Aetna may terminate the transaction agreement under certain circumstances if the acquisition of the Aetna Part D business has not been consummated by December 31, 2018.

If we are unable to consummate the acquisitions we pursue, such as the acquisition of the Aetna Part D business, our ongoing business may be materially adversely affected and, without realizing any of the benefits that we could have realized had the acquisition been completed, we will be subject to a number of risks, including the following:

- the market price of our common stock could decline;
- time and resources committed by our management to matters relating to the acquisition could otherwise have been devoted to pursuing other beneficial opportunities;
- we may experience negative reactions from the financial markets or from our customers or employees;
- we will be required to pay our costs relating to the acquisition, such as termination fees and legal, accounting and financial advisory expenses; and
- we could be subject to litigation related to any failure to complete the acquisition or related to any enforcement proceeding commenced against us to perform our obligations under the transaction agreement.

Similarly, delays in the completion of acquisitions, including the acquisition of the Aetna Part D business, could, among other things, result in additional transaction costs or other negative effects associated with uncertainty about completion of acquisition and cause us not to realize some or all of the benefits that we expect to achieve if the acquisition is successfully completed within its expected timeframe.

Once acquired, we may have difficulties integrating acquired businesses, such as Meridian and the Aetna Part D business, within our existing operations, due to factors such as:

- new associates who must become familiar with our operations and company culture;
- difficulty retaining legacy employees and/or attracting new employees because of potential uncertainty in our business relating to the business combination;
- 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;
- separate 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, may result in unforeseen expenses, and the anticipated benefits of the integration plan may be delayed or not be realized, which could materially affect our financial position, results of operations and cash flows. 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, including the Meridian acquisition.

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, enrollment caps, 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. 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:

- 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 managers in managing 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 quality and affordability 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 $20.6 million in connection with the expanded and combined Illinois Medicaid programs as of September 30, 2018. 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.

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 2018, CMS announced 2019 MA and PDP Star Ratings. Four of our 25 active MA contracts, serving certain members in California, Florida, Texas and New York/Maine, received an overall rating of 4.0 stars or higher and served approximately 41.2% of our total September 30, 2018 MA membership. Excluding members from our two dual demonstration MA contracts, which are not subject to star ratings, these four contracts served approximately 42.3% of our total September 30, 2018 MA membership.

Additionally, five of our MA contracts received an overall rating of 3.5 stars, including contracts serving certain of members in Arizona, Connecticut, Kentucky, North Carolina, New York and Texas; while, eight of our MA contracts received an overall rating of 3.0 stars, serving members in 11 states, and eight of our MA contracts have not been scored due to size, are too new to be rated or not subject to star ratings.

Our MA plan serving Hawaii and Louisiana received a score of 2.5 stars for its Part D operations for 2018 and 2019 and could be subject to termination by CMS if the score does not improve for 2020.

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.

In addition, lower quality scores for any of our lines of business 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 and for MeridianRX pharmaceutical discounts and rebates. 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, enrollment caps 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, delivery system reforms, changes in Medicaid eligibility methodologies, including recertification requirements for eligibility, increased Medicaid program integrity initiatives by CMS, enrollment caps, 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.

For the year ended December 31, 2017, and nine months ended September 30, 2018 our Medicaid operations in Florida and Kentucky each accounted for greater than 10% of our consolidated premium revenue. 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 initial terms of less than five 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, in April 2018, our subsidiary, WellCare of Florida, Inc. known as Staywell Health Plan (“Staywell”), received a Notice of Agency Decision from the Florida Agency for Health Care Administration that it intends to award Staywell a new five-year contract to provide managed care services to Medicaid-eligible beneficiaries, including Managed Medical Assistance and Long-Term Care in 10 of 11 regions and Serious Mental Illness Specialty Plan services statewide. The new Statewide Medicaid Managed Care program is expected to begin implementation on December 1, 2018. In July 2018, we received a Notice of Intent to Award a contract from the Florida Department of Health to provide statewide-managed care services to more than 60,000 children with medically complex conditions through the Children's Medical Services Managed Care Plan ("CMS Plan"). The proposed five-year contract award is intended to begin on January 1, 2019. These contract awards are still subject to a protest and appeal process. 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 benefit and non-benefit components. The estimation of these components use actuarially sound methods (actuarial standards of practice) based on historical utilization and price data, adjustments and trend factors, and other assumptions. When we commence operations in a new state or region or commence participation in a new program, the data, adjustments, factors and assumptions used to develop premiums and premium rates are subject to greater variability as there is limited managed care experience or information available to us and the state. Actual costs and financial results could differ from the assumptions used in the premium-setting process, which could result in premiums being insufficient to cover our medical and non-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 to reduce funding, which may result in changes to program design, including member eligibility and benefits for their Medicaid programs. For example, the State of Kentucky intends to implement new premium and work requirements for certain members to maintain their eligibility for the Medicaid program, 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 demonstration programs 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 2019 PDP bids resulted in 21 of 34 CMS regions in which we were below the benchmarks, and within the de minimis range in ten other regions, compared with our 2018 PDP bids in which we were below the benchmarks in 25 of the 34 CMS regions, and within the de minimis range in five 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.

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 September 30, 2018, we had approximately $2.1 billion in aggregate principal amount of total indebtedness outstanding primarily consisting of $1.2 billion senior notes due 2025 and $750.0 million senior notes due 2026 (together, the "Senior Notes) and $200.0 million outstanding under our $1.3 billion revolving credit facility (the "Amended and Restated 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 current indebtedness, as well as any additional debt we may incur. We cannot assure that financing sources will be available to us in amounts sufficient to enable us to pay our indebtedness, 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. 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 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, accreditation, 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.

