CENTENE CORP
Form 10-Q
April 25, 2017

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, DC 20549

FORM 10-Q

(Mark One)

[X] QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the quarterly period ended March 31, 2017
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: 001-31826

CENTENE CORPORATION
(Exact name of registrant as specified in its charter)

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

Registrant's telephone number, including area code:
(314) 725-4477

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: x Yes o No

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 (232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). x Yes o No

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer", "accelerated filer" and "small reporting company" in Rule 12b-2 of the Exchange Act. 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 April 14, 2017, the registrant had 172,277,703 shares of common stock outstanding.

CENTENE CORPORATION
QUARTERLY REPORT ON FORM 10-Q
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CAUTIONARY STATEMENT ON FORWARD-LOOKING STATEMENTS

All statements, other than statements of current or historical fact, contained in this filing or incorporated by reference herein are forward-looking statements. We intend such forward looking statements to be covered by the safe-harbor provisions for forward-looking statements contained in the Private Securities Litigation Reform Act of 1995, and we are including this statement for purposes of complying with these safe-harbor provisions. We have attempted to identify these statements by terminology including “believe,” “anticipate,” “plan,” “expect,” “estimate,” “intend,” “seek,” “targ “may,” “will,” “would,” “could,” “should,” “can,” “continue” and other similar words or expressions (and the negative thereof) connection with, among other things, any discussion of future operating or financial performance. In particular, these statements include without limitation statements about our market opportunity, our growth strategy, competition, expected activities and future acquisitions, investments and the adequacy of our available cash resources. These statements may be found in the various sections of this filing, such as Part I, Item 2. “Management's Discussion and Analysis of Financial Condition and Results of Operations,” Part II, Item 1. “Legal Proceedings,” and Part II, Item 1A. “Risk Factors.” Readers are cautioned that matters subject to forward-looking statements involve known and unknown risks and uncertainties, including economic, regulatory, competitive and other factors that may cause our or our industry’s actual results, levels of activity, performance or achievements to be materially different from any future results, levels of activity, performance or achievements expressed or implied by these forward-looking statements. These statements are not guarantees of future performance and are subject to risks, uncertainties and assumptions.

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

- our ability to accurately predict and effectively manage health benefits and other operating expenses and reserves;
- competition;
- membership and revenue declines or unexpected trends;
- changes in healthcare practices, new technologies, and advances in medicine;
- increased health care costs;
- changes in economic, political or market conditions;
- changes in federal or state laws or regulations, including changes with respect to government health care programs as well as changes with respect to the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act and any regulations enacted thereunder that may result from changing political conditions;
- rate cuts or other payment reductions or delays by governmental payors and other risks and uncertainties affecting our government businesses;
- our ability to adequately price products on federally facilitated and state based Health Insurance Marketplaces;
- tax matters;
- disasters or major epidemics;
- the outcome of legal and regulatory proceedings;
- changes in expected contract start dates;
- provider, state, federal and other contract changes and timing of regulatory approval of contracts;
- the expiration, suspension, or termination of our contracts with federal or state governments (including but not limited to Medicaid, Medicare, and TRICARE);
- challenges to our contract awards;
- cyber-attacks or other privacy or data security incidents;

- the possibility that the expected synergies and value creation from acquired businesses, including, without limitation, the acquisition of Health Net, Inc. (Health Net), will not be realized, or will not be realized within the expected time period, including, but not limited to, as a result of conditions, terms, obligations or restrictions imposed by regulators in connection with their approval of, or consent to, the acquisition;
- the exertion of management's time and our resources, and other expenses incurred and business changes required in connection with complying with the undertakings in connection with certain regulatory approvals;
- disruption from the acquisition making it more difficult to maintain business and operational relationships;
- the risk that unexpected costs will be incurred in connection with, among other things, the acquisition and/or the integration;
- changes in expected closing dates, estimated purchase price and accretion for acquisitions;
- the risk that acquired businesses will not be integrated successfully;
- our ability to maintain or achieve improvement in the Centers for Medicare and Medicaid Services (CMS) Star ratings and other quality scores that impact revenue;
- availability of debt and equity financing, on terms that are favorable to us;

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- inflation; and
- foreign currency fluctuations.

This list of important factors is not intended to be exhaustive. We discuss certain of these matters more fully, as well as certain other risk factors that may affect our business operations, financial condition and results of operations, in our filings with the Securities and Exchange Commission, including our annual reports on Form 10-K, quarterly reports on Form 10-Q and current reports on Form 8-K. Item 1A. “Risk Factors” of Part II of this filing contains a further discussion of these and other important factors that could cause actual results to differ from expectations. Due to these important factors and risks, we cannot give assurances with respect to our future performance, including without limitation our ability to maintain adequate premium levels or our ability to control our future medical costs.

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Non-GAAP Financial Presentation

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

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

	Three Months Ended March 31,	
	2017	2016
GAAP net earnings (loss) from continuing operations	$139	$(15)
Amortization of acquired intangible assets	40	9
Health Net acquisition related expenses	5	189
Penn Treaty assessment expense	47	—
Income tax effects of adjustments [1]	(34)	(87)
Adjusted net earnings from continuing operations	$197	$96
GAAP diluted earnings (loss) per share (EPS)	$0.79	$(0.12)
Amortization of acquired intangible assets [2]	0.14	0.04
Health Net acquisition related expenses [3]	0.02	0.82
Penn Treaty assessment expense [4]	0.17	—
Adjusted Diluted EPS from continuing operations	$1.12	$0.74

(1) The income tax effects of adjustments are based on the effective income tax rates applicable to adjusted (non-GAAP) results.

(2) The amortization of acquired intangible assets per diluted share are net of an income tax benefit of $0.09 and $0.03 for the three months ended March 31, 2017 and 2016, respectively.

(3) The Health Net acquisition related expenses per diluted share are net of an income tax benefit of $0.01 and $0.64 for the three months ended March 31, 2017 and 2016, respectively.

(4) The Penn Treaty assessment expense per diluted share is net of an income tax benefit of $0.09 for the three months ended March 31, 2017. For a further discussion of the Penn Treaty assessment, see Note 9, Contingencies.

	Three Months Ended March 31,	
	2017	2016
GAAP selling, general and administrative expenses	$1,091	$722
Health Net acquisition related expenses	5	189

Penn Treaty assessment expense	47	—
Adjusted selling, general and administrative expenses	$1,039	$533

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PART I
FINANCIAL INFORMATION

ITEM 1. Financial Statements.
CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED BALANCE SHEETS
(In millions, except share data)

	March 31, 2017 (Unaudited)	December 31, 2016
ASSETS		
Current assets:		
Cash and cash equivalents	$ 4,839	$ 3,930
Premium and related receivables	3,121	3,098
Short-term investments	725	505
Other current assets	723	832
Total current assets	9,408	8,365
Long-term investments	4,636	4,545
Restricted deposits	140	138
Property, software and equipment, net	841	797
Goodwill	4,712	4,712
Intangible assets, net	1,504	1,545
Other long-term assets	121	95
Total assets	$ 21,362	$ 20,197
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims liability	$ 4,290	$ 3,929
Accounts payable and accrued expenses	4,275	4,377
Unearned revenue	633	313
Current portion of long-term debt	4	4
Total current liabilities	9,202	8,623
Long-term debt	4,643	4,651
Other long-term liabilities	1,295	869
Total liabilities	15,140	14,143
Commitments and contingencies		
Redeemable noncontrolling interests	138	145
Stockholders' equity:		
Preferred stock, $0.001 par value; authorized 10,000,000 shares; no shares issued or outstanding at March 31, 2017 and December 31, 2016	—	—
Common stock, $0.001 par value; authorized 400,000,000 shares; 178,669,935 issued and 172,271,202 outstanding at March 31, 2017, and 178,134,306 issued and 171,919,071 outstanding at December 31, 2016	—	—
Additional paid-in capital	4,224	4,190
Accumulated other comprehensive loss	(21)	(36)
Retained earnings	2,059	1,920
Treasury stock, at cost (6,398,733 and 6,215,235 shares, respectively)	(192)	(179)
Total Centene stockholders' equity	6,070	5,895
Noncontrolling interest	14	14

Total stockholders' equity	6,084	5,909
Total liabilities and stockholders' equity	$ 21,362	$ 20,197

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

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

	Three Months Ended March 31,	
	2017	2016
Revenues:		
Premium	$10,638	$ 5,986
Service	527	425
Premium and service revenues	11,165	6,411
Premium tax and health insurer fee	559	542
Total revenues	11,724	6,953
Expenses:		
Medical costs	9,322	5,311
Cost of services	441	367
Selling, general and administrative expenses	1,091	722
Amortization of acquired intangible assets	40	9
Premium tax expense	590	450
Health insurer fee expense	—	74
Total operating expenses	11,484	6,933
Earnings from operations	240	20
Other income (expense):		
Investment and other income	41	15
Interest expense	(62)	(33)
Earnings from continuing operations, before income tax expense	219	2
Income tax expense	87	16
Earnings (loss) from continuing operations, net of income tax expense	132	(14)
Discontinued operations, net of income tax (benefit)	—	(1)
Net earnings (loss)	132	(15)
(Earnings) loss attributable to noncontrolling interests	7	(1)
Net earnings (loss) attributable to Centene Corporation	$139	$ (16)
Amounts attributable to Centene Corporation common shareholders:		
Earnings (loss) from continuing operations, net of income tax expense	$139	$ (15)
Discontinued operations, net of income tax (benefit)	—	(1)
Net earnings (loss)	$139	$ (16)
Net earnings (loss) per common share attributable to Centene Corporation:		
Basic:		
Continuing operations	$0.81	$ (0.12)
Discontinued operations	—	(0.01)
Basic earnings (loss) per common share	$0.81	$ (0.13)
Diluted:		
Continuing operations	$0.79	$ (0.12)
Discontinued operations	—	(0.01)
Diluted earnings (loss) per common share	$0.79	$ (0.13)

Weighted average number of common shares outstanding:		
Basic	172,073,968	125,543,076
Diluted	175,836,290	125,543,076

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

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

	Three Months Ended March 31,	
	2017	2016
Net earnings (loss)	$132	$(15)
Reclassification adjustment, net of tax	—	1
Change in unrealized gain on investments, net of tax	14	18
Foreign currency translation adjustments	1	1
Other comprehensive earnings	15	20
Comprehensive earnings	147	5
Comprehensive (earnings) loss attributable to noncontrolling interests	7	(1)
Comprehensive earnings attributable to Centene Corporation	$154	$4

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

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

Three Months Ended March 31, 2017

	Centene Stockholders' Equity								
	Common Stock					Treasury Stock			
	$.001 Par Value Shares	Amt	Additional Paid-in Capital	Accumulated Other Comprehensive Earnings (Loss)	Retained Earnings	$.001 Par Value Shares	Amt	Non-controlling Interest	Total
Balance, December 31, 2016	178,134,306	$ —	$ 4,190	$ (36)	$ 1,920	6,215,235	$ (179)	$ 14	$ 5,909
Comprehensive Earnings:									
Net earnings	—	—	—	—	139	—	—	—	139
Other comprehensive earnings, net of $8 tax	—	—	—	15	—	—	—	—	15
Common stock issued for employee benefit plans	535,629	—	2	—	—	—	—	—	2
Common stock repurchases	—	—	—	—	—	183,498	(13)	—	(13)
Stock compensation expense	—	—	32	—	—	—	—	—	32
Balance, March 31, 2017	178,669,935	$ —	$ 4,224	$ (21)	$ 2,059	6,398,733	$ (192)	$ 14	$ 6,084

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

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

	Three Months Ended March 31,	
	2017	2016
Cash flows from operating activities:		
Net earnings (loss)	$132	$(15)
Adjustments to reconcile net earnings (loss) to net cash provided by operating activities		
Depreciation and amortization	86	35
Stock compensation expense	32	51
Deferred income taxes	(51)	(17)
Gain on contingent consideration	—	(1)
Changes in assets and liabilities		
Premium and related receivables	59	(174)
Other assets	89	(46)
Medical claims liabilities	358	196
Unearned revenue	320	(64)
Accounts payable and accrued expenses	(237)	35
Other long-term liabilities	459	192
Other operating activities, net	1	4
Net cash provided by operating activities	1,248	196
Cash flows from investing activities:		
Capital expenditures	(83)	(45)
Purchases of investments	(594)	(212)
Sales and maturities of investments	349	203
Investments in acquisitions, net of cash acquired	—	(782)
Other investing activities, net	(1)	—
Net cash used in investing activities	(329)	(836)
Cash flows from financing activities:		
Proceeds from long-term debt	560	3,790
Payments of long-term debt	(560)	(1,388)
Common stock repurchases	(13)	(22)
Debt issuance costs	—	(51)
Other financing activities, net	3	(13)
Net cash (used in) provided by financing activities	(10)	2,316
Net increase in cash and cash equivalents	909	1,676
Cash and cash equivalents, beginning of period	3,930	1,760
Cash and cash equivalents, end of period	$4,839	$3,436
Supplemental disclosures of cash flow information:		
Interest paid	$72	$3
Income taxes paid	$2	$33
Equity issued in connection with acquisitions	$—	$3,105

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

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CENTENE CORPORATION AND SUBSIDIARIES
NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS
(Dollars in millions, except share data)
(Unaudited)

1. Organization and Operations

Basis of Presentation

The accompanying interim financial statements have been prepared under the presumption that users of the interim financial information have either read or have access to the audited financial statements included in the Form 10-K for the fiscal year ended December 31, 2016. The unaudited interim financial statements herein have been prepared pursuant to the rules and regulations of the Securities and Exchange Commission. Accordingly, footnote disclosures which would substantially duplicate the disclosures contained in the December 31, 2016 audited financial statements have been omitted from these interim financial statements where appropriate. In the opinion of management, these financial statements reflect all adjustments, consisting only of normal recurring adjustments, which are necessary for a fair presentation of the results of the interim periods presented.

