UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K

(Mark One)

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended December 31, 2020

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

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

Title of Each Class	Trading Symbol(s)	Name of Each Exchange on Which Registered
Common Stock, $0.001 Par Value	**CNC**	**New York Stock Exchange**

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

None

(Title of Class)

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes ☒ No ☐

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

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

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

Indicate by check mark whether the registrant has filed a report on and attestation to its management's assessment of the effectiveness of its internal control over financial reporting under Section 404(b) of the Sarbanes-Oxley Act (15 U.S.C. 7262(b)) by the registered public accounting firm that prepared or issued its audit report. ☒

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

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant, based upon the last reported sale price of the common stock on the New York Stock Exchange on June 30, 2020, was $36.8 billion.

As of February 19, 2021, the registrant had 581,593,037 shares of common stock issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Proxy Statement for the registrant's 2021 annual meeting of stockholders are incorporated by reference in Part III, Items 10, 11, 12, 13 and 14.

CENTENE CORPORATION
ANNUAL REPORT ON FORM 10-K
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CAUTIONARY STATEMENT ON FORWARD-LOOKING STATEMENTS

All statements, other than statements of current or historical fact, contained in this filing are forward-looking statements. Without limiting the foregoing, forward-looking statements often use words such as "believe," "anticipate," "plan," "expect," "estimate," "intend," "seek," "target," "goal," "may," "will," "would," "could," "should," "can," "continue" and other similar words or expressions (and the negative thereof). Centene Corporation and its subsidiaries (Centene, the Company, our or we) intends 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. In particular, these statements include, without limitation, statements about our future operating or financial performance, market opportunity, growth strategy, competition, expected activities in completed and future acquisitions, including statements about the impact of our proposed acquisition of Magellan Health (the Magellan Acquisition), our recently completed acquisition of WellCare Health Plans, Inc. (WellCare and such acquisition, the WellCare Acquisition), other recent 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 1. "Business," Part I, Item IA "Risk Factors," Part I, Item 3. "Legal Proceedings," and Part II, Item 7. "Management's Discussion and Analysis of Financial Condition and Results of Operations."

These forward-looking statements reflect our current views with respect to future events and are based on numerous assumptions and assessments made by us in light of our experience and perception of historical trends, current conditions, business strategies, operating environments, future developments and other factors we believe appropriate. By their nature, forward-looking statements involve known and unknown risks and uncertainties and are subject to change because they relate to events and depend on circumstances that will occur in the future, 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, variables and events including, but not limited to:

- the impact of COVID-19 on global markets, economic conditions, the healthcare industry and our results of operations and the response by governments and other third parties;
- the risk that regulatory or other approvals required for the Magellan Acquisition may be delayed or not obtained or are obtained subject to conditions that are not anticipated that could require the exertion of management's time and our resources or otherwise have an adverse effect on us;
- the risk that Magellan Health's stockholders do not approve the definitive merger agreement;
- the possibility that certain conditions to the consummation of the Magellan Acquisition will not be satisfied or completed on a timely basis and accordingly the Magellan Acquisition may not be consummated on a timely basis or at all;
- uncertainty as to the expected financial performance of the combined company following completion of the Magellan Acquisition;
- the possibility that the expected synergies and value creation from the Magellan Acquisition or the WellCare Acquisition will not be realized, or will not be realized within the applicable expected time periods;
- 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 any regulatory, governmental or third party consents or approvals for the Magellan Acquisition;
- the risk that unexpected costs will be incurred in connection with the completion and/or integration of the Magellan Acquisition or that the integration of Magellan Health will be more difficult or time consuming than expected;
- the risk that potential litigation in connection with the Magellan Acquisition may affect the timing or occurrence of the Magellan Acquisition or result in significant costs of defense, indemnification and liability;
- a downgrade of the credit rating of our indebtedness, which could give rise to an obligation to redeem existing indebtedness;
- the possibility that competing offers will be made to acquire Magellan Health;
- the inability to retain key personnel;
- disruption from the announcement, pendency and/or completion and/or integration of the Magellan Acquisition or the integration of the WellCare Acquisition, or similar risks from other acquisitions we may announce or complete from

