Evolent Health, Inc.
Form 10-K
February 28, 2019

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, D.C. 20549

FORM 10-K

(Mark One)
ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the fiscal year ended December 31, 2018
OR

TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the transition period from to

Commission File Number: 001-37415

Evolent Health, Inc.
(Exact name of registrant as specified in its charter)

Delaware	32-0454912
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
800 N. Glebe Road, Suite 500, Arlington, Virginia	22203
(Address of principal executive offices)	(Zip Code)

(571) 389-6000
Registrant's telephone number, including area code

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

Title of each class	Name of each exchange on which registered
Class A Common Stock, par value $0.01 per share	New York Stock Exchange

Securities registered pursuant to section 12(g) of the Act: None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes No
Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes No
Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes No
Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K.

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

Large accelerated filer Accelerated filer Non-accelerated filer Smaller reporting company Emerging growth company

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

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

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant (based on the closing price of the shares on the New York Stock Exchange on such date) as of the last business day of the registrant's most recently completed second fiscal quarter was $1,451.6 million.

As of February 25, 2019, there were 79,375,842 shares of the registrant's Class A common stock outstanding and 3,190,301 shares of the registrant's Class B common stock outstanding.

Documents Incorporated by Reference

Selected portions of the Proxy Statement for the Annual Meeting of Shareholders, scheduled for June 11, 2019, have been incorporated by reference into Part III of this Form 10-K to the extent stated herein. Such proxy statement will be filed with the Securities and Exchange Commission within 120 days of the registrant's fiscal year ended December 31, 2018.

Evolent Health, Inc.
Table of Contents

Explanatory Note

In this Annual Report on 10-K, unless the context otherwise requires, “Evolent,” the “Company,” “we,” “our” and “us” refer to Evolent Health, Inc. and its consolidated subsidiaries. Evolent Health LLC, a subsidiary of Evolent Health, Inc. through which we conduct our operations, has owned all of our operating assets and substantially all of our business since inception. Evolent Health, Inc. is a holding company and its principal asset is all of the Class A common units of Evolent Health LLC.

As used in this Annual Report on Form 10-K:

- “2021 Notes” means the $125.0 million aggregate principal amount 2.00% Convertible Senior Notes due 2021, issued by Evolent Health, Inc. in December 2016;
- “2025 Notes” means the $172.5 million aggregate principal amount 1.50% Convertible Senior Notes due 2025, issued by Evolent Health, Inc. in October 2018;
- “ACA” means the Patient Protection and Affordable Care Act;
- “Accordion” means Accordion Health, Inc.;
- “accountable care organizations,” or “ACOs,” means organizations of groups of doctors, hospitals and other health care providers which have come together voluntarily to provide coordinated care to their Medicare patients;
- “Aldera” means Aldera Holdings, Inc.;
- “ASU” means Accounting Standards Update;
- “capitated arrangements” means health care payment arrangements whereby providers are paid a fixed amount of money per patient during a given period of time rather than on a per-service or per-procedure basis;
- “CMS” means the Centers for Medicare and Medicaid Services;
- “DGCL” means General Corporation Law of the State of Delaware;
- “EMR” means electronic medical records;
- “Evolent Health Holdings” means Evolent Health Holdings, Inc., the predecessor to Evolent Health, Inc.;
- “Exchange Act” means the Securities Exchange Act of 1934, as amended;
- “FASB” means the Financial Accounting Standards Board;
- “FFS” means fee-for-service;
- “founders” means the Advisory Board Company (“The Advisory Board”), and the University of Pittsburgh Medical Center (“UPMC”);
- “FTC” means the United States Federal Trade Commission;
- “GAAP” means United States of America generally accepted accounting principles;
- “GPAC” means Georgia Physicians for Accountable Care, LLC;
- “health insurance exchanges” means organizations that provide a marketplace for individuals to purchase standardized and government regulated health insurance policies;
- “HIPAA” means The Health Insurance Portability and Accountability Act;
- “HITECH Act” means The Health Information Technology for Economic and Clinical Health Act;
- “IPO” means our initial public offering of 13.2 million shares of our Class A common stock at a public offering price of $17.00 per share in June 2015;
- “New Century Health” means NCIS Holdings, Inc.;
- “NMHC” means New Mexico Health Connections;
- “NOL” means net operating loss;
- “Note” means notes to consolidated financial statements presented in “Part II – Item 8. Financial Statements and Supplementary Data;”
- “NYSE” means the New York Stock Exchange;
- “Offering Reorganization” means the reorganization undertaken in 2015 prior to our IPO where our predecessor, Evolent Health Holdings, Inc. merged with and into Evolent Health, Inc.;
- “partners” means our customers, unless we indicate otherwise or the context otherwise implies;

- "Passport" means University Health Care, Inc. d./b/a/ Passport Health Plan;
- "pharmacy benefit management," or "PBM," means the administration of prescription drug programs, including developing and maintaining a list of medications that are approved to be prescribed, contracting with pharmacies, negotiating discounts and rebates with drug manufacturers and processing prescription drug claim payments;
- "PMPM" means per member per month;
- "population health" means an approach to health care that seeks to improve the health of an entire human population;
- "Ptolemy Capital" means Ptolemy Capital, LLC;
- "RAF" means risk-adjustment factor;
- "RSUs" means restricted stock units;
- "SEC" means the Securities and Exchange Commission;
- "Securities Act" means the Securities Act of 1933, as amended;
- "Series B Reorganization" means our reorganization undertaken in 2013 in connection with a round of equity financing;

- "third-party administration," or "TPA," means the processing of insurance claims or the administration of certain aspects of employee benefit plans for a separate entity;
- "True Health" means True Health New Mexico, Inc., a wholly-owned subsidiary of Evolent Health, Inc.;
- "TPG" means TPG Global, LLC and its affiliates including one or both of TPG Growth II BDH, LP and TPG Eagle Holdings, L.P.;
- "TRA" means the Income Tax Receivables Agreement. See "Part II – Item 8. Financial Statements and Supplementary Data - Note 12" for further details of the Tax Receivables Agreement;
- "UR" means utilization review;
- "Valence Health" means Valence Health, Inc., excluding Cicerone Health Solutions, Inc.;
- "value-based care" means a health care management strategy that is focused on high-quality and cost-effective care with the goals of promoting a healthy lifestyle, enhancing the patient experience and reducing preventable hospital admissions and emergency visits; and
- "Vestica" means Vestica Healthcare, LLC.

FORWARD-LOOKING STATEMENTS - CAUTIONARY LANGUAGE

Certain statements made in this report and in other written or oral statements made by us or on our behalf are "forward-looking statements" within the meaning of the Private Securities Litigation Reform Act of 1995 ("PSLRA"). A forward-looking statement is a statement that is not a historical fact and, without limitation, includes any statement that may predict, forecast, indicate or imply future results, performance or achievements, and may contain words like: "believe," "anticipate," "expect," "estimate," "aim," "predict," "potential," "continue," "plan," "project," "will," "should," "might" and other words or phrases with similar meaning in connection with a discussion of future operating or financial performance. In particular, these include statements relating to future actions, trends in our businesses, prospective services, future performance or financial results and the outcome of contingencies, such as legal proceedings. We claim the protection afforded by the safe harbor for forward-looking statements provided by the PSLRA.