Certain 2016 amounts in the consolidated financial statements and notes to the consolidated financial statements have been reclassified to conform to the 2017 presentation. The Company adopted Accounting Standards Update (ASU) 2016-09, Compensation-Stock Compensation (Topic 718): Improvements to Employee Share-Based Payment Accounting during the fourth quarter of 2016. The ASU simplifies several aspects of the accounting for employee share-based payment transactions. Among other elements, the ASU requires an entity to recognize all excess tax benefits and deficiencies related to stock-based compensation expense as income tax expense or benefit in the statements of operations. The ASU requires adjustments be reflected as of the beginning of the fiscal year of adoption and as a result, prior periods have been restated accordingly. The adoption resulted in a decrease to income tax expense of $1 million for the three months ended March 31, 2016.

In January 2017, the Company reclassified Cenpatico Behavioral Health of Arizona, LLC and the related Cenpatico Integrated Care health plan from the Specialty Services segment to the Managed Care segment due to a reorganization of the Arizona management structure following the Health Net integration. As a result, the financial results of Cenpatico Behavioral Health of Arizona, LLC and the related Cenpatico Integrated Care health plan have been reclassified from the Specialty Services segment to the Managed Care segment for all periods presented.

On March 24, 2016, the Company completed the acquisition of Health Net, Inc. (Health Net) for $6.0 billion, including the assumption of debt. The acquisition was accounted for as a business combination, which requires that assets acquired and liabilities assumed be recognized at their fair values as of the acquisition date. The valuation of all the assets acquired and liabilities assumed was finalized in the fourth quarter of 2016. As a result of the completion of the Health Net acquisition, the Company's results of operations for the three months ended March 31, 2016 include the results of operations of Health Net from March 24, 2016 to March 31, 2016.

Accounting Guidance Not Yet Adopted

In March 2017, the Financial Accounting Standards Board (FASB) issued an ASU which changes the period over which premiums on callable debt securities are amortized. The new standard requires the premiums on callable debt securities to be amortized to the earliest call date rather than to the contractual maturity date of the instrument. The new guidance more closely aligns the amortization period of premiums to expectations incorporated in the market pricing on the underlying securities. The new guidance is effective for annual and interim periods beginning after December 15, 2018. Early adoption is permitted. The new guidance is not expected to have a material impact on the

Company's consolidated financial position, results of operations or cash flows.

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In May 2014, the FASB issued an ASU which supersedes existing revenue recognition standards with a single model unless those contracts are within the scope of other standards (e.g., an insurance entity's insurance contracts). Under the new standard, recognition of revenue occurs when a customer obtains control of promised goods or services in an amount that reflects the consideration which the entity expects to receive in exchange for those goods or services. In addition, the standard requires disclosure of the nature, amount, timing and uncertainty of revenue and cash flows arising from contracts with customers. The new effective date is for annual and interim periods beginning after December 15, 2017. Early adoption is permitted. The Company is currently analyzing selected contracts to determine the impact of the new guidance and anticipates adopting the new guidance in the first quarter of 2018 using the modified retrospective approach with a cumulative-effect adjustment to retained earnings in the period of initial application. The Company also plans to elect the practical expedient of applying the new guidance only to contracts that are not completed as of the date of initial application. The majority of the Company's revenues are derived from insurance contracts and are excluded from the new standard; therefore, the new guidance is not expected to have a material impact on the Company's consolidated financial position, results of operations or cash flows.

2. Short-term and Long-term Investments, Restricted Deposits

Short-term and long-term investments and restricted deposits by investment type consist of the following ($ in millions):

	March 31, 2017				December 31, 2016			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$365	$ —	$ (1)	$364	$364	$ —	$ (1)	$363
Corporate securities	2,034	14	(9)	2,039	1,933	12	(13)	1,932
Restricted certificates of deposit	5	—	—	5	5	—	—	5
Restricted cash equivalents	12	—	—	12	6	—	—	6
Municipal securities	1,908	3	(22)	1,889	1,767	1	(35)	1,733
Asset-backed securities	331	1	(1)	331	317	1	(1)	317
Residential mortgage-backed securities	231	1	(5)	227	219	1	(5)	215
Commercial mortgage-backed securities	347	1	(5)	343	343	—	(5)	338
Cost and equity method investments	169	—	—	169	163	—	—	163
Life insurance contracts	122	—	—	122	116	—	—	116
Total	$5,524	$ 20	$ (43)	$5,501	$5,233	$ 15	$ (60)	$5,188

The Company’s investments are classified as available-for-sale with the exception of life insurance contracts and certain cost and equity method investments. The Company’s investment policies are designed to provide liquidity, preserve capital and maximize total return on invested assets with the focus on high credit quality securities. The Company limits the size of investment in any single issuer other than U.S. treasury securities and obligations of U.S. government corporations and agencies. As of March 31, 2017, 96% of the Company’s investments in rated securities carry an investment grade rating by S&P and Moody’s. At March 31, 2017, the Company held certificates of deposit, life insurance contracts and cost and equity method investments which did not carry a credit rating.

The Company's residential mortgage-backed securities are primarily issued by the Federal National Mortgage Association, Government National Mortgage Association or Federal Home Loan Mortgage Corporation, which carry implicit or explicit guarantees of the U.S. government. The Company's commercial mortgage-backed securities are primarily senior tranches with a weighted average rating of AA+ and a weighted average duration of 4.0 years at March 31, 2017.

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The fair value of available-for-sale investments with gross unrealized losses by investment type and length of time that individual securities have been in a continuous unrealized loss position were as follows ($ in millions):

	March 31, 2017				December 31, 2016			
	Less Than 12 Months		12 Months or More		Less Than 12 Months		12 Months or More	
	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$(1)	$311	$—	$3	$(1)	$215	$—	$2
Corporate securities	(9)	806	—	30	(12)	1,020	(1)	39
Municipal securities	(22)	1,177	—	39	(35)	1,423	—	30
Asset-backed securities	(1)	127	—	14	(1)	101	—	18
Residential mortgage-backed securities	(4)	175	(1)	16	(5)	188	—	—
Commercial mortgage-backed securities	(4)	258	(1)	15	(5)	271	—	—
Total	$(41)	$2,854	$(2)	$117	$(59)	$3,218	$(1)	$89

As of March 31, 2017, the gross unrealized losses were generated from 1,682 positions out of a total of 2,985 positions. The change in fair value of fixed income securities is primarily a result of movement in interest rates subsequent to the purchase of the security.

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

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

	March 31, 2017				December 31, 2016			
	Investments		Restricted Deposits		Investments		Restricted Deposits	
	Amortized Cost	Fair Value	Amortized Cost	Fair Value	Amortized Cost	Fair Value	Amortized Cost	Fair Value
One year or less	$656	$656	$92	$92	$500	$500	$91	$91
One year through five years	1,967	1,967	48	48	1,982	1,974	47	47
Five years through ten years	1,636	1,621	—	—	1,101	1,089	—	—
Greater than ten years	216	216	—	—	633	617	—	—
Asset-backed securities	909	901	—	—	879	870	—	—
Total	$5,384	$5,361	$140	$140	$5,095	$5,050	$138	$138

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

The Company continuously monitors investments for other-than-temporary impairment. Certain investments have experienced a decline in fair value due to changes in credit quality, market interest rates and/or general economic conditions. The Company recognizes an impairment loss for cost and equity method investments when evidence

demonstrates that it is other-than-temporarily impaired. Evidence of a loss in value that is other-than-temporary may include the absence of an ability to recover the carrying amount of the investment or the inability of the investee to sustain a level of earnings that would justify the carrying amount of the investment.

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3. Fair Value Measurements

Assets and liabilities recorded at fair value in the Consolidated Balance Sheets are categorized based upon observable or unobservable inputs used to estimate fair value. Level inputs are as follows:

Level Input:	Input Definition:
Level I	Inputs are unadjusted, quoted prices for identical assets or liabilities in active markets at the measurement date.
Level II	Inputs other than quoted prices included in Level I that are observable for the asset or liability through corroboration with market data at the measurement date.
Level III	Unobservable inputs that reflect management's best estimate of what market participants would use in pricing the asset or liability at the measurement date.

The following table summarizes fair value measurements by level at March 31, 2017, for assets and liabilities measured at fair value on a recurring basis ($ in millions):

	Level I	Level II	Level III	Total
Assets				
Cash and cash equivalents	$4,839	$—	$ —	$4,839
Investments available for sale:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$237	$4	$ —	$241
Corporate securities	—	2,039	—	2,039
Municipal securities	—	1,889	—	1,889
Asset-backed securities	—	331	—	331
Residential mortgage-backed securities	—	227	—	227
Commercial mortgage-backed securities	—	343	—	343
Total investments	$237	$4,833	$ —	$5,070
Restricted deposits available for sale:				
Cash and cash equivalents	$12	$—	$ —	$12
Certificates of deposit	5	—	—	5
U.S. Treasury securities and obligations of U.S. government corporations and agencies	123	—	—	123
Total restricted deposits	$140	$—	$ —	$140
Other long-term assets: Interest rate swap agreements	$—	$3	$ —	$3
Total assets at fair value	$5,216	$4,836	$ —	$10,052
Liabilities				
Other long term liabilities:				
Interest rate swap agreements	$—	$72	$ —	$72
Total liabilities at fair value	$—	$72	$ —	$72

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The following table summarizes fair value measurements by level at December 31, 2016, for assets and liabilities measured at fair value on a recurring basis ($ in millions):

	Level I	Level II	Level III	Total
Assets				
Cash and cash equivalents	$3,930	$—	$ —	$3,930
Investments available for sale:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$221	$15	$ —	$236
Corporate securities	—	1,932	—	1,932
Municipal securities	—	1,733	—	1,733
Asset-backed securities	—	317	—	317
Residential mortgage-backed securities	—	215	—	215
Commercial mortgage-backed securities	—	338	—	338
Total investments	$221	$4,550	$ —	$4,771
Restricted deposits available for sale:				
Cash and cash equivalents	$6	$—	$ —	$6
Certificates of deposit	5	—	—	5
U.S. Treasury securities and obligations of U.S. government corporations and agencies	127	—	—	127
Total restricted deposits	$138	$—	$ —	$138
Other long-term assets:				
Interest rate swap agreements	$—	$4	$ —	$4
Total assets at fair value	$4,289	$4,554	$ —	$8,843
Liabilities				
Other long-term liabilities:				
Interest rate swap agreements	$—	$62	$ —	$62
Total liabilities at fair value	$—	$62	$ —	$62

The Company periodically transfers U.S. Treasury securities and obligations of U.S. government corporations and agencies between Level I and Level II fair value measurements dependent upon the level of trading activity for the specific securities at the measurement date. The Company's policy regarding the timing of transfers between Level I and Level II is to measure and record the transfers at the end of the reporting period. At March 31, 2017, there were $4 million of transfers from Level I to Level II and $15 million of transfers from Level II to Level I. The Company utilizes matrix pricing services to estimate fair value for securities which are not actively traded on the measurement date. The Company designates these securities as Level II fair value measurements. The aggregate carrying amount of the Company's life insurance contracts and other non-majority owned investments, which approximates fair value, was $291 million and $279 million as of March 31, 2017 and December 31, 2016, respectively.

4. Medical Claims Liability

In January 2017, the Company reclassified Cenpatico Behavioral Health of Arizona, LLC and the related Cenpatico Integrated Care health plan from the Specialty Services segment to the Managed Care segment due to a reorganization of the Arizona management structure following the Health Net integration. As a result, the financial results of Cenpatico Behavioral Health of Arizona, LLC and the related Cenpatico Integrated Care health plan have been reclassified from the Specialty Services segment to the Managed Care segment for all periods presented. Due to this change in segment reporting, the Specialty Services segment now has an insignificant amount of medical claims liability and therefore disclosures related to medical claims liabilities have been aggregated and are presented on a consolidated basis.