time to time, including potential adverse reactions or changes to business relationships with customers, employees, suppliers or regulators, making it more difficult to maintain business and operational relationships;
- our ability to accurately predict and effectively manage health benefits and other operating expenses and reserves, including fluctuations in medical utilization rates due to the impact of COVID-19;
- competition;
- membership and revenue declines or unexpected trends;
- changes in healthcare practices, new technologies, and advances in medicine;
- increased healthcare costs;
- changes in economic, political or market conditions;
- changes in federal or state laws or regulations, including changes with respect to income tax reform or government healthcare programs as well as changes with respect to the Patient Protection and Affordable Care Act (ACA) and the Health Care and Education Affordability Reconciliation Act, collectively referred to as the ACA and any regulations enacted thereunder that may result from changing political conditions, the new administration or judicial actions, including the ultimate outcome in "Texas v. United States of America" regarding the constitutionality of the ACA;
- 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;
- tax matters;
- disasters or major epidemics;
- changes in expected contract start dates;
- provider, state, federal, foreign 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, TRICARE or other customers);
- the difficulty of predicting the timing or outcome of pending or future legal and regulatory proceedings or government investigations;
- 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 businesses we may acquire in the future, will not be realized, or will not be realized within the expected time period;
- 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 any regulatory, governmental or third party consents or approvals for acquisitions;
- disruption caused by significant completed and pending acquisitions making it more difficult to maintain business and operational relationships;
- the risk that unexpected costs will be incurred in connection with the completion and/or integration of acquisition transactions;
- changes in expected closing dates, estimated purchase price and accretion for acquisitions;
- the risk that acquired businesses will not be integrated successfully;
- restrictions and limitations in connection with our indebtedness;
- our ability to maintain or achieve improvement in the Centers for Medicare and Medicaid Services (CMS) Star ratings and maintain or achieve improvement in other quality scores in each case that can impact revenue and future growth;
- availability of debt and equity financing, on terms that are favorable to us;
- 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 factors that may affect our business operations, financial condition and results of operations, in our filings with the Securities and Exchange Commission (SEC), including quarterly reports on Form 10-Q and current reports on Form 8-K. Item 1A. "Risk Factors" of Part I of this filing contains a further discussion of these and other important factors that could cause actual results to differ from expectations. 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 and selling, general and administrative costs.

SUMMARY OF RISK FACTORS

Our business is subject to numerous risks and uncertainties that you should be aware of in evaluating our business, including risks that may prevent us from achieving our business objectives or may adversely affect our business, financial condition, results of operations, cash flows and prospects. The risks include, but are not limited to, the following, all of which are more fully described in Part 1, Item 1A "Risk Factors" section below. This summary should be read in conjunction with the Risk Factors section and should not be relied upon as an exhaustive summary of the material risks facing our business.

- Our business could be adversely affected by the effects of widespread public health pandemics, such as the spread of COVID-19;
- Our Medicare programs are subject to a variety of unique risks that could adversely impact our financial results;
- Failure to accurately estimate and price our medical expenses or effectively manage our medical costs or related administrative costs could negatively affect our results of operations, financial position and cash flows;
- Risk-adjustment payment systems make our revenue and results of operations more difficult to estimate and could result in retroactive adjustments that have a material adverse effect on our results of operations, financial condition and cash flows;
- Any failure to adequately price products offered or any reduction in products offered in the Health Insurance Marketplaces may have a negative impact on our results of operations, financial position and cash flow;
- We derive a portion of our cash flow and gross margin from our prescription drug plan (PDP) operations, for which we submit annual bids for participation. The results of our bids could materially affect our results of operations, financial condition and cash flows;
- Our encounter data may be inaccurate or incomplete, which could have a material adverse effect on our results of operations, financial condition, cash flows and ability to bid for, and continue to participate in, certain programs;
- 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;
- Ineffectiveness of state-operated systems and subcontractors could adversely affect our business;
- Execution of our growth strategy may increase costs or liabilities, or create disruptions in our business;
- 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;
- 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 derive a significant portion of our premium revenues from operations in a limited number of states, and our results of operations, financial position or cash flows could be materially affected by a decrease in premium revenues or profitability in any one of those states;
- Competition may limit our ability to increase penetration of the markets that we serve;
- If we are unable to maintain relationships with our provider networks, our profitability may be harmed;
- If we are unable to integrate and manage our information systems effectively, our operations could be disrupted;
- An impairment charge with respect to our recorded goodwill and intangible assets could have a material impact on our results of operations;
- 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;
- 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 results of operations, financial position and cash flows;
- The implementation of the ACA, as well as potential repeal of, changes to, or judicial challenges to the ACA, could materially and adversely affect our results of operations, financial position and cash flows;
- 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 businesses providing pharmacy benefit management 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;
- 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;
- 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;
- If we fail to comply with the extensive federal and state fraud, waste and abuse laws, our business, reputation, results of operations, financial position and cash flows could be materially and adversely affected;