These statements are only predictions based on our current expectations and projections about future events. Forward-looking statements involve risks and uncertainties that may cause actual results, level of activity, performance or achievements to differ materially from the results contained in the forward-looking statements. Risks and uncertainties that may cause actual results to vary materially, some of which are described within the forward-looking statements, include, among others:

- the significant portion of revenue we derive from our largest partners, and the potential loss, termination or renegotiation of customer contracts;
- uncertainty relating to expected future revenues from and our relationship with our largest customer, Passport, including as a result of ongoing litigation pertaining to rate adjustments and Passport's ability to remain solvent, which among other things could result in significantly reduced fees or a significant customer loss in 2019;
- the structural change in the market for health care in the United States;
- uncertainty in the health care regulatory framework, including the potential impact of policy changes;
- uncertainty in the public exchange market;
- the uncertain impact of CMS waivers to Medicaid rules and changes in membership and rates;
- the uncertain impact the results of elections may have on health care laws and regulations;
- our ability to effectively manage our growth, maintain an efficient cost structure;
- our ability to offer new and innovative products and services;
- risks related to completed and future acquisitions, investments, alliances and joint ventures, including the acquisition of assets from NMHC and the acquisitions of Valence Health, Aldera and New Century Health, which may be difficult to integrate, divert management resources, result in unanticipated costs or dilute our stockholders;
- our ability to consummate opportunities in our pipeline;
-

certain risks and uncertainties associated with the acquisition of assets from NMHC and the acquisitions of Valence Health, Aldera and New Century Health, including future revenues may be less than expected, the timing and extent of new lives expected to come onto the platform may not occur as expected and the expected results of Evolent may not be impacted as anticipated;

- risks relating to our ability to maintain profitability for our and New Century Health's performance-based contracts and products;
- the growth and success of our partners, which is difficult to predict and is subject to factors outside of our control, including enrollment numbers for our partner's plans (including in Florida), premium pricing reductions, selection bias in at-risk membership and the ability to control and, if necessary, reduce health care costs, particularly in New Mexico;
- our ability to attract new partners and succesfully capture new growth opportunities;
- the increasing number of risk-sharing arrangements we enter into with our partners;
- our ability to recover the significant upfront costs in our partner relationships;
- our ability to estimate the size of our target markets;
- our ability to maintain and enhance our reputation and brand recognition;
- consolidation in the health care industry;
- competition which could limit our ability to maintain or expand market share within our industry;

- risks related to governmental payer audits and actions, including whistleblower claims;
- our ability to partner with providers due to exclusivity provisions in our contracts;
- restrictions and penalties as a result of privacy and data protection laws;
- adequate protection of our intellectual property, including trademarks;
- any alleged infringement, misappropriation or violation of third-party proprietary rights;
- our use of "open source" software;
- our ability to protect the confidentiality of our trade secrets, know-how and other proprietary information;
- our reliance on third parties and licensed technologies;
- our ability to use, disclose, de-identify or license data and to integrate third-party technologies;
- data loss or corruption due to failures or errors in our systems and service disruptions at our data centers;
- online security risks and breaches or failures of our security measures;
- our reliance on Internet infrastructure, bandwidth providers, data center providers, other third parties and our own systems for providing services to our users;
- our reliance on third-party vendors to host and maintain our technology platform;
- our ability to contain health care costs, implement increases in premium rates on a timely basis, maintain adequate reserves for policy benefits or maintain cost effective provider agreements;
- the risk of a significant reduction in the enrollment in our health plan;
- our ability to accurately underwrite performance-based contracts;
- risks related to our offshore operations;
- our dependency on our key personnel, and our ability to attract, hire, integrate and retain key personnel;
- the risk of potential future goodwill impairment on our results of operations;
- our indebtedness and our ability to obtain additional financing;
- our ability to achieve profitability in the future;
- the requirements of being a public company;
- our adjusted results may not be representative of our future performance;
- the risk of potential future litigation;
- the impact of changes in accounting principles and guidance on our reported results;
- our holding company structure and dependence on distributions from Evolent Health LLC;
- our obligations to make payments to certain of our pre-IPO investors for certain tax benefits we may claim in the future;
- our ability to utilize benefits under the tax receivables agreement described herein;
- our ability to realize all or a portion of the tax benefits that we currently expect to result from past and future exchanges of Class B common units of Evolent Health LLC for our Class A common stock, and to utilize certain tax attributes of Evolent Health Holdings and an affiliate of TPG;
- distributions that Evolent Health LLC will be required to make to us and to the other members of Evolent Health LLC;
- our obligations to make payments under the tax receivables agreement that may be accelerated or may exceed the tax benefits we realize;
- different interests among our pre-IPO investors, or between us and our pre-IPO investors;
- the terms of agreements between us and certain of our pre-IPO investors;
- the conditional conversion feature of the 2025 Notes, which, if triggered, could require us to settle the 2025 Notes in cash;
- the impact of the accounting method for convertible debt securities that may be settled in cash;
- the potential volatility of our Class A common stock price;
- the potential decline of our Class A common stock price if a substantial number of shares are sold or become available for sale or if a large number of Class B common units are exchanged for shares of Class A common stock;
- provisions in our second amended and restated certificate of incorporation and second amended and restated by-laws and provisions of Delaware law that discourage or prevent strategic transactions, including a takeover of us;
- the ability of certain of our investors to compete with us without restrictions;

- provisions in our second amended and restated certificate of incorporation which could limit our stockholders' ability to obtain a favorable judicial forum for disputes with us or our directors, officers or employees;
- our intention not to pay cash dividends on our Class A common stock;
- our ability to maintain effective internal control over financial reporting;
- our expectations regarding the additional management attention and costs that will be required as we have transitioned from an "emerging growth company" to a "large accelerated filer"; and
- our lack of public company operating experience.

The risks included here are not exhaustive. Although we believe the expectations reflected in the forward-looking statements are reasonable, we cannot guarantee future results, level of activity, performance or achievements. More information on potential factors that could affect our businesses and financial performance is included in "Forward Looking Statements - Cautionary Language," "Risk Factors" and "Management's Discussion and Analysis of Financial Condition and Results of Operations" or similarly captioned sections of this Annual Report and the other period and current filings we make from time to time with the SEC. Moreover, we operate in a rapidly changing and competitive environment. New risk factors emerge from time to time, and it is not possible for management to predict all such risk factors.

Further, it is not possible to assess the effect of all risk factors on our businesses or the extent to which any factor, or combination of factors, may cause actual results to differ materially from those contained in any forward-looking statements. Given these risks and uncertainties, investors should not place undue reliance on forward-looking statements as a prediction of actual results. In addition, we disclaim any obligation to update any forward-looking statements to reflect events or circumstances that occur after the date of this report.

Market Data and Industry Forecasts and Projections

We use market data and industry forecasts and projections throughout this Annual Report on Form 10-K, and in particular in “Part I - Item 1. Business.” We have obtained the market data from certain publicly available sources of information, including publicly available independent industry publications and other third-party sources. Unless otherwise indicated, statements in this Annual Report on Form 10-K concerning our industry and the markets in which we operate, including our general expectations and competitive position, business opportunity and market size, growth and share, are based on information from independent industry organizations and other third-party sources (including industry publications, surveys and forecasts), data from our internal research and management estimates. We believe the data that third parties have compiled is reliable, but we have not independently verified the accuracy of this information and there is no assurance that any of the forecasted amounts will be achieved. Any forecasts are based on data (including third-party data), models and experience of various professionals and are based on various assumptions, all of which are subject to change without notice. While we are not aware of any misstatements regarding the industry data presented herein, forecasts, assumptions, expectations, beliefs, estimates and projections involve risks and uncertainties and are subject to change based on various factors, including those described under the heading “Forward-Looking Statements - Cautionary Language” and in “Part I - Item IA. Risk Factors.”