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The following table summarizes the change in medical claims liability ($ in millions):

	Three Months Ended March 31,	
	2017	2016
Balance, January 1	$3,929	$2,298
Less: Reinsurance Recoverable	5	—
Balance, January 1, net	3,924	2,298
Acquisitions	—	1,370
Incurred related to:		
Current year	9,557	5,478
Prior years	(235)	(167)
Total incurred	9,322	5,311
Paid related to:		
Current year	5,973	3,391
Prior years	2,991	1,725
Total paid	8,964	5,116
Balance at March 31, net	4,282	3,863
Plus: Reinsurance Recoverable	8	—
Balance, March 31	$4,290	$3,863

Reinsurance recoverables related to medical claims are included in premium and related receivables. Changes in estimates of incurred claims for prior years are primarily attributable to reserving under moderately adverse conditions. Additionally, as a result of minimum HBR and other return of premium programs, approximately $3 million and $17 million of the "Incurred related to: Prior years" was recorded as a reduction to premium revenues in the three months ended March 31, 2017 and 2016, respectively.

Incurred but not reported (IBNR) plus expected development on reported claims as of March 31, 2017 was $3,288 million. Total IBNR plus expected development on reported claims represents estimates for claims incurred but not reported, development on reported claims, and estimates for the costs necessary to process unpaid claims at the end of each period. We estimate our liability using actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. These actuarial methods consider factors such as historical data for payment patterns, cost trends, product mix, seasonality, utilization of healthcare services and other relevant factors.

5. Affordable Care Act

The Affordable Care Act (ACA) established risk spreading premium stabilization programs effective January 1, 2014. These programs, commonly referred to as the “three Rs,” include a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridor program. Additionally, the ACA established a minimum annual medical loss ratio (MLR) and cost sharing reductions. Each of the three R programs are taken into consideration to determine if the Company’s estimated annual medical costs are less than the minimum loss ratio and require an adjustment to Premium revenue to meet the minimum MLR. The 2016 benefit year was the final year for transitional reinsurance and risk corridor. No additional balances were recorded for the 2017 benefit year for these programs.

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

	March 31, 2017	December 31, 2016
Risk adjustment	$ (735)	$ (425)
Reinsurance	90	122

Risk corridor	(5)	(3)
Minimum MLR	(13)	(18)
Cost sharing reductions	(199)	(147)

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6. Debt

Debt consists of the following ($ in millions):

	March 31, 2017	December 31, 2016
$1,400 million 5.625% Senior notes, due February 15, 2021	$ 1,400	$ 1,400
$1,000 million 4.75% Senior notes, due May 15, 2022	1,008	1,008
$1,000 million 6.125% Senior notes, due February 15, 2024	1,000	1,000
$1,200 million 4.75% Senior notes, due January 15, 2025	1,200	1,200
Fair value of interest rate swap agreements	(69)	(58)
Total senior notes	4,539	4,550
Revolving credit agreement	100	100
Mortgage notes payable	63	64
Capital leases and other	18	18
Debt issuance costs	(73)	(77)
Total debt	4,647	4,655
Less current portion	(4)	(4)
Long-term debt	$ 4,643	$ 4,651

Senior Notes

The indentures governing the senior notes listed in the table above, contain non-financial and financial covenants of Centene Corporation, including requirements of a minimum fixed charge coverage ratio. At March 31, 2017, the Company was in compliance with all covenants.

Interest Rate Swaps

In February 2017 and in connection with the November 2016 issuance of $1,200 million of 4.75% Senior Notes, due January 15, 2025 ($1,200 Million Notes), the Company entered into interest rate swap agreements for a notional amount of $600 million, at floating rates of interest based on the one month LIBOR plus 2.53%. Gains and losses due to the changes in the fair value of the interest rate swaps completely offset changes in the fair value of the hedged portion of the underlying debt and are recorded as an adjustment to the $1,200 Million Notes.

The Company uses interest rate swap agreements to convert a portion of its interest rate exposure from fixed rates to floating rates to more closely align interest expense with interest income received on its cash equivalent and variable rate investment balances. The Company has $2,700 million of notional amount of interest rate swap agreements consisting of:

•$600 million expiring on February 15, 2021;
•$500 million expiring on May 15, 2022;
•$1,000 million expiring on February 15, 2024; and
•$600 million expiring on January 15, 2025.

Under the Swap Agreements, the Company receives a fixed rate of interest and pays an average variable rate of either the three or one month LIBOR plus 3.61% adjusted monthly or quarterly, based on the terms of the individual swap agreements. At March 31, 2017, the weighted average rate was 4.62%.

The Swap Agreements are formally designated and qualify as fair value hedges and are recorded at fair value in the Consolidated Balance Sheets in other assets or other liabilities. Gains and losses due to changes in fair value of the

interest rate swap agreements completely offset changes in the fair value of the hedged portion of the underlying debt. Therefore, no gain or loss has been recognized due to hedge ineffectiveness. Offsetting changes in fair value of both the interest rate swaps and the hedged portion of the underlying debt both were recognized in interest expense in the Consolidated Statements of Operations. The Company does not hold or issue any derivative instrument for trading or speculative purposes.

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Revolving Credit Agreement

The Company has an unsecured $1,000 million revolving credit facility. Borrowings under the agreement bear interest based upon LIBOR rates, the Federal Funds Rate or the Prime Rate. The agreement has a maturity date of March 24, 2021. As of March 31, 2017, the Company had $100 million of borrowings outstanding under the agreement with a weighted average interest rate of 4.5%.

The revolving credit facility contains non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios and maximum debt-to-EBITDA ratios. The Company is required to not exceed a maximum debt-to-EBITDA ratio of 3.0 to 1.0 on and subsequent to December 31, 2016. As of March 31, 2017, there were no limitations on the availability under the revolving credit agreement as a result of the debt-to-EBITDA ratio, and the Company was in compliance with all covenants.

Letters of Credit & Surety Bonds

The Company had outstanding letters of credit of $71 million as of March 31, 2017, which were not part of the revolving credit facility. The Company also had letters of credit for $45 million (valued at March 31, 2017 conversion rate), or €42 million, representing its proportional share of the letters of credit issued to support Ribera Salud's outstanding debt, which are a part of the revolving credit facility. Collectively, the letters of credit bore interest at 1.42% as of March 31, 2017. The Company had outstanding surety bonds of $397 million as of March 31, 2017.

7. Earnings Per Share

The following table sets forth the calculation of basic and diluted net earnings (loss) per common share ($ in millions, except per share data):

	Three Months Ended March 31,	
	2017	2016
Earnings (loss) attributable to Centene Corporation:		
Earnings (loss) from continuing operations, net of tax	$139	$ (15)
Discontinued operations, net of tax	—	(1)
Net earnings (loss)	$139	$ (16)
Shares used in computing per share amounts:		
Weighted average number of common shares outstanding	172,071,268	126,843,076
Common stock equivalents (as determined by applying the treasury stock method)	3,762,322	
Weighted average number of common shares and potential dilutive common shares outstanding	175,833,590	126,843,076
Net earnings (loss) per common share attributable to Centene Corporation:		
Basic:		
Continuing operations	$0.81	$ (0.12)
Discontinued operations	—	(0.01)
Basic earnings (loss) per common share	$0.81	$ (0.13)
Diluted:		
Continuing operations	$0.79	$ (0.12)
Discontinued operations	—	(0.01)
Diluted earnings (loss) per common share	$0.79	$ (0.13)

The calculation of diluted earnings (loss) per common share for the three months ended March 31, 2017 and 2016 excludes the impact of 55,170 and 6,742,714 shares (before application of the treasury stock method), respectively, related to anti-dilutive stock options, restricted stock and restricted stock units.

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8. Segment Information

Centene operates in two segments: Managed Care and Specialty Services. The Managed Care segment consists of Centene's health plans including all of the functions needed to operate them. The Specialty Services segment consists of Centene's specialty companies offering auxiliary healthcare services and products.

In January 2017, the Company reclassified Cenpatico Behavioral Health of Arizona, LLC and the related Cenpatico Integrated Care health plan from the Specialty Services segment to the Managed Care segment due to a reorganization of the Arizona management structure following the Health Net integration. As a result, the financial results of Cenpatico Behavioral Health of Arizona, LLC and the related Cenpatico Integrated Care health plan have been reclassified from the Specialty Services segment to the Managed Care segment for all periods presented.

Segment information for the three months ended March 31, 2017, follows ($ in millions):

	Managed Care	Specialty Services	Eliminations	Consolidated Total
Total revenues from external customers	$ 11,115	$ 609	$ —	$ 11,724
Total revenues from internal customers	11	2,333	(2,344)	—
Total revenues	$ 11,126	$ 2,942	$ (2,344)	$ 11,724
Earnings from operations	$ 187	$ 53	$ —	$ 240

Segment information for the three months ended March 31, 2016, follows ($ in millions):

	Managed Care	Specialty Services	Eliminations	Consolidated Total
Total revenues from external customers	$ 6,517	$ 436	$ —	$ 6,953
Total revenues from internal customers	34	1,448	(1,482)	—
Total revenues	$ 6,551	$ 1,884	$ (1,482)	$ 6,953
Earnings (loss) from operations	$ (19)	$ 39	$ —	$ 20

9. Contingencies

Overview

The Company records reserves and accrues costs for certain legal proceedings and regulatory matters to the extent that it determines an unfavorable outcome is probable and the amount of the loss can be reasonably estimated. While such reserves and accrued costs reflect the Company's best estimate of the probable loss for such matters, the recorded amounts may differ materially from the actual amount of any such losses. In some cases, no estimate of the possible loss or range of loss in excess of amounts accrued, if any, can be made because of the inherently unpredictable nature of legal and regulatory proceedings, which may be exacerbated by various factors, including but not limited to, they may involve indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or legal uncertainties; involve disputed facts; represent a shift in regulatory policy; involve a large number of parties, claimants or regulatory bodies; are in the early stages of the proceedings; involve a number of separate proceedings and/or a wide range of potential outcomes; or result in a change of business practices.

As of the date of this report, amounts accrued for legal proceedings and regulatory matters were not material. However, it is possible that in a particular quarter or annual period the Company's financial condition, results of operations, cash flow and/or liquidity could be materially adversely affected by an ultimate unfavorable resolution of or development in legal and/or regulatory proceedings, including as described below. Except for the proceedings discussed below, the Company believes that the ultimate outcome of any of the regulatory and legal proceedings that are currently pending against it should not have a material adverse effect on financial condition, results of operations,

cash flow or liquidity.

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California

The Company's California subsidiary, Health Net of California, Inc. (Health Net California), has been named as a defendant in a California taxpayer action filed in Los Angeles County Superior Court, captioned as Michael D. Myers v. State Board of Equalization, et al., Los Angeles Superior Court Case No. BS158655. This action is brought under a California statute that permits an individual taxpayer to sue a governmental agency when the taxpayer believes the agency has failed to enforce governing law. Plaintiff contends that Health Net California, a California licensed Health Care Service Plan (HCSP), is an “insurer” for purposes of taxation despite acknowledging it is not an “insurer” under regulatory law. Under California law, “insurers” must pay a gross premiums tax (GPT), calculated as 2.35% on gross premiums. As a licensed HCSP, Health Net California has paid the California Corporate Franchise Tax (CFT), the tax generally paid by California businesses. Plaintiff contends that Health Net California must pay the GPT rather than the CFT. Plaintiff seeks a writ of mandate directing the California taxing agencies to collect the GPT, and seeks an order requiring Health Net California to pay GPT, interest and penalties for a period dating to eight years prior to the October 20, 2015 filing of the complaint. This lawsuit is being coordinated with similar lawsuits filed against other entities. The Company expects an initial status conference shortly. The Company intends to vigorously defend itself against these claims; however, this matter is subject to many uncertainties, and an adverse outcome in this matter could potentially have a materially adverse impact on our financial position and results of operations.

Federal Securities Class Action

On November 14, 2016, a putative federal securities class action was filed against the Company and certain of its executives in the U.S. District Court for the Central District of California. On March 1, 2017, the court entered an order transferring the matter to the U.S. District Court for the Eastern District of Missouri. The plaintiffs in the lawsuit allege that the Company's accounting and related disclosures for certain liabilities acquired in the acquisition of Health Net violated federal securities laws. The Company denies any wrongdoing and is vigorously defending itself against these claims. Nevertheless, this matter is subject to many uncertainties and the Company cannot predict how long this litigation will last or what the ultimate outcome will be, and an adverse outcome in this matter could potentially have a materially adverse impact on our financial position and results of operations.

Civil Investigative Demand

On December 15, 2016, a Civil Investigative Demand (CID) was issued to Health Net by the United States Department of Justice regarding Health Net’s submission of risk adjustment claims to the CMS under Parts C and D of Medicare. The CID may be related to a federal qui tam lawsuit filed under seal in 2011 naming more than a dozen health insurers including Health Net. The lawsuit was recently unsealed when the Department of Justice intervened in the case with respect to one of the insurers (not Health Net). The Company is complying with the CID and will vigorously defend any lawsuits. At this point, it is not possible to determine what level of liability, if any, the Company may face as a result of this matter.