In May 2016, CMS published regulations that overhauled Medicaid managed care requirements. These regulations include requirements that state Medicaid programs evaluate network adequacy standards and, if a state chooses to

impose a minimum MLR, requires managed care organizations ("MCO") to report MLRs annually to states, requires those states to 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 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.

However, five states, including Nebraska, are currently challenging the requirement that the ACA industry fee be included in the determination of actuarially sound rates. If this challenge is upheld, the states in which we provide Medicaid services may not be required to reimburse us for the ACA industry fee, which may have a material adverse effect on 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, 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.

Further, changes in existing federal or state laws or regulations or the adoption of new laws or regulations relating to patent term extensions, purchase discount and rebate arrangements with pharmaceutical manufacturers, or to formulary management or other pharmaceutical benefit management services could also reduce the discounts or rebates we receive on pharmaceutical drugs. In addition, changes in federal or state laws or regulations or the adoption of new laws or regulations relating to claims processing and billing, the development and use of formularies and other utilization management tools, the use of average wholesale prices, a list of maximum allowable costs, transmission fees or other pricing benchmarks, pricing for specialty pharmaceuticals, limited access to networks and pharmacy network reimbursement methodologies, could adversely affect our profitability.
In addition, our pharmacy benefit manager provides services to sponsors of health benefit plans that are subject to ERISA. A private party or the Department of Labor, which is the agency that enforces ERISA, could assert that the fiduciary obligations imposed by the statute apply to some or all of the services provided by our pharmacy benefit manager even if it is not contractually obligated to assume fiduciary obligations and we could be subject to claims for breaches of fiduciary obligations or claims that we entered into certain prohibited transactions.
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, pharmacy network, benefits provided and quality of service. We may not be able to develop innovative products and services that are attractive to members. We may not be able to comply with the service level agreements or other terms of our pharmaceutical benefit management contracts held by MeridianRx with third-parties, and lose customers, or be required to pay penalties. 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.

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, financial condition and cash flows.

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, third party administrator, or pharmaceutical benefit manager 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 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 the agreements governing our indebtedness, 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, such as the $1.4 billion in equity proceeds we raised and the $750 million in new senior notes we issued to fund the purchase price of the Meridian acquisition.

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 Amended and Restated 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 Amended and Restated Credit Agreement is variable.

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 our Amended and Restated 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 Amended and Restated 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 pay 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. We expect the debt instruments relating to any future debt we incur to include similar covenants and restrictions.

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.

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. For instance, we issued 5,207,547 shares of common stock to fund a portion of the Meridian Acquisition. 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.

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

Although we currently anticipate that the Meridian acquisition will be accretive to earnings per share (on an adjusted earnings basis that is not pursuant to GAAP and excluding transaction and integration costs), this expectation is based on assumptions, including about our and Meridian’s business, and preliminary estimates, each of which may change materially. As a result, the Meridian acquisition may cause dilution to our earnings per share or the expected accretive effect of the Meridian acquisition may be less than anticipated or delayed, each of which may cause a decrease in the market price of our common stock. In addition, we could encounter additional transaction-related costs or other factors, such as the failure to realize all of the benefits anticipated in the Meridian acquisition, including cost and revenue synergies. All of these factors could cause dilution to our earnings per share or decrease or delay the expected accretive effect of the Meridian acquisition and cause a decrease in the market price of our common 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 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 2. Unregistered Sales of Equity Securities and Use of Proceeds.

Recent Sales of Unregistered Securities

None.

Issuer Purchases of Equity Securities

None.

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 cash dividends in the foreseeable future. In addition, our Amended and Restated Credit Agreement and the Indentures governing the 2026 Notes and the 2025 Notes have certain restrictions on our ability to pay cash dividends.

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. 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 Part I – Financial Information, Item 2 – Management's Discussion and Analysis of Financial Condition and Results of Operations – Liquidity and Capital Resources.

Item 3. Defaults Upon Senior Securities.

Not Applicable.

Item 4. Mine Safety Disclosures.

Not Applicable.

Item 5. Other Information.

Not Applicable.

Item 6. Exhibits.

Exhibits are incorporated herein by reference or are filed with this report as set forth in the Exhibit Index.

EXHIBIT INDEX

Exhibit Number	Description	INCORPORATED BY REFERENCE Form	Filing Date with SEC	Exhibit Number
10.1	Amended and Restated Executive Severance Plan†			
31.1	Certification of Chief Executive Officer pursuant to Section 302 of Sarbanes-Oxley Act of 2002 †			
31.2	Certification of Chief Financial Officer pursuant to Section 302 of Sarbanes-Oxley Act of 2002 †			
32.1	Certification of Chief Executive Officer pursuant to Section 906 of Sarbanes-Oxley Act of 2002 †			
32.2	Certification of Chief Financial Officer pursuant to Section 906 of Sarbanes-Oxley Act of 2002 †			
101.INS	XBRL Instance Document ††			
101.SCH	XBRL Taxonomy Extension Schema Document ††			
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document ††			
101.LAB	XBRL Taxonomy Extension Label Linkbase Document ††			
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document ††			
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document ††			

† Filed herewith.

†† Furnished herewith and not filed for purposes of Section 11 and Section 12 of the Securities Act of 1933 and Section 18 of the Securities Exchange Act of 1934.

SIGNATURES

Pursuant to the requirements of the Securities and Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized on October 30, 2018.

WELLCARE HEALTH PLANS, INC.
By: /s/ Andrew L. Asher
Andrew L. Asher
Executive Vice President and Chief Financial Officer (Principal Financial Officer)

By: /s/ Michael Troy Meyer
Michael Troy Meyer
Vice President and Chief Accounting Officer (Principal Accounting Officer)