PART I

Item 1. Business

Company Overview

We are a market leader in the new era of health care delivery and payment, in which leading health systems and physician organizations, which we refer to as providers, are taking on increasing clinical and financial responsibility for the populations they serve. We provide integrated, technology-enabled services to our national network of leading health systems, physician organizations and national and regional payers across Medicare, Medicaid and commercial markets. By partnering with providers to accelerate their path to value-based care, we enable our provider partners to expand their market opportunity, diversify their revenue streams, grow market share and improve the quality of the care they provide.

We believe we are pioneers in enabling health systems to succeed in value-based payment models. We were founded in 2011 by members of our management team, UPMC, an integrated delivery system based in Pittsburgh, Pennsylvania, and The Advisory Board, to enable providers to pursue a value-based business model and evolve their competitive position and market opportunity. We consider value-based care to be the necessary convergence of health care payment and delivery. We believe the pace of this convergence is accelerating, driven by price pressure in traditional FFS health care, a market environment that is incentivizing value-based care models and innovation in data and technology. We believe providers are positioned to lead this transition to value-based care because of their control over large portions of health care delivery costs, their primary position with consumers and their strong local brand.

We believe that the transition to value-based care is impacting the business model of both providers and payers and is impacting the reimbursement and delivery of care in all segments of the market, including Medicare, Medicaid and commercial markets. For providers, the transformation of the business model will require a set of core capabilities, including the ability to aggregate and understand disparate clinical and financial data, standardize and integrate technology into care processes, manage population health and build a financial and administrative infrastructure that capitalizes on the clinical and financial value it delivers. To that end, we provide an end-to-end, built-for-purpose, technology-enabled platform for providers to transition their organization and business model to succeed in value-based payment models. To succeed under value-based care reimbursement, payers are under increasing pressure to manage high cost complex patient populations. We offer technology-enabled services to address these populations.

As of December 31, 2018, we had contractual relationships with over 35 operating partners. A significant portion of our revenue is concentrated with a single partner, Passport, which comprised 17.5% of our consolidated revenue for 2018. Recent changes in the way the state of Kentucky distributes federal Medicaid benefits have had a significant negative impact on Passport. See “Risk factors- Recent rate changes in Kentucky have negatively impacted Passport, our largest partner in terms of revenue for 2018, and could significantly harm our business, financial condition and results of operations” for additional information. As of December 31, 2018, our average contractual relationship with our operating partners was approximately 5.6 years. We believe our Services business model provides strong visibility and aligns our partners’ incentives with our own. We capture value through a variety of value-based payment arrangements and, in certain circumstances, participate alongside our partners in risk-sharing arrangements. A large portion of our Services revenue is derived from our multi-year contracts, which are linked to the number of members that our partners are managing under a value-based care arrangement. This variable pricing model depends on the population being served as well as the number of services and technology applications that our partners utilize to advance their value-based care strategies and the number of members they are able to attract over time. We participate alongside our partners in risk-sharing arrangements whereby we share in a portion of the upside and downside performance of the value strategy. We expect to grow with current partners as they increase membership in their existing value-based programs, through expanding the number of services we provide to our existing partners, by adding new partners and by capturing value through risk-sharing arrangements and co-ownership.

We believe we are in the early stages of capitalizing on these aligned operating partnerships. We believe our health system partners' current value-based care arrangements represent a small portion of the health system's total revenue each year. We believe the proportion of value-based care related revenues to total health system revenues will continue to grow, driven by continued price pressure in FFS, new government payment programs, growth in consumer-focused insurance programs, such as Medicare Advantage and managed Medicaid, and innovation in data and technology. Our Services business model benefits from scale, as we leverage our purpose-built technology-enabled solutions and centralized resources in conjunction with the growth of our partners' membership base. While our absolute investment in our centralized resources and technologies will increase over time, we expect it will decrease as a percentage of revenue as we are able to scale this investment across a broader group of partners.

In October 2018, we acquired New Century Health, a national population health leader in managing specialty care for Medicare, commercial and Medicaid members under performance-based arrangements, focused primarily on oncology and cardiovascular care. In January 2018, we acquired a commercial health plan in New Mexico that focuses on small and large businesses, True Health.

We manage our operations and allocate resources across two reportable segments, our Services segment and our True Health segment.

Our Market Opportunity

For 2018, health care spending in the United States was projected to be approximately $3.5 trillion. The U.S. health care system is undergoing a shift to a value-based care delivery and reimbursement model. While there is not a universally agreed-upon definition of value-based care, we estimate that more than 50% of health care payments were paid through value-based care programs in 2018. This estimate is based on goals set by CMS, as well as statements made by the large health care insurers. Furthermore, we believe that there will be an increasing level of risk-transfer between payers and providers in value based care reimbursement. This was evident in CMS's "Pathways to Success" program launched in late 2018, which over time, will require ACOs to absorb the financial consequences of cost overruns within Medicare Shared Savings Programs. Our technology-enabled solutions allow providers and payers to capitalize on this transition, which we believe will position us to continue to be at the forefront of the transformation to value-based care.

Our Solutions

Services

Our Services segment includes three types of services designed to help our partners manage patient health in a more cost-effective manner: (1) value-based care services, (2) specialty care management services and (3) comprehensive health plan administration services. Our partners engage us to provide one type of service, or multiple types of services, depending on specific needs.

Value-based care services

Core elements of our value-based care services include: (1) Identifi®, our proprietary technology system that aggregates and analyzes data, manages care workflows and engages patients, (2) population health performance, which supports the delivery of patient-centric cost effective care, (3) delivery network alignment, comprising the development of high performance delivery networks and (4) integrated cost and revenue management solutions including PBM and patient risk scoring.

We integrate change management processes and ongoing physician-led transformation into all value-based services to build engagement, integration and alignment within our partners to successfully deliver value-based care and sustain performance. We have standardized the processes described below and are able to leverage our expertise across our entire partner base. Through the technological and clinical integration, we achieve, our solutions are delivered as engrained components of our partners' core operations rather than as add-on solutions.

Identifi®

Identifi® is our proprietary technology system that aggregates and analyzes data, manages care workflows and engages patients. Identifi® links our processes with those of our provider partners and other third parties to create a connected clinical delivery ecosystem, stratify patient populations, standardize clinical work flows and enable high-quality, cost-effective care. The configurable nature and broad capabilities of Identifi® help enhance the benefits our partners receive from our value-based care services and increase the effectiveness of our partners' existing technology architecture. Highlights of the capabilities of Identifi® include the following:

- Data and integration services: Data from disparate sources, such as EMRs, and lab and pharmacy data, is collected, assembled, integrated and maintained to provide health care professionals with a holistic view of the patient.
- Clinical and business content: Clinical and business content is applied to the integrated data to create actionable information to optimize clinical and financial performance.
-

EMR integration: Data and clinical insights from Identifi® are fed back into partner EMRs to improve both provider and patient satisfaction, create workflow efficiencies, promote clinical documentation and coding and provide clinical support at the point-of-care.

- Applications: A suite of cloud-based applications manages the clinical, financial and operational aspects of the value-based model. Our applications are individually purchased and scale with the clinical, financial and administrative needs of our provider partners. As additional capabilities are required by our partners, they are often deployed as applications through Identifi®.

Population Health Performance

Population Health Performance is an integrated suite of technology-enabled solutions that supports the delivery of quality care in an environment where a provider's need to manage health has significantly expanded. These solutions include:

- Clinical programs: Care processes and ongoing clinical innovation that enables providers to target the right intervention at the right time for a given patient.
- Specialized care team: Multi-disciplinary team that is deployed telephonically from a centralized location or throughout a local market to operate clinical programs, engage patients and support physicians.
- Patient engagement: Integrated technologies and processes that enable outreach to engage patients in their own care process.
- Quality and risk coding: Engagement of physicians to identify opportunities to close gaps in care and improve clinical documentation efforts.