- Our investment portfolio may suffer losses which could materially and adversely affect our results of operations or liquidity;
- Adverse credit market conditions may have a material adverse effect on our liquidity or our ability to obtain credit on acceptable terms;
- We have substantial indebtedness outstanding and may incur additional indebtedness in the future. Such indebtedness could reduce our agility and may adversely affect our financial condition;
- Changes in the method pursuant to which the LIBOR rates are determined and potential phasing out of LIBOR after 2021 may affect the value of the financial obligations to be held or issued by us that are linked to LIBOR or our results of operations or financial condition;
- Mergers and acquisitions may not be accretive and may cause dilution to our earning per share, which may cause the market price of our common stock to decline;
- We may be unable to successfully integrate our existing business with acquired businesses and realize the anticipated benefits of such acquisitions;
- The financing arrangements that we entered into in connection with the WellCare Acquisition may, under certain circumstances, contain restrictions and limitations that could significantly impact our ability to operate our business;
- The merger with Magellan Health is subject to conditions, some or all of which may not be satisfied, or completed on a timely basis, if at all. Failure to complete the merger with Magellan Health could have adverse effects on our business;
- Centene and Magellan Health may be targets of securities class action and derivative lawsuits that could result in substantial costs and may delay or prevent the Magellan Acquisition from being completed;
- Completion of the Magellan Acquisition may trigger change in control or other provisions in certain agreements to which Magellan Health or its subsidiaries are a party, which may have an adverse impact on the combined company’s business and results of operations; and
- We may be unable to attract, retain or effectively manage the succession of key personnel; and
- Future issuances and sales of additional shares of preferred or common stock could reduce the market price of our shares of common stock.

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, 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).

	Year Ended December 31,		
	2020	**2019**	**2018**
GAAP net earnings attributable to Centene	$ 1,808	$ 1,321	$ 900
Amortization of acquired intangible assets	719	258	211
Acquisition related expenses	602	104	425
Other adjustments (1)	29	301	30
Income tax effects of adjustments (2)	(262)	(127)	(155)
Adjusted net earnings	$ 2,896	$ 1,857	$ 1,411
GAAP diluted earnings per share (EPS) attributable to Centene	$ 3.12	$ 3.14	$ 2.26
Amortization of acquired intangible assets (3)	0.95	0.47	0.41
Acquisition related expenses (4)	0.86	0.19	0.81
Other adjustments (1)	0.07	0.62	0.06
Adjusted Diluted EPS	$ 5.00	$ 4.42	$ 3.54

(1) Other adjustments include the following items:

2020 - (a) gain related to the divestiture of certain products of our Illinois health plan of $104 million, or $0.10 per diluted share, net of an income tax expense of $0.08; (b) non-cash impairment of our third-party care management software business of $72 million, or $0.10 per diluted share, net of an income tax benefit of $0.02; and (c) debt extinguishment costs of $61 million, or $0.07 per diluted share, net of an income tax benefit of $0.04.

2019 - (a) non-cash goodwill and intangible asset impairment of $271 million or $0.57 per diluted share, net of an income tax benefit of $0.08 and (b) debt extinguishment costs of $30 million or $0.05 per diluted share, net of an income tax benefit of $0.02; and

2018 - the impact of retroactive changes to the California minimum medical loss ratio (MLR) of $30 million of expense or $0.06 per diluted share, net of an income tax benefit of $0.02.

(2) The income tax effects of adjustments are based on the effective income tax rates applicable to each adjustment.

(3) Amortization of acquired intangible assets is net of an income tax benefit of $0.29, $0.14, and $0.12 per diluted share for the years ended December 31, 2020, 2019 and 2018, respectively.

(4) Acquisition related expenses are net of an income tax benefit of $0.18, $0.06 and $0.25 per diluted share for the years ended December 31, 2020, 2019 and 2018, respectively.

	Year Ended December 31,		
	2020	2019	2018
GAAP selling, general and administrative expenses	$ 9,867	$ 6,533	$ 6,043
Acquisition related expenses	580	85	421
Adjusted selling, general and administrative expenses	$ 9,287	$ 6,448	$ 5,622

PART I
ITEM 1. *Business*

OVERVIEW

We are a leading multi-national healthcare enterprise that is committed to helping people live healthier lives. We take a local approach - with local brands and local teams - to provide fully integrated, high-quality, and cost-effective services to government-sponsored and commercial healthcare programs, focusing on under-insured and uninsured individuals. We also provide education and outreach programs to inform and assist members in accessing quality, appropriate healthcare services. We believe our local approach, including member and provider services, enables us to provide accessible, quality, culturally-sensitive healthcare coverage to our communities. Our population health management, educational and other initiatives are designed to help members best utilize the healthcare system to ensure they receive appropriate, medically necessary services and effective management of routine, severe and chronic health problems, resulting in better health outcomes. We combine our decentralized local approach for care with a centralized infrastructure of support functions such as finance, information systems and claims processing.