Guaranty Fund Assessment

Under state guaranty association laws, certain insurance companies can be assessed for certain obligations to the policyholders and claimants of impaired or insolvent insurance companies that write the same line or similar lines of business. In 2009, the Pennsylvania Insurance Commissioner placed long-term care insurer Penn Treaty Network America Insurance Company and its subsidiary (Penn Treaty), neither of which is affiliated with the Company, in rehabilitation and petitioned a state court for approval to liquidate Penn Treaty. In March 2017, the court issued the final liquidation order, and as a result, in the three months ended March 31, 2017, the Company recognized $47 million representing its undiscounted estimated share of the guaranty association assessment as selling, general and administrative expenses.

Miscellaneous Proceedings

Excluding the matters discussed above, the Company is also routinely subjected to legal and regulatory proceedings in the normal course of business. These matters can include, without limitation:

- periodic compliance and other reviews and investigations by various federal and state regulatory agencies with respect to requirements applicable to the Company's business, including, without limitation, those related to payment of out-of-network claims, submissions to CMS for risk adjustment payments or the False Claims Act, pre-authorization penalties, timely review of grievances and appeals, timely and accurate payment of claims, and the Health Insurance Portability and Accountability Act of 1996;

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- litigation arising out of general business activities, such as tax matters, disputes related to health care benefits coverage or reimbursement, putative securities class actions and medical malpractice, privacy, real estate, intellectual property and employment-related claims;
- disputes regarding reinsurance arrangements, claims arising out of the acquisition or divestiture of various assets, class actions and claims relating to the performance of contractual and non-contractual obligations to providers, members, employer groups and others, including, but not limited to, the alleged failure to properly pay claims and challenges to the manner in which the Company processes claims, and claims alleging that the Company has engaged in unfair business practices.

Among other things, these matters may result in awards of damages, fines or penalties, which could be substantial, and/or could require changes to the Company's business. The Company intends to vigorously defend itself against the miscellaneous legal and regulatory proceedings to which it is currently a party; however, these proceedings are subject to many uncertainties. In some of the cases pending against the Company, substantial non-economic or punitive damages are being sought.

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ITEM 2. Management’s Discussion and Analysis of Financial Condition and Results of Operations.

The following discussion of our financial condition and results of operations should be read in conjunction with our consolidated financial statements and the related notes included elsewhere in this filing. The discussion contains forward-looking statements that involve known and unknown risks and uncertainties, including those set forth under Part II, Item 1A. “Risk Factors” of this Form 10-Q. The following discussion and analysis, with the exception of cash flow information, is presented in the context of continuing operations unless otherwise identified.

EXECUTIVE OVERVIEW

General

We are a diversified, multi-national healthcare enterprise that provides services to government sponsored and commercial healthcare programs, focusing on under-insured and uninsured individuals. We provide member-focused services through locally based staff by assisting in accessing care, coordinating referrals to related health and social services and addressing member concerns and questions.

Results of operations depend on our ability to manage expenses associated with health benefits (including estimated costs incurred) and selling, general and administrative (SG&A) costs. We measure operating performance based upon two key ratios. The health benefits ratio (HBR) represents medical costs as a percentage of premium revenues, excluding premium tax and health insurer fee revenues that are separately billed, and reflects the direct relationship between the premium received and the medical services provided. The SG&A expense ratio represents SG&A costs as a percentage of premium and service revenues, excluding premium tax and health insurer fee revenues that are separately billed.

Health Net Acquisition

On March 24, 2016, the Company acquired all of the issued and outstanding shares of Health Net, a publicly traded managed care organization that delivers healthcare services through health plans and government-sponsored managed care plans. The transaction was valued at $6.0 billion, including the assumption of debt. The acquisition allows the Company to offer a more comprehensive and scalable portfolio of solutions and provides opportunity for additional growth across the combined company's markets. Due to the size of this acquisition, the primary drivers of the quarter over quarter variances discussed throughout this section are related to the acquisition of Health Net.

Regulatory Trends and Uncertainties

The U.S. Presidential administration and certain members of Congress had affirmatively indicated that they will pursue full repeal of or significant amendment to the Affordable Care Act (ACA). However, in the first quarter of 2017, the House Republican leaders retracted the legislation to repeal the ACA from consideration by the House of Representatives due to concerns that the bill would not pass. Overall, the impact of the new U.S. Presidential administration is not yet clear. There are various contingents within Congress with varying agendas, and it will take time to see if any resolution can be reached. There are still discussions of a repeal and replace bill, but the ultimate outcome remains uncertain. Even if the ACA is not amended or repealed, the new administration could propose changes impacting implementation of the ACA. We continue to believe we have both the capacity and capability to successfully navigate industry changes to the benefit of our members, customers and shareholders.

For additional information regarding regulatory trends and uncertainties, see Part II, Item 1A, "Risk Factors."

First Quarter 2017 Highlights

Our financial performance for the first quarter of 2017 are summarized as follows:

- Managed care membership of 12.1 million, an increase of 605,000 members, or 5% year over year.
- Total revenues of $11.7 billion, representing 69% growth year over year.
- Health benefits ratio of 87.6%, compared to 88.7% in 2016.
- SG&A expense ratio of 9.8%, or 9.3% excluding the Penn Treaty assessment and Health Net acquisition related expenses, for the first quarter of 2017, compared to 11.3%, or 8.3% excluding Health Net acquisition related expenses, in the first quarter of 2016.
- Operating cash flows of $1,248 million.

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- Diluted earnings (loss) per share (EPS) for the first quarter of 2017 of $0.79, compared to $(0.12) for the first quarter of 2016.
- Adjusted Diluted EPS for the first quarter of 2017 of $1.12, compared to $0.74 for the first quarter of 2016.

Adjusted Diluted EPS is highlighted below and additional detail is provided above under the heading "Non-GAAP Financial Presentation":

	Three Months Ended March 31,	
	2017	2016
GAAP diluted EPS	$0.79	$(0.12)
Amortization of acquired intangible assets	0.14	0.04
Health Net acquisition related expenses	0.02	0.82
Penn Treaty assessment expense	0.17	—
Adjusted Diluted EPS from continuing operations	$1.12	$0.74

In the three months ended March 31, 2017, we recognized $47 million for our estimated share of the undiscounted guaranty association assessment resulting from a court ordered liquidation of the Pennsylvania based Penn Treaty Network America Insurance Company and its subsidiary (Penn Treaty) as SG&A expenses.

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

- Arizona. In January 2017, we continued our participation as a qualified health plan issuer in the Arizona Health Insurance Marketplace and exited the Health Net preferred provider organization offerings in Arizona.

- Centurion. In April 2016, Centurion began providing correctional healthcare services for the Florida Department of Corrections in Regions 1, 2 and 3. In June 2016, Centurion began operating under two new contracts with the State of New Mexico Corrections Department to provide correctional medical healthcare services and pharmacy services.

- Health Insurance Marketplace. In January 2017, we added over 500,000 new members across our Health Insurance Marketplace service areas.

- Health Net. On March 24, 2016, we acquired all of the issued and outstanding shares of Health Net for approximately $6.0 billion, including the assumption of debt. This strategic acquisition broadened our service offerings, providing expansion in both Medicaid and Medicare programs. This acquisition provided further diversification across our markets and products through the addition of commercial products and government sponsored care under federal contracts with the Department of Defense (DoD) and the U.S. Department of Veteran's Affairs (VA), as well as Medicare Advantage. Health Net's operations are primarily concentrated in the states of California, Arizona, Oregon, and Washington.

- Indiana. In January 2017, our Indiana subsidiary, Managed Health Services, began operating under a contract with the Indiana Family & Social Services Administration to provide risk-based managed care services for enrollees in the Healthy Indiana Plan and Hoosier Healthwise programs.

- Louisiana. In July 2016, our Louisiana subsidiary, Louisiana Healthcare Connections began serving Medicaid expansion members.

- Nebraska. In January 2017, our Nebraska subsidiary, Nebraska Total Care, began operating under a contract with the Nebraska Department of Health and Human Services' Division of Medicaid and Long Term Care as one of three managed care organizations to administer its new Heritage Health Program for Medicaid, ABD, CHIP, Foster Care

and LTC enrollees.

- Texas. In November 2016, our Texas subsidiary, Superior HealthPlan, Inc., began operating under a new contract with the Texas HHSC to serve STAR Kids Medicaid population in seven delivery areas, more than any other successful bidder.

- Washington. In April 2016, our Washington subsidiary, Coordinated Care of Washington, began operating as the sole contractor with the Washington State Health Care Authority to provide foster care services through the Apple Health Foster Care contract.

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

- We expect to realize the full year benefit in 2017 from the Health Net acquisition completed on March 24, 2016.

- We expect to realize the full year benefit in 2017 of business commenced during 2016 in Florida, Louisiana, New Mexico, Texas and Washington, and Health Insurance Marketplace membership growth in January 2017, as discussed above.

- In January 2017, we signed a joint venture agreement with the North Carolina Medical Society, working in conjunction with the North Carolina Community Health Center, to collaborate on a patient-focused approach to Medicaid under the reform plan enacted in the State of North Carolina. The newly created health plan, Carolina Complete Health, was created to establish, organize and operate a physician-led health plan to provide Medicaid managed care services in North Carolina.

- In January 2017, our Pennsylvania subsidiary, Pennsylvania Health & Wellness, was selected by the Pennsylvania Department of Human Services to serve Medicaid recipients enrolled in the HealthChoices program in three zones. Expected contract commencement dates vary by zone, starting January 2018, and will be fully implemented by January 2019, pending regulatory approval and successful completion of a readiness review.

- In November 2016, our Georgia subsidiary, Peach State Health Plan, was awarded a statewide managed care contract to continue serving members enrolled in the Georgia Families managed care program, including PeachCare for Kids and Planning for Healthy Babies. Through the new contract, Peach State Health Plan will be one of four managed care organizations providing medical, behavioral, dental and vision health benefits for its members. The contract is expected to become effective July 1, 2017.

- In November 2016, our Nevada subsidiary, Silver Summit Health Plan, was selected to serve Medicaid recipients enrolled in Nevada's Medicaid managed care program. The contract is expected to commence on July 1, 2017, pending regulatory approval and successful completion of a readiness review.

- In October 2016, our Missouri subsidiary, Home State Health, was selected to provide managed care services to MO HealthNet Managed Care beneficiaries. Under the new contract, Home State Health expects to serve MO HealthNet Managed Care beneficiaries in each of the state's 114 counties and the city of St. Louis. The contract is expected to commence May 1, 2017.

- In August 2016, our Pennsylvania subsidiary, Pennsylvania Health & Wellness, was selected by the Pennsylvania Department of Human Services to serve enrollees in the Community HealthChoices program statewide. Expected contract commencement dates vary by zone, starting January 2018, and will be fully implemented by January 2019, pending regulatory approval and successful completion of a readiness review.

- In July 2016, it was announced that the Department of Defense awarded our wholly-owned subsidiary, Health Net Federal Services, the TRICARE West Region contract. We currently administer services for the TRICARE program in the North Region. In connection with this latest generation of TRICARE contracts, the Department of Defense has consolidated the prior North, South and West TRICARE regions into two: the West and East Regions (the East combining the current North and South Regions). We expect health care delivery for this new contract to begin on January 1, 2018.

- In May 2016, our specialty solutions subsidiary, Envolve, Inc., was selected by Maryland Care Inc. d/b/a Maryland Physicians Care MCO to provide health plan management services for its Medicaid operations in Maryland effective

July 1, 2017.

In February 2017, our Alabama subsidiary withdrew our contracts with five nonprofit regional care organizations in Alabama to provide management services due to uncertainty in the political environment. Subsequent to our withdrawal, the governor of Alabama resigned.