Delivery Network Alignment

We help our partners build the capabilities that are required to develop and maintain a coordinated and financially-aligned provider network that can deliver high-quality care necessary for value-based contracts. These capabilities include:

- High-performance network: Supporting the capabilities needed to build, maintain and optimize provider- and clinically-integrated networks.
- Value compensation models: Developing and supporting physician incentive payment programs that are linked to quality outcomes, payer shared savings arrangements and health plan performance.
- Integrated specialty partnerships: Supporting the technology-enabled strategies, analytics and staff needed to optimize network referral patterns.

Integrated Cost and Revenue Management Solutions

We seek to integrate traditional cost and revenue management solutions such as PBM, and risk adjustment to achieve greater adoption and performance than traditional payer-led models.

- Pharmacy benefit management: Our team of professionals support the drug component of providers' plan offerings and bring national buying power and dedicated resources that are tightly integrated with the care delivery model. Differentiated from what we consider to be traditional PBMs, our solution is integrated into patient care and engages population health levers including generic utilization, provider management, and utilization management to reduce unit pharmacy costs.
- Risk adjustment: Our provider-led risk adjustment solution leverages Identifi® and integrates with partners' EMRs to minimize disruption to the physician practice and maximize physician engagement. Our prospective and retrospective risk adjustment offerings utilize comprehensive data sources to capture medical history and sophisticated analytics and workflow tools with the aim of increasing the accuracy and efficiency of retrieval and documentation. We believe that through better provider engagement and intelligent use of data, our integrated model drives more accurate documentation of patient acuity, which optimizes reimbursement and improves the quality of care.

Specialty care management services

On October 1, 2018, we acquired New Century Health, a national population health leader in managing specialty care for Medicare, commercial and Medicaid members under performance-based and administrative services arrangements. Since its founding in 2002, New Century Health has focused on the oncology and cardiology markets and using

clinical data analytics, predictive modeling and decision support tools has developed proprietary clinical pathways in these markets. Managed through its proprietary specialty care management platform, New Century combines high performance networks of specialists and enhanced clinical pathways to deliver higher quality, more affordable care to patients, providers and payers. To date, New Century has focused on the Medicare market and offers performance based contracts as well ASO arrangements primarily to payers in the Medicare HMO segment of the overall Medicare market.

New Century Health provides a differentiated approach designed to meet market challenges based on (i) networks of high-performance providers, (ii) design of evidence-based clinical pathways and (iii) leveraging our proprietary specialty care management technology.

High performance provider networks

We develop high-performance provider networks with tools, capabilities and incentives to align and support physicians. We develop and manage comprehensive specialty networks, provide physician engagement and support and identify provider financial incentive alignment. Key features include:

- Direct contracts with specialists facilitates ease of care.
- Comprehensive specialty networks include multiple downstream subspecialists.
- Dedicated provider operations provide staff to support practices.
- Clinical response team provides clinical education on-site to practice staff.
- Dedicated central call center facilitates referrals and helps to resolve claims issues.
- Established system of ongoing provider education and training.

Design evidence-based clinical pathways

We design high-quality evidence-based clinical pathways to drive provider behavior towards improved quality of care at a lower cost. The transparent pathway development process for our specialty population health focal areas, oncology and cardiology, is designed to achieve the following objectives:

- Reduce unnecessary clinical variation.
- Support physician clinical decision making of evidence-based therapies.
- Facilitate total cost-of-care management.

Our clinical pathways are based on national guidelines with independent scientific advisory boards, in-house clinical expertise with original publications and presentations at national congress. We employ a collaborative review process that is not based on denials, which includes customized clinical review based on tier 1-5 drugs and proactive monitoring response to therapy. We employ quality metrics and clinical benchmarking to continually improve our pathways. We incentivize financial payment for quality by minimizing “buy and bill” incentives and through a shared savings methodology.

Leverage proprietary specialty care management technology

We leverage a custom specialty care management workflow platform to provide clinical decision support and manage providers to high-quality care, while aiming to achieve significant cost savings. Our technology consists of a clinical decision support portal that provides oversight of individual treatment plans for pathway adherence. Our platform integrates clinical analytics and protocols, pharmacy management, physician engagement, network management and claims payment to drive improved outcomes for partners.

- Decision support portal delivers specialty specific clinical experience based on assigned roles (e.g. cardiologist vs. oncologist).
- Custom-built rules engine allows flexibility for multiple specialties and automated decisions based on clinical relevance, considering, for example, rigor levels based on specified payers and providers.
- Workflow capability facilitates a seamless collaboration within and across organizations, connecting payers and clearing houses for systematic data exchange.
- Nurse triage system leverages proprietary technology infrastructure.
- Overall flexibility enables a new business launch of existing specialty within 60 days.

Comprehensive health plan administration services

We help providers assemble the complete infrastructure required to operate, manage and capitalize on a variety of financial and administrative management services. These services include:

- Health plan services: A comprehensive suite of services including third-party administration, enrollment and billing support, medical and utilization management, third-party payment and program integrity support and provider network contracting services. Other health plan related services include sales and marketing, product development, actuarial, and regulatory and compliance.
- Risk management: The capabilities needed to successfully manage risk from payers, including analysis, data and operational integration with payer processes, and ongoing performance management.
- Analytics and reporting: The ongoing and ad hoc analytic teams and reports required to measure, inform and improve performance, including population health analytics, market analytics, network evaluation, staffing models, physician effectiveness, clinical delivery optimization and patient engagement.
- Leadership and management: Our local and national talent assist our partners in effectively managing the performance of their value-based operations.

True Health

True Health is a physician-led health plan in New Mexico available through the commercial market for employer-sponsored health coverage. On January 2, 2018, Evolent acquired certain assets from New Mexico Health Connections-one of the first Consumer Operated and Oriented Plans established following the implementation of the ACA-including a commercial plan and health plan management services organization. The acquired assets were contributed to a new entity, True Health New Mexico, Inc., a wholly-owned subsidiary of Evolent.

The core elements of True Health include:

- A statewide network of primary care and specialty providers, with an emphasis on primary care coordination.
- Extensive care management and prevention capabilities leveraging diagnostic and actuarial analysis to drive care and health metrics.
- Focus on community partnerships, both medical and socioeconomic, to improve individual and population health status and promote trusted collaborations with clinicians in facilitating access to care and working through insurance issues.
- Advanced analytics aim to avoid costly interventions and complications in the future by focusing on preventative care.

Our True Health segment derives revenue from premiums earned over the terms of the related insurance policies. As of December 31, 2018, True Health served approximately 17,000 members, consisting principally of large group and off-exchange small group members. True Health provides an opportunity for us to leverage our Services offerings to support True Health and transform the health plan into a value-based provider-centric model of care.

True Health continues to share a physician network with NMHC. Because of the shared physician network and the enhanced terms that we derive through the combined membership of the two health plans, we believe we have a strategic rationale for providing support to NMHC. To that end, during the fourth quarter of 2017, we entered into a 15-month, $10.0 million capital-only reinsurance agreement with NMHC, expiring on December 31, 2018. The purpose of the capital-only reinsurance was to provide balance sheet support to NMHC. There was no uncertainty to the outcome of the arrangement as there was no transfer of underwriting risk to Evolent or True Health, and neither Evolent nor True Health was at risk for any cash payments on behalf of NMHC. As a result, this arrangement did not qualify for reinsurance accounting and we recorded the fees received under the deposit-only reinsurance agreement as non-operating income on our Consolidated Statements of Operations and Comprehensive Income (Loss).

During the fourth quarter of 2018, the Company terminated its prior reinsurance agreement with NMHC and entered into an updated 15-month quota-share reinsurance agreement with NMHC (“Reinsurance Agreement”). As a result of certain changes in terms as compared to the prior reinsurance agreement, the Reinsurance Agreement qualified for reinsurance accounting due to the deemed risk transfer and, as such, the Company began recording the full amount of the gross reinsurance premiums and claims assumed by the Company on its Consolidated Statements of Operations and Comprehensive Income (Loss) from the legal effective date of the Reinsurance Agreement. Under the terms of the Reinsurance Agreement, NMHC will cede 90% of its gross premiums to the Company and the Company will indemnify NMHC for 90% of its claims liability. The maximum amount of insurance risk to the Company is capped at 105% of premiums ceded to the Company by NMHC. Refer to “Part II - Item 8. Financial Statements and Supplementary Data - Note 9” for additional discussion regarding the Reinsurance Agreement.

Competitive Strengths

We believe we are well-positioned to benefit from the transformations occurring in health care payment and delivery described above. We believe this environment that rewards the better use of information to drive patient outcomes

aligns with our business model, recent investments and other competitive strengths.

Early Innovator

We believe we are an innovator in the delivery of a comprehensive value-based care solutions. We were founded in 2011, ahead of the implementation of the ACA and before the rapid expansion of programs, such as Medicare ACOs or Medicare Bundled Payment Initiatives. Since our inception, we have invested a significant amount in expanding our offerings.

Comprehensive End-to-End Solutions

We provide end-to-end, built-for-purpose, technology-enabled solutions for our partners to succeed in value-based payment models. We believe that offering comprehensive and integrated solutions which bring together population health management along with financial and administrative management allows providers to accelerate their path to adoption of value-based care.

Depth of Market Experience

With experience across Medicare, Medicaid and commercial markets, our depth and variety of expertise allows us to serve a variety of customer types in the broad health care marketplace including health systems, providers, physicians, health plans, ACOs, delegated arrangements and other payers.

Integrated Proprietary Technology

Our integrated proprietary technology, Identifi®, allows us to deliver a connected delivery ecosystem, implement replicable clinical processes, scale our value-based services and capitalize on multiple types of value-based payment relationships.

We believe we are creating scaled benefits for our partners in areas such as data analytics, administrative services and care management. We expect Identifi® to enable us to deliver increasing levels of efficiency to our partners.

Provider-Centric Brand Identity

We believe our provider-centric brand identity and origins differentiate us from our competitors in the value-based care services area. We believe our solutions resonate with potential partners seeking proven solutions from providers rather than large payers or non-health care businesses. Our analytical and clinical solutions are rooted in UPMC's experience in growing a provider-led, integrated delivery network over the past 15 years, and growing to become one of the largest provider-owned health plans in the country. Our unique position allows for the sharing of data across multiple payers and care delivery integration regardless of payer, which we believe is not possible with payer led solutions.

Partnership-Driven Business Model

Our business model is predicated on strategic partnerships with leading providers and payers that are attempting to evolve two of their most critical business functions: how they deliver care and how they are compensated for it. The partnership model enables cultural alignment, integration into the provider care delivery and payment work flow, contractual relationships and a cycle of clinical and cost improvement with shared financial benefit. In certain cases, we also agree to participate alongside our partners in risk-sharing or other support arrangements to increase our alignment of interests.

Proven Leadership Team

We have made a significant investment in building an industry-leading management team. Our senior leadership team has extensive experience in the health care industry and a track record of delivering measurable clinical, financial and operational improvement for health care providers and payers. Our chief executive officer, Frank Williams, was formerly the chief executive officer of The Advisory Board, where he oversaw the growth of the company and its IPO.

Growth Opportunities

Multiple Avenues for Growth with Our Existing, Embedded Partner Base

We have established a multi-year partnership model with multiple drivers of embedded growth through the following avenues:

- growth in lives in existing covered populations;
- partners expanding into new lines of value-based care to capture growth in new profit pools;

- partners utilizing our additional capabilities, such as new technology-enabled applications within our value-based services, our specialty care management services and our comprehensive health plan administration services; and
- capturing value created through a variety of value-based arrangements by participating alongside our partners in upside risk sharing arrangements.

In addition to growth within our existing partner base, we also evaluate and consider pursuing opportunities to expand into businesses related to the services we currently provide.

Early Stages of a Rapidly Growing Transformational Addressable Market

We believe that our existing partners represent a small fraction of health systems that could benefit from our solutions. The transformation of the care delivery and payment model in the United States has been rapid, but it is still in the early stages. Approximately 50% of health care payments were paid through value-based care programs in 2018 and it is estimated that this number will continue to grow.

We believe there is a significant market opportunity in our newly acquired specialty care services business. As of December 31, 2018, New Century Health served approximately 462,000 Medicare HMO patients out of total population of approximately 12 million. This represents a market share of less than 4% of this total population. We believe that the adoption of specialty care management services in oncology and cardiology by payers serving the Medicare HMO market is very low but is likely to increase as the growth in spending in these specialties is higher than the growth in overall health care spending.

Capitalize on Growth in Select Government-Driven Programs

Significant growth is projected in the number of people managed by government-driven programs in the United States. Specifically, CMS projects the number of Medicare beneficiaries to grow to approximately 63 million by 2020 from approximately 56 million at the end of 2016. We expect health systems to be direct beneficiaries of growth in Medicare Advantage and Medicaid Managed Care because those specific markets are well suited for value-based care. We believe that the growth in government programs will create an opportunity for health systems to capture a greater portion of the over two trillion dollars in annual health insurance expenditures. For example, in 2016, we launched our Next Generation ACO offering wherein, in addition to our services offering, we share in a portion of the upside and downside financial performance of the ACO through our fee structures with certain customers. The nature of our variable fee economic model enables us to benefit from this growth in government-managed lives. A significant portion of our revenues are attributable to government-driven programs, primarily comprised of Medicaid and, to a less significant extent, Medicare. This dynamic results in part from our acquisition of Valence Health as well as our strategic alliance with Passport. Since 2016, the Company has significantly expanded its presence in Medicaid and continues to look for additional ways to expand in the market, in part, by aligning itself with providers by participating in state mandated managed Medicaid initiatives. To this end, the Company has entered into several joint venture agreements to participate in various state mandated managed Medicaid initiatives.

Ability to Capture Additional Value through Delivering Clinical Results

We are capturing only a portion of the administrative dollars in the market through our current solutions. We believe there is a significant opportunity to capture a portion of the medical dollar over time—namely the remainder of the premium dollar which goes to medical expenses. As our health system partners continue to own a larger percentage of overall premiums, we have begun to pursue business models that allow us to participate in the medical savings through a variety of risk-sharing arrangements that align incentives to reduce costs and improve quality outcomes.

Expand Offerings to Meet Evolving Market Needs

There are multiple business offerings that health systems may require to operate in a value-based care environment that we do not currently provide, including but not limited to:

- PBM expansion to include additional specialty pharmacy management capabilities;
- health savings account administration;
- on-site or specialty clinic services; and
- consumer engagement and digital outreach.

Selectively Pursue Strategic Acquisitions and Investments

We believe that the nature of our competitive landscape provides meaningful acquisition and investment opportunities. Our industry is in the early stages of its life cycle and there are multiple firms attempting to capitalize on the transformation of the care delivery model and the various forms of new profit pools. We believe that providers will require an end-to-end solution and we believe we are well positioned to meet this demand by expanding the breadth of our offerings through not only organic growth, but also the acquisition of niche providers and non-core

portions of larger enterprises. From time to time, we may also pursue acquisition and investment opportunities of businesses related to services we currently provide or that are complementary to our technical capabilities. As an example of executing on our strategy, on October 1, 2018, we completed the acquisition of New Century Health, a national population health leader in managing specialty care for Medicare, commercial and Medicaid members under risk-based, capitated relationships. Our acquisition of New Century Health opened a direct sales channel to the payer market.