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MEMBERSHIP

From March 31, 2016 to March 31, 2017, we increased our managed care membership by 605,000, or 5%. The following table sets forth the Company's membership by state for its managed care organizations:

	March 31, 2017	December 31, 2016	March 31, 2016
Arizona	684,300	598,300	607,000
Arkansas	98,100	58,600	50,700
California	2,980,100	2,973,500	3,125,400
Florida	872,000	716,100	660,800
Georgia	568,300	488,000	495,500
Illinois	253,800	237,700	239,100
Indiana	335,800	285,800	290,300
Kansas	133,100	139,700	141,100
Louisiana	484,100	472,800	381,200
Massachusetts	44,200	48,300	52,400
Michigan	2,100	2,000	2,600
Minnesota	9,500	9,400	9,500
Mississippi	349,500	310,200	328,300
Missouri	106,100	105,700	100,000
Nebraska	79,200	—	—
New Hampshire	77,800	77,400	81,500
New Mexico	7,100	7,100	—
Ohio	328,900	316,000	314,000
Oregon	211,900	217,800	209,000
South Carolina	121,900	122,500	107,700
Tennessee	21,900	21,700	20,100
Texas	1,243,900	1,072,400	1,036,700
Vermont	1,600	1,600	1,500
Washington	254,400	238,400	226,500
Wisconsin	71,700	73,800	78,400
Total at-risk membership	9,341,300	8,594,800	8,559,300
TRICARE eligibles	2,804,100	2,847,000	2,819,700
Non-risk membership	—	—	161,400
Total	12,145,400	11,441,800	11,540,400

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

	March 31, 2017	December 31, 2016	March 31, 2016
Medicaid:			
TANF, CHIP & Foster Care	5,714,100	5,630,000	5,464,200
ABD & LTC	825,600	785,400	757,600
Behavioral Health	466,900	466,600	456,500
Commercial	1,864,700	1,239,100	1,487,900
Medicare & Duals [(1)]	328,100	334,300	334,100
Correctional	141,900	139,400	59,000
Total at-risk membership	9,341,300	8,594,800	8,559,300
TRICARE eligibles	2,804,100	2,847,000	2,819,700
Non-risk membership	—	—	161,400

Total	12,145,400	11,441,800	11,540,400

(1) Membership includes Medicare Advantage, Medicare Supplement, Special Needs Plans, and Medicare-Medicaid Plans.

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The following table sets forth additional membership statistics, which are included in the membership information above:

	March 31, 2017	March 31, 2016
Dual-eligible	458,700	435,100
Health Insurance Marketplace	1,188,700	683,000
Medicaid Expansion	1,091,300	984,900

RESULTS OF OPERATIONS

The following discussion and analysis is based on our Consolidated Statements of Operations, which reflect our results of operations for the three months ended March 31, 2017 and 2016, prepared in accordance with generally accepted accounting principles in the United States.

Summarized comparative financial data for the three months ended March 31, 2017 and 2016 is as follows ($ in millions, except per share data):

	Three Months Ended March 31,		
	2017	2016	% Change 2016-2017
Premium	$10,638	$5,986	78 %
Service	527	425	24 %
Premium and service revenues	11,165	6,411	74 %
Premium tax and health insurer fee	559	542	3 %
Total revenues	11,724	6,953	69 %
Medical costs	9,322	5,311	76 %
Cost of services	441	367	20 %
Selling, general and administrative expenses	1,091	722	51 %
Amortization of acquired intangible assets	40	9	344 %
Premium tax expense	590	450	31 %
Health insurer fee expense	—	74	(100)%
Earnings from operations	240	20	n.m.
Investment and other income (expense), net	(21)	(18)	(17)%
Earnings from continuing operations, before income tax expense	219	2	n.m.
Income tax expense	87	16	444 %
Earnings (loss) from continuing operations, net of income tax expense	132	(14)	n.m.
Discontinued operations, net of income tax (benefit)	—	(1)	100 %
Net earnings (loss)	132	(15)	n.m.
(Earnings) loss attributable to noncontrolling interests	7	(1)	n.m.
Net earnings (loss) attributable to Centene Corporation	$139	$(16)	n.m.
Amounts attributable to Centene Corporation common shareholders:			
Earnings (loss) from continuing operations, net of income tax expense	$139	$(15)	n.m.
Discontinued operations, net of income tax (benefit)	—	(1)	100 %
Net earnings (loss)	$139	$(16)	n.m.
Diluted earnings (loss) per common share attributable to Centene Corporation:			
Continuing operations	$0.79	$(0.12)	n.m.
Discontinued operations	—	(0.01)	100 %

Total diluted earnings (loss) per common share	$0.79	$(0.13)	n.m.

n.m.: not meaningful

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Three Months Ended March 31, 2017 Compared to Three Months Ended March 31, 2016

Total Revenues

Total revenues increased 69% in the three months ended March 31, 2017 over the corresponding period in 2016 primarily due to the acquisition of Health Net, as well as the impact from expansions and new programs in many of our states in 2016 and 2017, and growth in the Health Insurance Marketplace business in 2017. During the three months ended March 31, 2017, we received premium rate adjustments which yielded a net 1% composite change across all of our markets.

Operating Expenses

Medical Costs

Results of operations depend on our ability to manage expenses associated with health benefits and to accurately estimate costs incurred. The health benefits ratio, or HBR, represents medical costs as a percentage of premium revenues (excluding premium tax and health insurer fee revenues) and reflects the direct relationship between the premium received and the medical services provided.

The HBR for the three months ended March 31, 2017 was 87.6%, compared to 88.7% in the same period in 2016. The decrease compared to last year is primarily attributable to the acquisition of Health Net, which operates at a lower HBR due to a greater mix of commercial business and growth in the Health Insurance Marketplace business in 2017.

Cost of Services

Cost of services increased by $74 million in the three months ended March 31, 2017, compared to the corresponding period in 2016. This was primarily due to the acquisition of Health Net and growth in our correctional business, partially offset by lower pharmacy sales to external customers. The cost of service ratio for the three months ended March 31, 2017, was 83.7%, compared to 86.4% in the same period in 2016.

Selling, General & Administrative Expenses

Selling, general and administrative expenses, or SG&A, increased by $369 million in the three months ended March 31, 2017, compared to the corresponding period in 2016. This was primarily due to the acquisition of Health Net as well as the impact from expansions and new programs in many of our states in 2016 and 2017, partially offset by a reduction in Health Net acquisition related expenses. In addition, in the three months ended March 31, 2017, we recognized $47 million for our estimated share of the undiscounted guaranty association assessment resulting from the liquidation of Penn Treaty.

The SG&A expense ratio was 9.8%, or 9.3% excluding the Penn Treaty assessment and Health Net acquisition related expenses, for the first quarter of 2017, compared to 11.3%, or 8.3% excluding Health Net acquisition related expenses, in the first quarter of 2016. The increase in the SG&A expense ratio excluding the Penn Treaty assessment and Health Net acquisition related expenses is primarily attributable to the addition of the Health Net business, which operates at a higher SG&A ratio due to a greater mix of commercial and Medicare business.

Health Insurer Fee Expense

Due to the health insurer fee moratorium, which suspended the health insurance provider fee for the 2017 calendar year, we did not record health insurer fee expense for the three months ended March 31, 2017, compared to $74

million for the three months ended March 31, 2016.

Other Income (Expense)

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

	2017	2016
Investment and other income	$41	$15
Interest expense	(62)	(33)
Other income (expense), net	$(21)	$(18)

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The increase in investment income in 2017 reflects an increase in investment balances over 2016. Interest expense increased in 2017 compared to 2016, reflecting the issuance of an additional $2,400 million in Senior Notes in February 2016 in connection with the financing of the Health Net transaction, the issuance of an additional $500 million in Senior Notes in June 2016, and the issuance of the $1,200 million in Senior Notes in November 2016. These increases were partially offset by the redemption of the $425 million 5.75% Senior Notes in November 2016.

Income Tax Expense

For the three months ended March 31, 2017, we recorded income tax expense of $87 million on pre-tax earnings of $219 million, or an effective tax rate of 39.7%. The current quarter effective tax rate reflects the impact of the health insurer fee moratorium. For the three months ended March 31, 2016, we recorded income tax expense of $16 million on pre-tax earnings of $2 million, primarily as a result of the non-deductibility of the health insurer fee expense as well as the non-deductibility of certain acquisition costs incurred in connection with the closing of our acquisition of Health Net.

Segment Results

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

	2017	2016	% Change 2016-2017
Total Revenues			
Managed Care	$11,126	$6,551	70 %
Specialty Services	2,942	1,884	56 %
Eliminations	(2,344)	(1,482)	(58)%
Consolidated Total	$11,724	$6,953	69 %
Earnings (loss) from Operations			
Managed Care	$187	$(19)	n.m.
Specialty Services	53	39	36 %
Consolidated Total	$240	$20	n.m.

In January 2017, we reclassified Cenpatico Behavioral Health of Arizona, LLC and the related Cenpatico Integrated Care health plan from the specialty segment to the Managed Care segment due to a reorganization of the Arizona management structure following the Health Net integration. As a result, the financial results of Cenpatico Behavioral Health of Arizona, LLC and the related Cenpatico Integrated Care health plan have been reclassified from the Specialty Services segment to the Managed Care segment for all periods presented.

Managed Care

Total revenues increased 70% in the three months ended March 31, 2017, compared to the corresponding period in 2016, primarily as a result of the acquisition of Health Net, as well as expansions, new programs and growth in many of our states, particularly Florida, Georgia, Louisiana, Nebraska, and Texas. Earnings from operations increased $206 million between years primarily reflecting the impact of the Health Net acquisition, including decreased acquisition related expenses in 2017, partially offset by the Penn Treaty assessment expense and increased amortization expense incurred in the first quarter of 2017.

Specialty Services

Total revenues increased 56% in the three months ended March 31, 2017, compared to the corresponding period in 2016, resulting primarily from the acquisition of Health Net, growth in our correctional services business, and increased services associated with membership growth in the Managed Care segment. Earnings from operations increased $14 million in the three months ended March 31, 2017, compared to the corresponding period in 2016, primarily due to the acquisition of Health Net.

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LIQUIDITY AND CAPITAL RESOURCES

Shown below is a condensed schedule of cash flows used in the discussion of liquidity and capital resources ($ in millions).

	Three Months Ended March 31,	
	2017	2016
Net cash provided by operating activities	$1,248	$196
Net cash used in investing activities	(329)	(836)
Net cash (used in) provided by financing activities	(10)	2,316
Net increase in cash and cash equivalents	$909	$1,676

Cash Flows Provided by Operating Activities

Normal operations are funded primarily through operating cash flows and borrowings under our revolving credit facility. Operating activities provided cash of $1,248 million in the three months ended March 31, 2017, compared to cash provided of $196 million in the comparable period in 2016. The cash provided by operating activities in 2017 was primarily due to net earnings, an increase in medical claims liabilities resulting from growth in the Health Insurance Marketplace business and the commencement of the Nebraska health plan, an increase in other long-term liabilities driven by the recognition of risk adjustment payable for Health Insurance Marketplace in 2017 and an increase in unearned revenue primarily due to the receipt of several April capitation payments in March.

Cash flows provided by operations in 2016 was primarily related to an increase in medical claims liabilities resulting from the growth in the business and an increase in other long-term liabilities, partially offset by increases in premium and related receivables.

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

Cash Flows Used in Investing Activities

Investing activities used cash of $329 million for the three months ended March 31, 2017, and $836 million in the comparable period in 2016. Cash flows used in investing activities in 2017 primarily consisted of net additions to the investment portfolio of our regulated subsidiaries, including transfers from cash and cash equivalents to long-term investments, and capital expenditures.

Cash flows used in investing activities in 2016 primarily consisted of our acquisition of Health Net, net additions to the investment portfolio of our regulated subsidiaries, including transfers from cash and cash equivalents to long-term investments, and capital expenditures.

We spent $83 million and $45 million in the three months ended March 31, 2017 and 2016, respectively, on capital expenditures for system enhancements and market expansions.

As of March 31, 2017, our investment portfolio consisted primarily of fixed-income securities with an average duration of 3.2 years. We had unregulated cash and investments of $306 million at March 31, 2017, compared to $264 million at December 31, 2016.

Cash Flows (Used in) Provided by Financing Activities

Our financing activities used cash of $10 million in the three months ended March 31, 2017, compared to providing cash of $2,316 million in the comparable period in 2016. During 2017, our net financing activities primarily related to common stock repurchases resulting from stock relinquished to us by employees for payment of taxes upon vesting of restricted stock units.

During 2016, our financing activities primarily related to the proceeds from the issuance of Senior Notes associated with the Health Net acquisition.

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In February 2016, our wholly owned unrestricted subsidiary (Escrow Issuer) issued $1,400 million of 5.625% Senior Notes ($1,400 Million Notes) at par due 2021 and $1,000 million of 6.125% Senior Notes ($1,000 Million Notes) at par due 2024. We used the net proceeds of the offering, together with borrowings under the our new $1,000 million revolving credit facility and cash on hand, to fund the cash consideration for the Health Net acquisition and to pay acquisition and offering related fees and expenses. In connection with the February 2016 issuance, we entered into interest rate swap agreements for notional amounts of $600 million and $1,000 million, at floating rates of interest based on the three month LIBOR plus 4.22% and the three month LIBOR plus 4.44%, respectively. Gains and losses due to changes in the fair value of the interest rate swaps completely offset changes in the fair value of the hedged portion of the underlying debt and are recorded as an adjustment to the $1,400 Million Notes and $1,000 Million Notes.

In connection with the closing of the Health Net acquisition on March 24, 2016, our then-existing unsecured $500 million revolving credit facility was terminated and simultaneously replaced with a new $1,000 million unsecured revolving credit facility (Revolving Credit Facility). Borrowings under the agreement bear interest based upon LIBOR rates, the Federal Funds Rate or the Prime Rate. The agreement has a maturity date of March 24, 2021.

Liquidity Metrics

The credit agreement underlying our Revolving Credit Facility contains non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios and maximum debt-to-EBITDA ratios. We are required to not exceed a maximum debt-to-EBITDA ratio of 3.0 to 1.0 on and subsequent to December 31, 2016. As of March 31, 2017, we had $100 million in borrowings outstanding under our revolving credit facility, and we were in compliance with all covenants. As of March 31, 2017, there were no limitations on the availability under the revolving credit agreement as a result of the debt-to-EBITDA ratio.

We had outstanding letters of credit of $71 million as of March 31, 2017, which were not part of our revolving credit facility. We also had letters of credit for $45 million (valued at the March 31, 2017 conversion rate), or €42 million, representing our proportional share of the letters of credit issued to support Ribera Salud’s outstanding debt which are a part of the revolving credit facility. Collectively, the letters of credit bore weighted interest of 1.42% as of March 31, 2017. In addition, we had outstanding surety bonds of $397 million as of March 31, 2017.

The indentures governing our various maturities of senior notes contain non-financial and financial covenants of Centene Corporation, including requirements of a minimum fixed charge coverage ratio. As of March 31, 2017, we were in compliance with all covenants.

In February 2017 and in connection with the November 2016 issuance of $1,200 million of 4.75% Senior Notes, due January 15, 2025 ($1,200 Million Notes), the Company entered into interest rate swap agreements for a notional amount of $600 million, at floating rates of interest based on the one month LIBOR plus 2.53%. Gains and losses due to the changes in the fair value of the interest rate swaps completely offset changes in the fair value of the hedges portion of the underlying debt and are recorded as an adjustment to the $1,200 Million Notes.

At March 31, 2017, we had working capital, defined as current assets less current liabilities, of $206 million, compared to negative $258 million at December 31, 2016. We manage our short-term and long-term investments with the goal of ensuring that a sufficient portion is held in investments that are highly liquid and can be sold to fund short-term requirements as needed.

At March 31, 2017, our debt to capital ratio, defined as total debt divided by the sum of total debt and total equity, was 43.3%, compared to 44.1% at December 31, 2016. Excluding the $63 million non-recourse mortgage note, our debt to capital ratio was 43.0% as of March 31, 2017, compared to 43.7% at December 31, 2016. We utilize the debt to

capital ratio as a measure, among others, of our leverage and financial flexibility.

2017 Expectations

During the remainder of 2017, we expect to make net capital contributions to our insurance subsidiaries of approximately $160 million associated with our growth and spend approximately $415 million in additional capital expenditures primarily associated with system enhancements and market expansions. These amounts are expected to be funded by unregulated cash flow generation in 2017 and borrowings on our Revolving Credit Facility. However, from time to time we may elect to raise additional funds for these and other purposes, either through issuance of debt or equity, the sale of investment securities or otherwise, as appropriate. In addition, we may strategically pursue refinancing opportunities to extend maturities and/or improve terms of our indebtedness if we believe such opportunities are favorable to us.

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

REGULATORY CAPITAL AND DIVIDEND RESTRICTIONS

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

Our regulated subsidiaries are required to maintain minimum capital requirements prescribed by various regulatory authorities in each of the states in which we operate. As of March 31, 2017, our subsidiaries had aggregate statutory capital and surplus of $4,691 million, compared with the required minimum aggregate statutory capital and surplus requirements of $2,231 million. During the three months ended March 31, 2017, we received net dividends of $26 million from our regulated subsidiaries. For our subsidiaries that file with the National Association of Insurance Commissioners (NAIC), we estimate our RBC percentage to be in excess of 350% of the Authorized Control Level.

Under the California Knox-Keene Health Care Service Plan Act of 1975, as amended (“Knox-Keene”), certain of our California subsidiaries must comply with tangible net equity (TNE) requirements. Under these Knox-Keene TNE requirements, actual net worth less unsecured receivables and intangible assets must be more than the greater of (i) a fixed minimum amount, (ii) a minimum amount based on premiums or (iii) a minimum amount based on health care expenditures, excluding capitated amounts. In addition, certain of our California subsidiaries have made certain undertakings to the DMHC to restrict dividends and loans to affiliates, to the extent that the payment of such would reduce such entities' TNE below the required amount as specified in the undertaking.

The NAIC has adopted rules which set minimum risk based capital requirements for insurance companies, managed care organizations and other entities bearing risk for healthcare coverage. As of March 31, 2017, each of our health plans was in compliance with the risk-based capital requirements enacted in those states.

As a result of the above requirements and other regulatory requirements, certain of our subsidiaries are subject to restrictions on their ability to make dividend payments, loans or other transfers of cash to their parent companies. Such restrictions, unless amended or waived or unless regulatory approval is granted, limit the use of any cash generated by these subsidiaries to pay our obligations. The maximum amount of dividends that can be paid by our insurance company subsidiaries without prior approval of the applicable state insurance departments is subject to restrictions relating to statutory surplus, statutory income and unassigned surplus. As of March 31, 2017, the amount of capital and surplus or net worth that was unavailable for the payment of dividends or return of capital to us was $2,231 million in the aggregate.

RECENT ACCOUNTING PRONOUNCEMENTS

For this information, refer to Note 1, Organization and Operations, in the Notes to the Consolidated Financial Statements, included herein.

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ITEM 3. Quantitative and Qualitative Disclosures About Market Risk.

INVESTMENTS AND DEBT

As of March 31, 2017, we had short-term investments of $725 million and long-term investments of $4,776 million, including restricted deposits of $140 million. The short-term investments generally consist of highly liquid securities with maturities between three and 12 months. The long-term investments consist of municipal, corporate and U.S. Treasury securities, government sponsored obligations, life insurance contracts, asset backed securities and equity securities and have maturities greater than one year. Restricted deposits consist of investments required by various state statutes to be deposited or pledged to state agencies. Due to the nature of the states' requirements, these investments are classified as long-term regardless of the contractual maturity date. Substantially all of our investments are subject to interest rate risk and will decrease in value if market rates increase. Assuming a hypothetical and immediate 1% increase in market interest rates at March 31, 2017, the fair value of our fixed income investments would decrease by approximately $167 million. Declines in interest rates over time will reduce our investment income.

We have interest rate swap agreements for a notional amount of $2,700 million with creditworthy financial institutions to manage the impact of market interest rates on interest expense. Our swap agreements convert a portion of our interest expense from fixed to variable rates to better match the impact of changes in market rates on our variable rate cash equivalent investments. As a result, the fair value of $2,700 million of our long-term debt varies with market interest rates. Assuming a hypothetical and immediate 1% increase in market interest rates at March 31, 2017, the fair value of our debt would decrease by approximately $139 million. An increase in interest rates decreases the fair value of the debt and conversely, a decrease in interest rates increases the value.

For a discussion of the interest rate risk that our investments are subject to, see "Risk Factors – Our investment portfolio may suffer losses which could materially and adversely affect our results of operations or liquidity."

INFLATION

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

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

ITEM 4. Controls and Procedures.

Evaluation of Disclosure Controls and Procedures - We maintain disclosure controls and procedures as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (Exchange Act) that are designed to provide reasonable assurance that information required to be disclosed by us in reports that we file or submit under the Exchange Act is (i) recorded, processed, summarized and reported within the time periods specified in SEC rules and forms; and (ii) accumulated and communicated to our management, including our principal executive officer and principal financial officer, as appropriate to allow timely decisions regarding required disclosure.

In connection with the filing of this Form 10-Q, management evaluated, under the supervision and with the participation of our Chief Executive Officer and Chief Financial Officer, the effectiveness of the design and operation of our disclosure controls and procedures as of March 31, 2017. Based upon that evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective at the reasonable assurance level as of March 31, 2017.

Changes in Internal Control Over Financial Reporting - No change in our internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act) occurred during the quarter ended March 31, 2017 that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

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PART II
OTHER INFORMATION

ITEM 1. Legal Proceedings.

A description of the legal proceedings to which the Company and its subsidiaries are a party is contained in Note 9 to the consolidated financial statements included in Part I of this Quarterly Report on Form 10-Q, and is incorporated herein by reference.

ITEM 1A. Risk Factors.

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

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

Reductions in funding, changes to eligibility requirements for government sponsored healthcare programs in which we participate and any inability on our part to effectively adapt to changes to these programs could substantially affect our financial position, results of operations and cash flows.

The majority of our revenues come from government subsidized healthcare programs including Medicaid, Medicare, TRICARE, VA, CHIP, LTC, ABD, Foster Care and Health Insurance Marketplace premiums. Under most programs, the base premium rate paid for each program differs, depending on a combination of factors such as defined upper payment limits, a member's health status, age, gender, county or region and benefit mix. Since Medicaid was created in 1965, the federal government and the states have shared the costs for this program, with the federal share currently averaging around 57%. We are therefore exposed to risks associated with U.S. and state government contracting or participating in programs involving a government payor, including but not limited to the general ability of the federal and/or state government to terminate contracts with it, in whole or in part, without prior notice, for convenience or for default based on performance; potential regulatory or legislative action that may materially modify amounts owed; and our dependence upon Congressional or legislative appropriation and allotment of funds and the impact that delays in government payments could have on our operating cash flow and liquidity. For example, future levels of funding and premium rates may be affected by continuing government efforts to contain healthcare costs and may further be affected by state and federal budgetary constraints. Governments periodically consider reducing or reallocating the amount of money they spend for Medicaid, Medicare, TRICARE, VA, CHIP, LTC, ABD and Foster Care. Furthermore, Medicare remains subject to the automatic spending reductions imposed by the Budget Control Act of 2011 and the American Taxpayer Relief Act of 2012 ("sequestration"), subject to a 2% cap. In addition, reductions in defense spending could have an adverse impact on certain government programs in which we currently participate by, among other things, terminating or materially changing such programs, or by decreasing or delaying payments made under such programs. Adverse economic conditions may continue to put pressures on state budgets as tax and other state revenues decrease while the population that is eligible to participate in these programs remains steady or increases, creating more need for funding. We anticipate this will require government agencies to find funding alternatives, which may result in reductions in funding for programs, contraction of covered benefits, and limited or no premium rate increases or premium rate decreases. A reduction (or less than expected increase), a protracted delay,

or a change in allocation methodology in government funding for these programs, as well as termination of the contract for the convenience of the government, may materially and adversely affect our results of operations, financial position and cash flows. In addition, if a federal government shutdown were to occur for a prolonged period of time, federal government payment obligations, including its obligations under Medicaid, Medicare, TRICARE, VA, CHIP, LTC, ABD, Foster Care and the Health Insurance Marketplaces, may be delayed. Similarly, if state government shutdowns were to occur, state payment obligations may be delayed. If the federal or state governments fail to make payments under these programs on a timely basis, our business could suffer, and our financial position, results of operations or cash flows may be materially affected.

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There can be no assurance that we will avoid payment delays from government payors in the future, which, if extended for any significant period of time, could have a material adverse effect on our results of operations, financial position, cash flows or liquidity. In addition, delays in obtaining, or failure to obtain or maintain, governmental approvals, or moratoria imposed by regulatory authorities, could adversely affect our revenue or membership, increase costs or adversely affect our ability to bring new products to market as forecasted. Other changes to our government programs could affect our willingness or ability to participate in any of these programs or otherwise have a material adverse effect on our business, financial condition or results of operations.

Finally, changes in these programs could reduce the number of persons enrolled in or eligible for these programs or increase our administrative or healthcare costs under these programs. For example, maintaining current eligibility levels could cause states to reduce reimbursement or reduce benefits in order for states to afford to maintain eligibility levels. If any state in which we operate were to decrease premiums paid to us or pay us less than the amount necessary to keep pace with our cost trends, it could have a material adverse effect on our results of operations, financial position and cash flows.

Our Medicare programs are subject to a variety of risks that could adversely impact our financial results.

If we fail to design and maintain programs that are attractive to Medicare participants; if our Medicare operations are subject to program audits, sanctions or penalties; if we do not submit adequate bids in our existing markets or any expansion markets; if our existing contracts are terminated; or if we fail to maintain or improve our quality star ratings, our current Medicare business and our ability to expand our Medicare operations could be materially and adversely affected, negatively impacting our financial performance. There are also specific additional risks under Title XVIII, Part D of the Social Security Act associated with our provision of Medicare Part D prescription drug benefits as part of our Medicare Advantage plan offerings. These risks include potential uncollectibility of receivables, inadequacy of pricing assumptions, inability to receive and process information and increased pharmaceutical costs, as well as the underlying seasonality of this business, and extended settlement periods for claims submissions. Our failure to comply with Part D program requirements can result in financial and/or operational sanctions on our Part D products, as well as on our Medicare Advantage products that offer no prescription drug coverage.