Sales and Marketing

We market and sell our services to providers throughout the United States. Our sales team works closely with our leadership team and subject matter experts to foster long-term relationships with our partners' leadership and board of directors given the nature of our partnerships. Our dedicated business development team works closely with our partners to identify additional service opportunities on a continuous basis.

Services Partner Relationships

Our Services business is predicated on strategic partnerships with leading providers that are attempting to evolve two of their most critical business functions: how they deliver care and how they are compensated for it. The partnership model enables cultural alignment, integration into the provider care delivery and payment work flow, contractual relationships and a cycle of clinical and cost improvement with shared financial benefit.

We have sought to partner with leading providers in sizable markets, which we believe creates a growth cycle that benefits from the secular transition to value-based care. By helping these systems lower clinical and administrative costs, we believe we are positioning them to offer a low cost, effective care setting to payers, employers and consumers, which enables them to capture greater market share. As providers have succeeded in lowering costs and growing market share, this enables them to increase their value-based offerings. We benefit from our partners' growth and, in certain cases, we participate alongside our partners through various risk-sharing arrangements, including loans, provisions of letters of credit, equity investments, reinsurance and capitation arrangements and other extensions of capital.

As of December 31, 2018, we had contractual relationships with over 35 operating partners and a significant portion of our revenue is concentrated with a single partner, Passport, which comprised 17.5% of our revenue for 2018. Recent changes in the way the state of Kentucky distributes federal Medicaid benefits have had a significant negative impact on Passport. See "Risk factors- Recent rate changes in Kentucky have negatively impacted Passport, our largest partner in terms of revenue for 2018, and could significantly harm our business, financial condition and results of operations" for additional information. As of December 31, 2018, our average contractual relationship with our operating partners was approximately 5.6 years, with an average of 1.8 years of performance remaining per contract. The contracts of New Century Health typically run for one-year terms, with year-to-year renewal provisions. The average length of its existing long term partnerships is 7.0 years.

The contracts governing the relationships with our operating partners include key terms which may include the period of performance, revenue rates, advanced billing terms, service level agreements, termination clauses, exclusivity clauses and right of first refusal clauses. Typically, these contracts provide for a monthly payment calculated based on a specified rate multiplied by the number of members that our partners are managing. The specified rate varies depending on which market-facing solutions the partner has adopted and the number of services and technology applications they are utilizing. In some cases, our contracts also include a combination of advisory fees, percentage of plan premiums or shared medical savings arrangements. Typically our contracts allow for advance billing of our partners. In some of our contracts, a defined portion of the revenue is at risk and can be refunded to the partner if certain service levels are not attained. We monitor our compliance with the service levels to determine whether a refund will be provided and record an estimate of these refunds. In addition, certain of our contracts provide that if we fail to meet specified implementation targets, the contracts will terminate and we will be subject to financial penalties. Separately, the contracts of New Century Health typically run for one year terms. While they typically contain year-to-year renewal provisions, we cannot assure you any or all of these contracts will be renewed in any particular year.

Although the revenue from our contracts is not guaranteed because certain of our contracts are terminable for convenience by our partners after a notice period has passed, certain partners would be required to pay us a termination fee in certain circumstances. Termination fees and the related notice period in certain of our contracts are determined based on the scope of the market-facing solutions that the partner has adopted and the duration of the contract. Most of our contracts include cure periods for certain breaches, during which time we may attempt to resolve any issues that would trigger a partner's ability to terminate the contract. However, certain of our contracts are also terminable immediately on the occurrence of certain events. For example, some of our contracts may be terminated by the partner if we fail to achieve target performance metrics over a specified period. Certain of our contracts may be terminated by the partner immediately following repeated failures by us to provide specified levels of service over

periods ranging from six months to more than a year. Certain of our contracts may be terminated immediately by the partner if we lose applicable licenses, go bankrupt, lose our liability insurance, become insolvent, file for bankruptcy or receive an exclusion, suspension or debarment from state or federal government authorities. Additionally, if a partner, including Passport, were to lose applicable licenses, go bankrupt, lose liability insurance, become insolvent, file for bankruptcy or receive an exclusion, suspension or debarment from state or federal government authorities, our contract with such partner could in effect be terminated. The loss, termination or renegotiation of any contract could negatively impact our results. In addition, as our partners' businesses respond to market dynamics and financial pressures, and as our partners make strategic business decisions in respect of the lines of business they pursue and programs in which they participate, we expect that certain of our partners will, from time to time, seek to restructure their agreements with us.

The contracts often contain exclusivity or other restrictive provisions, which may limit our ability to partner with or provide services to other providers or purchase services from other vendors within certain time periods and in certain geographic areas. The exclusivity and other restrictive provisions are negotiated on an individual basis and vary depending on many factors, including the term and scope of the contract. The time limit on these exclusivity and other restrictive provisions typically corresponds to the term of the contract. These exclusivity or other restrictive provisions often apply to specific competitors of our health system partners or specific geographic areas within a particular state or an entire state, subject to certain exceptions, including, for example, exceptions for

employer plan entities that have operations in the restricted geographic areas but that are headquartered elsewhere. Accordingly, these exclusivity clauses may prevent us from entering into relationships with certain potential partners.

The contracts with our partners impose other obligations on us. For example, we typically agree that all services provided under the partner contract and all employees providing such services will comply with our partner's policies and procedures. In addition, in most instances, we have agreed to indemnify our partners against certain third-party claims, which may include claims that our services infringe the intellectual property rights of such third parties.

Competition

The market for our products and services is fragmented, competitive and characterized by rapidly evolving technology standards, customer needs and the frequent introduction of new products and services. Our competitors range from smaller niche companies to large, well-financed and technologically-sophisticated entities.

We compete based on several factors, including breadth, depth and quality of product and service offerings, ability to deliver clinical, financial and operational performance improvement using products and services, quality and reliability of services, ease of use and convenience, brand recognition and the ability to integrate services with existing technology. We also compete based on price.

Our health plan, True Health, also competes with local and regional health care benefits plans, health care benefits and other plans sponsored by large commercial health care benefit insurance companies, health system owned health plans, new entrants into the marketplace and numerous for-profit and not-for-profit organizations. For additional information related to competition in our health plan business, see "Part I - Item 1A. Risk Factors - Risks relating to our business and industry."

Health Care and Insurance Laws and Regulations

Our business is subject to extensive, complex and rapidly changing federal and state laws and regulations. Various federal and state agencies have discretion to issue regulations and interpret and enforce health care laws. While we believe we comply in all material respects with applicable health care and insurance laws and regulations, these regulations can vary significantly from jurisdiction to jurisdiction, and interpretation of existing laws and regulations may change periodically. Federal and state legislatures also may enact various legislative proposals that could materially impact certain aspects of our business. The following are summaries of key federal and state laws and regulations that impact our operations:

Health Care Reform

In March 2010, the ACA and the Health Care and Education Reconciliation Act of 2010, which we refer to, collectively, as health care reform, was signed into law. Health care reform contains provisions that have changed and will continue to change the health insurance industry in substantial ways. For example, health care reform includes a mandate that employers with over 50 employees offer their employees group health insurance coverage or face tax penalties; prohibitions against insurance companies that offer Individual Major Medical plans using pre-existing health conditions as a reason to deny an application for health insurance; medical loss ratio requirements that require each health insurance carrier to spend a certain percentage of their premium revenue on reimbursement for clinical services and activities that improve health care quality; establishment of health insurance exchanges to facilitate access to, and the purchase of, health insurance; and subsidies and cost-sharing credits to make health insurance more affordable for those below certain income levels.

Health care reform amended various provisions in many federal laws, including the Code, the Employee Retirement Income Security Act of 1974 and the Public Health Services Act. Health care reform is being implemented by the

Department of Health and Human Services, the Department of Labor and the Department of Treasury. Most of the ACA regulations became effective on January 1, 2014.

The current administration and Congress have been seeking, and we expect they will continue to seek, legislative and regulatory changes to health care laws and regulations, including repeal and replacement of certain provisions of the ACA. In January 2017, President Trump issued an executive order titled “Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal.” The order directed agencies with authorities and responsibilities under the ACA to waive, defer, grant exemptions from, or delay the implementation of any provision of the ACA that would impose a fiscal or regulatory burden on states, individuals, health care providers, health insurers, or manufacturers of pharmaceuticals or medical devices. In October 2017, President Trump issued a second executive order relating to the ACA titled “Promoting Healthcare Choice and Competition Across the United States,” which further directs federal agencies to modify how the ACA is implemented, and soon after announced the termination of the cost sharing subsidies that reimburse insurers under the ACA. To date, Congressional efforts to completely repeal and replace the ACA have been unsuccessful. However, the individual mandate was repealed by Congress as part of the Tax Cuts and Jobs Act (the “Tax Act”) that was signed into law on December 22, 2017.

In December 2018, a federal district court in Texas ruled the individual mandate was unconstitutional and could not be severed from the ACA. As a result, the court ruled the remaining provisions of the ACA were also invalid, though the court declined to issue a preliminary injunction with respect to the ACA. It remains unclear whether the court's ruling will be upheld by appellate courts. The impact of the repeal and the executive orders as well as the future of the ACA remain unclear, and we are continuing to evaluate their effect on our business. Further, the public exchange market is currently experiencing significant disruptions, as many insurers have incurred significant losses and announced their withdrawal from health insurance exchanges in several states. Because of the continued uncertainty about the implementation of the ACA, including the timing of and potential for further legal challenges, repeal or amendment of that legislation and future of the health insurance exchanges, we cannot quantify or predict with any certainty the likely impact of the ACA on our business, financial condition, operating results and prospects. In addition, Congress, state legislatures and third-party payers may continue to review and assess alternative health care delivery and payment systems and may in the future propose and adopt legislation or policy changes or implementations effecting additional fundamental changes in the health care delivery system, including with respect to Medicare and Medicaid programs. We cannot assure you as to the ultimate content, timing, or effect of any changes, nor is it possible at this time to estimate the impact of any such potential legislation or changes. Health care reform has resulted in profound changes to the individual health insurance market and our business, and we expect these changes to continue.

Stark Law

We are subject to federal and state “self-referral” laws. The Stark Law is a federal statute that prohibits physicians from referring patients for items covered by Medicare or Medicaid to entities with which the physician has a financial relationship, unless that relationship falls within a specified exception. The Stark Law is a strict liability statute and is violated even if the parties did not have an improper intent to induce physician referrals. The Stark Law is relevant to our business because we frequently organize arrangements of various kinds under which (a) physicians and hospitals jointly invest in and own ACOs, clinically integrated networks and other entities that engage in value-based contracting with third-party payers or (b) physicians are paid by hospitals or hospital affiliates for care management, medical or other services related to value-based contracts. We evaluate when these investment and compensation arrangements create financial relationships under the Stark Law and design structures that are intended to satisfy exceptions under the Stark Law or Medicare Shared Savings Program waiver.

Anti-kickback Laws

In the United States, there are federal and state anti-kickback laws that generally prohibit the payment or receipt of kickbacks, bribes or other remuneration in exchange for the referral of patients or other health-related business. The United States federal health care programs’ Anti-Kickback Statute makes it unlawful for individuals or entities knowingly and willfully to solicit, offer, receive or pay any kickback, bribe or other remuneration, directly or indirectly, in exchange for or to induce the referral of an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a federal health care program or the purchase, lease or order, or arranging for or recommending purchasing, leasing or ordering, any good, facility, service, or item for which payment may be made in whole or in part under a federal health care program. Penalties for violations include criminal penalties and civil sanctions such as fines, imprisonment and possible exclusion from federal health care programs. The Anti-Kickback Statute raises similar compliance issues as the Stark Law. While there are safe harbors under the Anti-Kickback Statute, they differ from the Stark Law exceptions in that compliance with a safe harbor is not mandatory. If an arrangement falls outside the safe harbors, it must be evaluated on its specific facts to assess whether regulatory authorities might take the position that one purpose of the arrangement is to induce referrals of federal health care program business. Our business arrangements implicate the Anti-Kickback Statute for the same reasons they raise Stark Law issues. We evaluate whether investment and compensation arrangements being developed by us on behalf of hospital partners fall within one of the safe harbors or Medicare Shared Savings Program waiver. If not, we consider the factors that regulatory authorities are likely to consider in attempting to identify the intent behind such arrangements. We also design business models that reduce

the risk that any such arrangements might be viewed as abusive and trigger Anti-Kickback Statute claims.

Antitrust Laws

The antitrust laws are designed to prevent competitors from jointly fixing prices. However, competitors often work collaboratively to reduce the cost of health care and improve quality. To balance these competing goals, antitrust enforcement agencies have established a regulatory framework under which claims of per se price fixing can be avoided if a network of competitors (such as an ACO or clinically integrated network) is financially or clinically integrated. In this context, we evaluate the tests for financial and clinical integration that would be applied to the provider networks that we are helping to create and support, including the nature and extent of any financial risk that must be assumed to be deemed financially integrated and the types of programs that must be implemented to achieve clinical integration. However, even if a network is integrated, it is still subject to a “rule of reason” test to determine whether its activities are, on balance, pro-competitive. The key factors in the rule of reason analysis are market share and exclusivity. We focus on network size, composition and contracting policies to strengthen our partners’ position that their networks meet the rule of reason test.

Federal Civil False Claims Act and State False Claims Laws

The federal civil False Claims Act imposes liability on any person or entity who, among other things, knowingly presents, or causes to be presented, a false or fraudulent claim for payment by a federal health care program. The "qui tam" or "whistleblower" provisions of the False Claims Act allow a private individual to bring actions on behalf of the federal government alleging that the defendant has submitted a false claim to the federal government, and to share in any monetary recovery. Our activities relating to the way we sell and market our services, including our provider-led risk adjustment solution, may be subject to scrutiny under these laws.

HIPAA, Privacy and Data Security Regulations

By processing data on behalf of our partners, we are subject to specific compliance obligations under privacy and data security-related laws, including HIPAA, the HITECH Act and related state laws. We are also subject to federal and state security breach notification laws, as well as state laws regulating the processing of protected personal information, including laws governing the collection, use and disclosure of social security numbers and related identifiers.

The regulations that implement HIPAA and the HITECH Act establish uniform standards governing the conduct of certain electronic health care transactions and protecting the security and privacy of individually identifiable health information maintained or transmitted by health care providers, health plans and health care clearinghouses, all of which are referred to as "covered entities," and their "business associates" (which includes anyone who performs a service on behalf of a covered entity involving the use or disclosure of protected health information and is not a member of the covered entity's workforce). Our partners' health plans generally will be covered entities, and, as their business associate, they may ask us to contractually comply with certain aspects of these standards by entering into requisite business associate agreements.

HIPAA Health Care Fraud Standards

The HIPAA health care fraud statute created a class of federal crimes, including health care fraud and false statements relating to health care matters, known as the "federal health care offenses." The HIPAA health care fraud statute prohibits, among other things, executing a scheme to defraud any health care benefit program, while the HIPAA false statements statute prohibits, among other things, concealing a material fact or making a materially false statement in connection with the payment for health care benefits, items or services. Entities that are found to have aided or abetted in a violation of the HIPAA federal health care offenses are deemed by statute to have committed the offense and are punishable as a principal.