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

Our profitability, to a significant degree, depends on our ability to estimate and effectively manage expenses related to health benefits through, among other things, our ability to contract favorably with hospitals, physicians and other healthcare providers. For example, our Medicaid revenue is often based on bids submitted before the start of the initial contract year. If our actual medical expense exceeds our estimates, our health benefits ratio (HBR), or our expenses related to medical services as a percentage of premium revenue, would increase and our profits would decline. Because of the narrow margins of our health plan business, relatively small changes in our HBR can create significant changes in our financial results. Changes in healthcare regulations and practices, the level of utilization of healthcare services, hospital and pharmaceutical costs, disasters, the potential effects of climate change, major epidemics, pandemics or newly emergent viruses, new medical technologies, new pharmaceutical compounds, increases in provider fraud and other external factors, including general economic conditions such as inflation and unemployment levels, are generally beyond our control and could reduce our ability to accurately predict and effectively control the costs of providing health benefits. In addition, the 2017 marketplace for individual products may be less stable than in 2016 because, among other things, other health plans have changed or stopped offering their Health Insurance Marketplace products in the states we expect to serve in 2017. Also, member behavior could be influenced by uncertainty of potential changes to the Patient Protection and Affordable Care Act and the accompanying Health Care and Education Affordability Reconciliation Act, collectively referred to as Affordable Care Act (ACA).

Our medical expense includes claims reported but not paid, estimates for claims incurred but not reported, and estimates for the costs necessary to process unpaid claims at the end of each period. Our development of the medical claims liability estimate is a continuous process which we monitor and refine on a monthly basis as claims receipts and payment information as well as inpatient acuity information becomes available. As more complete information becomes available, we adjust the amount of the estimate, and include the changes in estimates in medical expense in the period in which the changes are identified. Given the uncertainties inherent in such estimates, there can be no assurance that our medical claims liability estimate will be adequate, and any adjustments to the estimate may unfavorably impact our results of operations and may be material.

Additionally, when we commence operations in a new state, region or product, we have limited information with which to estimate our medical claims liability. For a period of time after the inception of the new business, we base our estimates on government-provided historical actuarial data and limited actual incurred and received claims and inpatient acuity information. The addition of new categories of eligible individuals as well as evolving Health Insurance Marketplace plans may pose difficulty in estimating our medical claims liability.

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

The implementation of the ACA, as well as potential repeal of or changes to the ACA, could materially and adversely affect our results of operations, financial position and cash flows.

In March 2010, the ACA was enacted. While the constitutionality of the ACA was generally upheld by the Supreme Court in 2012, the Court determined that states could elect to opt out of the Medicaid expansion portion of ACA without losing all federal money for their existing Medicaid programs.

Under the ACA, Medicaid coverage was expanded to all individuals under age 65 with incomes up to 138% of the federal poverty level beginning January 1, 2014, subject to each states' election. The federal government pays the entire costs for Medicaid coverage for newly eligible beneficiaries for three years (2014 through 2016). Beginning in 2017, the federal share begins to decline, ending at 90% for 2020 and subsequent years. As of March 31, 2017, 31 states and the District of Columbia have expanded Medicaid eligibility, and additional states continue to discuss expansion. The ACA also maintained CHIP eligibility standards through September 2019.

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

Any failure to adequately price products offered in the Health Insurance Marketplaces may have a negative impact on our results of operations, financial position and cash flow. Among other things, we may be adversely selected by individuals who have a higher acuity level than the anticipated pool of participants. In addition, the risk corridor, reinsurance and risk adjustment ("three Rs") provisions of the ACA established to apportion risk amongst insurers may not be effective in appropriately mitigating the financial risks related to the Marketplace product. Further, the three Rs may not be adequately funded. Moreover, changes in the competitive marketplace over time may exacerbate the uncertainty in these relatively new markets. For example, competitors seeking to gain a foothold in the changing market may introduce pricing that we may not be able to match, which may adversely affect our ability to compete effectively. Competitors may also choose to exit the market altogether or otherwise suffer financial difficulty, which could adversely impact the pool of potential insured, require us to increase premium rates or result in funding issues under the three Rs. These potential exits and other continued volatility in this market may be further exacerbated by the conclusion of the risk corridor and reinsurance programs as of January 1, 2017. Our continued success in the exchanges is dependent on our ability to successfully respond to these changes in the market over time. Any significant variation from our expectations regarding acuity, enrollment levels, adverse selection, the three Rs, or other assumptions utilized in setting adequate premium rates could have a material adverse effect on our results of operations, financial position and cash flows.

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

The ACA imposed an annual insurance industry assessment of $8.0 billion in 2014, and $11.3 billion in each of 2015 and 2016, with increasing annual amounts thereafter. The health insurer fee payable in 2017 was suspended by the Consolidated Appropriations Act for fiscal year 2016. Such assessments are not deductible for federal and most state income tax purposes. The fee is allocated based on health insurers' premium revenues in the previous year. Each health insurer's fee is calculated by multiplying its market share by the annual fee. Market share is based on commercial, Medicare, and Medicaid premium revenue. Not-for-profit insurers may have a competitive advantage since they are exempt from paying the fee if they receive at least 80% of their premium revenue from Medicare, Medicaid, and CHIP, and other not-for-profit insurers are allowed to exclude 50% of their premium revenue from the fee calculation. If we are not reimbursed by the states for the cost of the federal premium assessment (including the associated tax impact), or if we are unable to otherwise adjust our business model to address this new assessment, our results of operations, financial position and cash flows may be materially adversely affected.

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There are numerous steps regulators required for continued implementation of the ACA, including the promulgation of a substantial number of new and potentially more onerous federal regulations. For example, in April 2016, CMS issued final regulations that revised existing Medicaid managed care rules by establishing a minimum MLR standard for Medicaid of 85% and strengthening provisions related to network adequacy and access to care, enrollment and disenrollment protections, beneficiary support information, continued service during beneficiary appeals, and delivery system and payment reform initiatives, among others. If we fail to effectively implement or appropriately adjust our operational and strategic initiatives with respect to the implementation of healthcare reform, or do not do so as effectively as our competitors, our results of operations may be materially adversely affected.

In addition, the U.S. Court of Appeals for the D.C. circuit has granted a motion to put a lawsuit challenging the ACA's cost-sharing subsidies on hold until the new administration takes over. Now that the U.S. Court of Appeals has stayed the case, the new administration and Congress will decide how they want to proceed, including whether to seek policy changes such as ACA repeal or replacement that affect the issues under review in this case.

Changes to, or repeal of, the ACA, could materially and adversely affect our business and financial position, results of operations or cash flows. Even if the ACA is not amended or repealed, the new administration could propose changes impacting implementation of the ACA, which could materially and adversely affect our financial position or operations. However, the ultimate content, timing or effect of any potential future legislation enacted under the new administration cannot be predicted.

Our business activities are highly regulated and new laws or regulations or changes in existing laws or regulations or their enforcement or application could force us to change how we operate and could harm our business.

Our business is extensively regulated by the states in which we operate and by the federal government. In addition, the managed care industry has received negative publicity that has led to increased legislation, regulation, review of industry practices and private litigation in the commercial sector. Such negative publicity may adversely affect our stock price and damage our reputation in various markets.

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

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

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

Our contracts with states may require us to maintain a minimum HBR or may require us to share profits in excess of certain levels. In certain circumstances, our plans may be required to return premium back to the state in the event profits exceed established levels or HBR does not meet the minimum requirement. Other states may require us to meet

certain performance and quality metrics in order to maintain our contract or receive additional or full contractual revenue.

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

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

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

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

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

If any of our government contracts are terminated or are not renewed on favorable terms or at all, or if we receive an adverse finding or review resulting from an audit or investigation, our business may be adversely affected.

A substantial portion of our business relates to the provision of managed care programs and selected services to individuals receiving benefits under governmental assistance or entitlement programs. We provide these and other healthcare services under contracts with government entities in the areas in which we operate. Our government contracts are generally intended to run for a fixed number of years and may be extended for additional specified number of years if the contracting entity or its agent elects to do so. When our contracts with the government expire, they may be opened for bidding by competing healthcare providers, and there is no guarantee that our contracts will be renewed or extended. Competitors may buy their way into the market by submitting bids with lower pricing. Even if our responsive bids are successful, the bids may be based upon assumptions or other factors which could result in the contracts being less profitable than we had anticipated. Further, our government contracts contain certain provisions regarding eligibility, enrollment and dis-enrollment processes for covered services, eligible providers, periodic financial and informational reporting, quality assurance, timeliness of claims payment and agreement to maintain a Medicare plan in the state and financial standards, among other things, and are subject to cancellation if we fail to perform in accordance with the standards set by regulatory agencies.

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We are also subject to various reviews, audits and investigations to verify our compliance with the terms of our contracts with various governmental agencies, as well as compliance with applicable laws and regulations. Any adverse review, audit or investigation could result in, among other things: cancellation of our contracts; refunding of amounts we have been paid pursuant to our contracts; imposition of fines, penalties and other sanctions on us; loss of our right to participate in various programs; increased difficulty in selling our products and services; loss of one or more of our licenses; or require changes to the way we do business. In addition, under government procurement regulations and practices, a negative determination resulting from a government audit of our business practices could result in a contractor being fined, debarred and/or suspended from being able to bid on, or be awarded, new government contracts for a period of time.

If any of our government contracts are terminated, not renewed, renewed on less favorable terms, or not renewed on a timely basis, or if we receive an adverse finding or review resulting from an audit or investigation, our business and reputation may be adversely impacted, our goodwill could be impaired and our financial position, results of operations or cash flows may be materially affected.

We contract with independent third party vendors and service providers who provide services to us and our subsidiaries or to whom we delegate selected functions. Violations of, or noncompliance with, laws and regulations governing our business by such third parties, or governing our dealings with such parties, could, among other things, subject us to additional audits, reviews and investigations and other adverse effects.

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

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

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

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

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

Our growth strategy includes, without limitation, the acquisition of health plans participating in government sponsored healthcare programs and specialty services businesses, contract rights and related assets of other health plans both in our existing service areas and in new markets and start-up operations in new markets or new products in existing markets. Although we review the records of companies or businesses we plan to acquire, it is possible that we could assume unanticipated liabilities or adverse operating conditions, or an acquisition may not perform as well as expected or may not achieve timely profitability. We also face the risk that we will not be able to effectively integrate acquisitions into our existing operations effectively without substantial expense, delay or other operational or financial problems and we may need to divert more management resources to integration than we planned.

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

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

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

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

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

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

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

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

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

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

Operations in a limited number of states have accounted for most of our premium revenues to date. If we were unable to continue to operate in any of those states or if our current operations in any portion of one of those states were significantly curtailed, our revenues could decrease materially. Our reliance on operations in a limited number of states could cause our revenue and profitability to change suddenly and unexpectedly depending on legislative or other governmental or regulatory actions and decisions, economic conditions and similar factors in those states. For example, states we currently serve may open the bidding for their Medicaid program to other health insurers through a request for proposal process. Our inability to continue to operate in any of the states in which we operate could harm our business.

Competition may limit our ability to increase penetration of the markets that we serve.

We compete for members principally on the basis of size and quality of provider networks, benefits provided and quality of service. We compete with numerous types of competitors, including other health plans and traditional state Medicaid programs that reimburse providers as care is provided, among others. In addition, the impact of the ACA and potential growth in our segment may attract new competitors.

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

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

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

In any particular market, physicians and other healthcare providers could refuse to contract, demand higher payments, or take other actions that could result in higher medical costs or difficulty in meeting regulatory or accreditation requirements, among other things. In some markets, certain healthcare providers, particularly hospitals, physician/hospital organizations or multi-specialty physician groups, may have significant market positions or near monopolies that could result in diminished bargaining power on our part. In addition, accountable care organizations, practice management companies, which aggregate physician practices for administrative efficiency and marketing leverage, and other organizational structures that physicians, hospitals and other healthcare providers choose may change the way in which these providers interact with us and may change the competitive landscape. Such organizations or groups of healthcare providers may compete directly with us, which could adversely affect our operations, and our results of operations, financial position and cash flows by impacting our relationships with these providers or affecting the way that we price our products and estimate our costs, which might require us to incur costs to change our operations. Provider networks may consolidate, resulting in a reduction in the competitive environment. In addition, if these providers refuse to contract with us, use their market position to negotiate contracts unfavorable to us or place us at a competitive disadvantage, our ability to market products or to be profitable in those areas could be materially and adversely affected.

From time to time healthcare providers assert or threaten to assert claims seeking to terminate non-cancelable agreements due to alleged actions or inactions by us. If we are unable to retain our current provider contract terms or enter into new provider contracts timely or on favorable terms, our profitability may be harmed. In addition, from time to time, we may be subject to class action or other lawsuits by healthcare providers with respect to claim payment procedures or similar matters. For example, the Company’s wholly owned subsidiary, Health Net Life Insurance Company (“HNL”), is and may continue to be subject to such disputes with respect to HNL’s payment levels in connection with the processing of out-of-network provider reimbursement claims for the provision of certain substance abuse related services. HNL expects to vigorously defend its claims payment practices. Nevertheless, in the event HNL receives an adverse finding in any related legal proceeding or from a regulator, or is otherwise required to reimburse providers for these claims at rates that are higher than expected or for claims HNL otherwise believes are unallowable, the Company’s financial condition and results of operations may be materially adversely affected. In addition, regardless of whether any such lawsuits brought against us are successful or have merit, they will still be time-consuming and costly and could distract our management’s attention. As a result, under such circumstances we may incur significant expenses and may be unable to operate our business effectively.