Medicare and Medicaid

Medicare is a federal program that provides hospital and medical insurance benefits to persons age 65 and over, as well as certain other individuals. Medicaid programs are jointly funded by federal and state governments and are administered by states under an approved plan that provides hospital and other health care benefits to qualifying individuals. As we increase our exposure to Medicare and Medicaid businesses through new and existing partners, we increase our exposure to changes in government policy with respect to and regulation of the Medicaid and Medicare programs in which we and our partners participate. We are subject to regulation by both CMS and state agencies in respect of certain services we provide relating to Medicaid and Medicare programs.

Because some of our partners are participants in governmental programs, our services have in the past and may again in the future be subject to periodic surveys and audits by governmental entities or contractors for compliance with Medicare and other standards and requirements. As a result of surveys or audits, CMS may seek premium and other refunds, prohibit us from continuing to market or enroll members in plans, exclude us from participating in one or

more programs or institute other sanctions against us if we fail to comply with CMS regulations or Medicare contractual requirements.

The regulations and requirements applicable to us and other participants in Medicaid and Medicare programs are complex and subject to change. In January 2018, CMS released guidance to states on how to design and test programs that require “community engagement” as a condition to receiving Medicaid benefits. Kentucky was the first state to obtain a waiver from CMS for its program and other states have since received similar waivers. We cannot quantify or predict with any certainty the likely impact of such waivers on our business, financial condition, operating results and prospects.

Following the 2018 congressional, state and local elections, Congress and state and local legislatures may propose and adopt legislation or policy changes or implementations effecting additional fundamental changes with respect to Medicare and Medicaid programs. Such changes in the law, or new interpretations of existing laws, may have a significant impact on our methods and costs of doing business. Additionally, expansion of enforcement activity could adversely affect our business and financial condition. Going forward, we expect CMS and Congress to continue to closely scrutinize each component of the Medicare program as well as modify the terms and requirements of the program. It is not possible to predict the outcome of this Congressional or regulatory activity, either of which could adversely affect us. Similarly, we cannot predict whether pending or future federal or state legislation or court proceedings will change various aspects of the Medicaid and Medicare programs, nor can we predict the impact those changes will have on our business operations or financial results, but the effects could be materially adverse.

Consumer Protection Laws

Federal and state consumer protection laws are being applied increasingly by the FTC, Federal Communications Commission and states' attorneys general to regulate the collection, use, storage and disclosure of personal or patient information, through websites or otherwise, and to regulate the presentation of website content and to regulate direct marketing, including telemarketing and telephonic communication. Courts may also adopt the standards for fair information practices promulgated by the FTC, which concern consumer notice, choice, security and access.

State Privacy Laws

In addition to federal regulations issued under HIPAA, some states have enacted privacy and security statutes or regulations, which we refer to as state privacy laws, that govern the use and disclosure of a person's medical information or records and, in some cases, are more stringent than those issued under HIPAA. These state privacy laws include regulation of health insurance providers and agents, regulation of organizations that perform certain administrative functions, such as UR, or TPA, issuance of notices of privacy practices and reporting and providing access to law enforcement authorities. In those cases, it may be necessary to modify our operations and procedures to comply with these more stringent state privacy laws. If we fail to comply with applicable state privacy laws, we could be subject to additional sanctions.

Other State Laws

State insurance laws require licenses for certain health plan administrative activities, including TPA licenses for the processing, handling and adjudication of health insurance claims and UR agent licenses for providing medical management services. Given the nature and scope of services that we provide to certain partners, we are required to maintain TPA and UR agent licenses and ensure that such licenses are in good standing on an annual basis. In addition, laws in many states govern prompt payment obligations for health care services. These laws generally define claims payment processes and set specific time frames for submission, payment, and appeal steps. Failure to meet these requirements and time frames may result in rejection, delay of claims and possible interest and regulatory penalties. The Company has also established a captive insurance company under the laws of the State of Vermont and is subject to the captive insurance laws of that state.

Insurance subsidiaries must be licensed by and are subject to the regulations of the jurisdictions in which they conduct business. For example, True Health is regulated under specific New Mexico laws and regulations and indirectly affected by other health care-related laws and regulations. State regulations mandate minimum capital or restricted cash reserve requirements.

Employees

As of December 31, 2018, we had approximately 3,800 employees. None of our employees are represented by a labor union, and we are not a party to any collective bargaining agreements. We consider our employee relations to be good.

Intellectual Property

Our continued growth and success depend, in part, on our ability to protect our intellectual property and proprietary technology, including our Identifi® software. We primarily protect our intellectual property through a combination of copyrights, trademarks and trade secrets, intellectual property licenses and other contractual rights (including confidentiality, non-disclosure and assignment-of-invention agreements with our employees, independent contractors, consultants and companies with which we conduct business).

However, these intellectual property rights and procedures may not prevent others from creating a competitive online presence or otherwise competing with us. We may be unable to obtain, maintain and enforce the intellectual property rights on which our business depends, and assertions by third parties that we violate their intellectual property rights could have a material adverse effect on our business, financial condition and results of operations. For additional information related to our intellectual property position see “Part I - Item 1A. Risk Factors - Risks relating to our business and industry.”

Research and Development

Our research and development expenditures primarily consist of our strategic investment in enhancing the functionality and usability of our software, Identifi® and developing programs and processes to maximize care delivery efficiency and effectiveness. We also capitalize software development costs related to Identifi®. Our research and development expenditures and capitalized software development costs also include the suite of products developed by New Century Health, Accordion, Valence Health and Aldera.

Organizational Structure

(1) The board of directors of UPMC has voting and dispositive power over the shares of Class A common stock held by UPMC. The members of such board of directors disclaim beneficial ownership with respect to such shares.
(2) Includes public stockholders and employees/partners. Also includes Class B common stock issued to former New Century Health shareholders as part of the acquisition. See “Part II - Item 8. Financial Statements and Supplementary Data - Note 4,” for further discussion of the New Century Health acquisition.
(3) Such shares are held by Ptolemy Capital. Michael R. Stone has voting and dispositive power over the shares of Class B common stock held by Ptolemy Capital.

Corporate Information

Evolent began business operations in August 2011. Evolent Health, Inc., the registrant, was incorporated in the State of Delaware in December 2014. We completed our IPO in June 2015 and our Class A common stock is listed on the NYSE under the symbol “EVH.” Evolent Health, Inc. is a holding company whose principal asset is all of the Class A common units it holds in Evolent Health LLC, and its only business is to act as sole managing member of Evolent Health LLC. Substantially all of our operations are conducted through Evolent Health LLC and its consolidated subsidiaries and the financial results of Evolent Health LLC are consolidated in the financial statements of Evolent Health, Inc.

Available Information

We file annual, quarterly and current reports, proxy statements and other documents with the SEC under the Exchange Act. The SEC maintains a website that contains reports, proxy and information statements and other information regarding issuers, including Evolent, that file electronically with the SEC. The public can obtain any documents that we file with the SEC at www.sec.gov.

We also make available, free of charge, on or through our website, ir.evolenthealth.com, our Annual Report on Form 10-K, Quarterly
Reports on Form 10-Q, Current Reports on Form 8-K and amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Exchange Act as soon as reasonably practicable after we electronically file such material with, or furnish it to, the SEC. Except as specifically indicated otherwise, the information available on our website and the SEC’s website is not and shall not be deemed a part of this Annual Report on Form 10-K.

Executive Offic