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

We are highly dependent on our ability to attract and retain qualified personnel to operate and expand our business. We would be adversely impacted if we are unable to adequately plan for the succession of our executives and senior management. While we have succession plans in place for members of our executive and senior management team, these plans do not guarantee that the services of our executive and senior management team will continue to be available to us. Our ability to replace any departed members of our executive and senior management or other key employees may be difficult and may take an extended period of time because of the limited number of individuals in the managed care and specialty services industry with the breadth of skills and experience required to operate and successfully expand a business such as ours. Competition to hire from this limited pool is intense, and we may be unable to hire, train, retain or motivate these personnel. If we are unable to attract, retain and effectively manage the succession plans for key personnel, executives and senior management, our business and financial position, results of operations or cash flows could be harmed.

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If we are unable to integrate and manage our information systems effectively, our operations could be disrupted.

Our operations depend significantly on effective information systems. The information gathered and processed by our information systems assists us in, among other things, monitoring utilization and other cost factors, processing provider claims, and providing data to our regulators. Our healthcare providers also depend upon our information systems for membership verifications, claims status and other information. Our information systems and applications require continual maintenance, upgrading and enhancement to meet our operational needs and regulatory requirements. We regularly upgrade and expand our information systems' capabilities. If we experience difficulties with the transition to or from information systems or do not appropriately integrate, maintain, enhance or expand our information systems, we could suffer, among other things, operational disruptions, loss of existing members and difficulty in attracting new members, regulatory problems and increases in administrative expenses. In addition, our ability to integrate and manage our information systems may be impaired as the result of events outside our control, including acts of nature, such as earthquakes or fires, or acts of terrorists.

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

From time to time we are a defendant in lawsuits and regulatory actions and are subject to investigations relating to our business, including, without limitation, medical malpractice claims, claims by members alleging failure to pay for or provide health care, claims related to non-payment or insufficient payments for out-of-network services, claims alleging bad faith, investigations regarding our submission of risk adjuster claims, putative securities class actions, and claims related to the imposition of new taxes, including but not limited to claims that may have retroactive application. Due to the inherent uncertainties of litigation and regulatory proceedings, we cannot accurately predict the ultimate outcome of any such proceedings. An unfavorable outcome could have a material adverse impact on our business and financial position, results of operations and/or cash flows and may affect our reputation. In addition, regardless of the outcome of any litigation or regulatory proceedings, such proceedings are costly and time consuming and require significant attention from our management, and could therefore harm our business and financial position, results of operations or cash flows.

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

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

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

As part of our normal operations, we collect, process and retain confidential member information. We are subject to various federal and state laws and rules regarding the use and disclosure of confidential member information, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information

Technology for Economic and Clinical Health (HITECH) Act of 2009 and the Gramm-Leach-Bliley Act, which require us to protect the privacy of medical records and safeguard personal health information we maintain and use. Certain of our businesses are also subject to the Payment Card Industry Data Security Standard, which is a multifaceted security standard that is designed to protect credit card account data as mandated by payment card industry entities. Despite our best attempts to maintain adherence to information privacy and security best practices as well as compliance with applicable laws, rules and contractual requirements, our facilities and systems, and those of our third party service providers, may be vulnerable to privacy or security breaches, acts of vandalism or theft, malware or other forms of cyber attack, misplaced or lost data including paper or electronic media, programming and/or human errors or other similar events. In the past, we have had data breaches resulting in disclosure of confidential or protected health information that have not resulted in any material financial loss or penalty to date. However, future data breaches could require us to expend significant resources to remediate any damage, interrupt our operations and damage our reputation, subject us to state or federal agency review and could also result in enforcement actions, material fines and penalties, litigation or other actions which could have a material adverse effect on our business, reputation and results of operations, financial position and cash flows.

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In addition, HIPAA broadened the scope of fraud and abuse laws applicable to healthcare companies. HIPAA established new enforcement mechanisms to combat fraud and abuse, including civil and, in some instances, criminal penalties for failure to comply with specific standards relating to the privacy, security and electronic transmission of protected health information. The HITECH Act expanded the scope of these provisions by mandating individual notification in instances of breaches of protected health information, providing enhanced penalties for HIPAA violations, and granting enforcement authority to states' Attorneys General in addition to the HHS Office for Civil Rights. It is possible that Congress may enact additional legislation in the future to increase penalties and to create a private right of action under HIPAA, which could entitle patients to seek monetary damages for violations of the privacy rules. Additionally, HHS continued its auditing program in 2016 to assess compliance efforts by covered entities and business associates. Through a second phase of audits, which commenced for covered entities in July 2016, HHS focused on a review of policies and procedures adopted and employed by covered entities and their business associates to meet selected standards and implementation specifications of the HIPAA Privacy, Security, and Breach Notification Rules. An audit resulting in findings or allegations of noncompliance could have a material adverse effect on our results of operations, financial position and cash flows.

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

We, along with all other companies involved in public health care programs are the subject of fraud and abuse investigations from time to time. The regulations and contractual requirements applicable to participants in these public sector programs are complex and subject to change. Violations of fraud and abuse laws applicable to us could result in civil monetary penalties, criminal fines and imprisonment, and/or exclusion from participation in Medicaid, Medicare, TRICARE, VA and other federal health care programs and federally funded state health programs. Fraud and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical services, improper marketing and violations of patient privacy rights. These fraud and abuse laws include the federal False Claims Act, which prohibits the known filing of a false claim or the known use of false statements to obtain payment from the federal government and the federal Anti-kickback statute, which prohibits the payment or receipt of remuneration to induce referrals or recommendations of healthcare items or services. Many states have false claim act and anti-kickback statutes that closely resemble the federal False Claims Act and the federal Anti-kickback statute. In addition, the Deficit Reduction Act of 2005 encouraged states to enact state-versions of the federal False Claims Act that establish liability to the state for false and fraudulent Medicaid claims and that provide for, among other things, claims to be filed by qui tam relators. Federal and state governments have made investigating and prosecuting health care fraud and abuse a priority. In the event we fail to comply with the extensive federal and state fraud and abuse laws, our business, reputation, results of operations, financial position and cash flows could be materially and adversely affected.

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

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

Security breaches may arise from external or internal threats. External breaches include hacking personal information for financial gain, attempting to cause harm or interruption to our operations, or intending to obtain competitive information. We experience attempted external hacking or malicious attacks on a regular basis. We maintain a rigorous system of preventive and detective controls through our security programs; however, our prevention and

detection controls may not prevent or identify all such attacks on a timely basis, or at all. Internal breaches may result from inappropriate security access to confidential information by rogue employees, consultants or third party service providers. Any security breach involving the misappropriation, loss or other unauthorized disclosure or use of confidential member information, financial data, competitively sensitive information, or other proprietary data, whether by us or a third party, could have a material adverse effect on our business reputation, financial condition, cash flows, or results of operations.

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

We completed the acquisition of Health Net on March 24, 2016. The success of the acquisition of Health Net will depend, in part, on our ability to successfully combine the businesses of the Company and Health Net and realize the anticipated benefits, including synergies, cost savings, growth in earnings, innovation and operational efficiencies, from the combination. If we are unable to achieve these objectives within the anticipated time frame, or at all, the anticipated benefits may not be realized fully or at all, or may take longer to realize than expected and the value of our common stock may be harmed.

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

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

Many of these factors will be outside of our control and any one of them could result in delays, increased costs, decreases in the amount of expected revenues and diversion of management's time and energy, which could materially affect our financial position, results of operations and cash flows.

We have incurred substantial expenses related to the completion of the acquisition of Health Net and are incurring substantial expenses related to the integration of Health Net.

We are in the process of integrating a large number of processes, policies, procedures, operations, technologies and systems, including purchasing, accounting and finance, sales, payroll, pricing, revenue management, marketing and benefits, among other things. In addition, the businesses of Centene and Health Net will continue to maintain a presence in St. Louis, Missouri and Woodland Hills, California, respectively. The substantial majority of these costs will be non-recurring expenses related to the acquisition (including financing of the acquisition), facilities and systems consolidation costs. We may incur additional costs to maintain employee morale and to retain key employees. We are also incurring transaction fees and costs related to formulating integration plans for the combined business, and the execution of these plans may lead to additional unanticipated costs. These incremental transaction and acquisition-related costs may exceed the savings we expect to achieve from the elimination of duplicative costs and the realization of other efficiencies related to the integration of the businesses, particularly in the near term and in the event there are material unanticipated costs.

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

The market price of our common stock is generally subject to volatility, and there can be no assurances regarding the level or stability of our share price at any time. The market price of our common stock may decline as a result of the acquisition if, among other things, we are unable to achieve the expected growth in earnings, or if the operational cost savings estimates in connection with the integration of Health Net's business with ours are not realized, or if the transaction costs related to the acquisition and integration are greater than expected. The market price also may decline if we do not achieve the perceived benefits of the acquisition as rapidly or to the extent anticipated by financial or industry analysts or if the effect of the acquisition on our financial position, results of operations or cash flows is not consistent with the expectations of financial or industry analysts.

Our future results may be adversely impacted if we do not effectively manage our expanded operations following the completion of our acquisition of Health Net.

The size of our business following the acquisition of Health Net is significantly larger than the size of either Centene's or Health Net's respective businesses prior to the acquisition. Our ability to successfully manage the expanded business

will depend, in part, upon management's ability to design and implement strategic initiatives that address the increased scale and scope of the combined business with its associated increased costs and complexity. We will also have to manage our expanded operations in compliance with certain undertakings with regulators that were agreed to in connection with the approval of the acquisition. These undertakings require significant investments by us, may restrict or impose additional material costs on our future operations and strategic initiatives in certain geographies, and subject us to various enforcement mechanisms. There can be no assurances that we will be successful in managing our expanded operations or that we will realize the expected growth in earnings, operating efficiencies, cost savings and other benefits.

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We are significantly more leveraged today than we have previously been.

As of March 31, 2017, we had consolidated indebtedness of approximately $4,647 million, which is significantly greater than the indebtedness that we have previously had. This increased indebtedness and higher debt-to-equity ratio will have the effect, among other things, of reducing our flexibility to respond to changing business and economic conditions and increasing borrowing costs.

Among other things, our revolving credit facility requires us to comply with various covenants that impose restrictions on our operations, including our ability to incur additional indebtedness, create liens, pay dividends, make investments or other restricted payments, sell or otherwise dispose of substantially all of our assets and engage in other activities. Our revolving credit facility also requires us to comply with a maximum leverage ratio and a minimum fixed charge coverage ratio. These restrictive covenants could limit our ability to pursue our business strategies. In addition, any failure by us to comply with these restrictive covenants could result in an event of default under the revolving credit facility and, in some circumstances, under the indentures governing our notes, which, in any case, could have a material adverse effect on our financial condition.

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ITEM 2. Unregistered Sales of Equity Securities and Use of Proceeds.

Issuer Purchases of Equity Securities
First Quarter 2017

Period	Total Number of Shares Purchased [1]	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number of Shares that May Yet Be Purchased Under the Plans or Programs[2]
January 1 - January 31, 2017	15,941	$ 61.27	—	3,335,448
February 1 - February 28, 2017	149,209	67.76	—	3,335,448
March 1 - March 31, 2017	18,348	67.48	—	3,335,448
Total	183,498	$ 67.17	—	3,335,448

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

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ITEM 6. Exhibits.

EXHIBIT NUMBER	DESCRIPTION
12.1	Computation of ratio of earnings to fixed charges.
31.1	Certification of Chairman, President and Chief Executive Officer pursuant to Rule 13(a)-14(a) under the Securities Exchange Act of 1934, as amended.
31.2	Certification of Executive Vice President and Chief Financial Officer pursuant to Rule 13(a)-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of Chairman, President and Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Executive Vice President and Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.1	XBRL Taxonomy Instance Document.
101.2	XBRL Taxonomy Extension Schema Document.
101.3	XBRL Taxonomy Extension Calculation Linkbase Document.
101.4	XBRL Taxonomy Extension Definition Linkbase Document.
101.5	XBRL Taxonomy Extension Label Linkbase Document.
101.6	XBRL Taxonomy Extension Presentation Linkbase Document.

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SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized as of April 25, 2017.

CENTENE CORPORATION

By: /s/ MICHAEL F. NEIDORFF
Chairman, President and Chief Executive Officer
(principal executive officer)

By: /s/ JEFFREY A. SCHWANEKE
Executive Vice President and Chief Financial Officer
(principal financial officer)

By: /s/ CHRISTOPHER R. ISAAK
Senior Vice President, Corporate Controller and Chief Accounting Officer
(principal accounting officer)