Our initial health plan commenced operations in Wisconsin in 1984. We were organized in Wisconsin in 1993 as a holding company for our initial health plan and reincorporated in Delaware in 2001. Our stock is publicly traded on the New York Stock Exchange under the ticker symbol "CNC."

We operate in two segments: Managed Care and Specialty Services. Our Managed Care segment provides health plan coverage to individuals through government subsidized and commercial programs. Our Specialty Services segment includes companies offering diversified healthcare services and products to our Managed Care segment and other external customers. For the year ended December 31, 2020, our Managed Care and Specialty Services segments accounted for 96% and 4%, respectively, of our total external revenues. Our membership totaled 25.5 million as of December 31, 2020. For the year ended December 31, 2020, our total revenues and net earnings attributable to Centene were $111.1 billion and $1.8 billion, respectively, and our total cash flow from operations was $5.5 billion.

Magellan Acquisition

In January 2021, we announced that we entered into a definitive merger agreement under which we will acquire Magellan Health for $95.00 per share in cash for a total enterprise value of approximately $2.2 billion. The transaction, which was unanimously approved by the Boards of Directors of both companies, is expected to broaden and deepen our whole health capabilities and establish a leading behavioral health platform. The transaction is subject to clearance under the Hart-Scott Rodino Act, receipt of required state regulatory approvals, the approval of the definitive merger agreement by Magellan Health's stockholders and other customary closing conditions. The transaction is not contingent upon financing. We intend to fund the acquisition primarily through debt financing. The transaction is expected to close in the second half of 2021.

WellCare Acquisition

On January 23, 2020, we acquired all of the issued and outstanding shares of WellCare Health Plans, Inc. (WellCare, and such acquisition, the WellCare Acquisition). The transaction was valued at $19.6 billion, including the assumption of $1.95 billion of outstanding debt. The WellCare Acquisition brought a high-quality Medicare platform and further extended our robust Medicaid offerings. The WellCare Acquisition also enables us to provide access to more comprehensive and differentiated solutions across more markets with a continued focus on affordable, high-quality, culturally-sensitive healthcare services. With the WellCare Acquisition, we further broadened our product offerings by adding a Medicare prescription drug plan to our existing business lines.

INDUSTRY

We provide a full spectrum of managed healthcare products and services, primarily through Medicaid, Medicare and commercial products. We currently have operations domestically and internationally.

Medicaid

Established in 1965, Medicaid is the largest publicly funded program in the United States, and provides health insurance to low-income families and individuals with disabilities. Authorized by Title XIX of the Social Security Act, Medicaid is an entitlement program funded jointly by the federal and state governments and administered by the states. The majority of funding is provided by the federal government. Each state establishes its own eligibility standards, benefit packages, payment

rates and program administration within federal standards. As a result, there are 56 Medicaid programs - one for each U.S. state, each U.S. territory and the District of Columbia. Eligibility is based on a combination of household income and assets, often determined by an income level relative to the federal poverty level. Historically, children have represented the largest eligibility group. Many states have selected Medicaid managed care as a means of delivering quality healthcare and controlling costs. We refer to these states as mandatory managed care states.

Under the Affordable Care Act (ACA), Medicaid coverage was expanded to all individuals under age 65 with incomes up to 138% of the federal poverty level, subject to the states' elections. The federal government paid the entire costs for Medicaid Expansion coverage for newly eligible beneficiaries from 2014 through 2016, 95% of the costs in 2017, 94% of the costs in 2018, 93% of the costs in 2019, and 90% of the costs in 2020. Assuming that the current program remains in effect unchanged, in subsequent years the federal share is scheduled to remain at 90%.

Established in 1972 and authorized by Title XVI of the Social Security Act, the Aged, Blind, or Disabled (ABD) program covers low-income persons with chronic physical disabilities or behavioral health impairments. ABD beneficiaries represent a growing portion of all Medicaid recipients. In addition, ABD recipients typically utilize more services as a result of their more complicated health status.

The Balanced Budget Act of 1997 created the State Children's Health Insurance Program (CHIP) to help states expand coverage primarily to children whose families earned too much to qualify for Medicaid, yet not enough to afford private health insurance. Costs related to the largest eligibility group, children, are primarily composed of pediatrics and family care. These costs tend to be more predictable than those associated with other healthcare issues which predominantly affect the adult population.

Long-Term Services and Supports (LTSS) is a Medicaid product that covers Institutional/Residential Care (Nursing Facilities, Intermediate Care Facilities) and Home and Community Based Services (HCBS) for beneficiaries requiring assistance with their activities of daily living, such as bathing, dressing and transferring. The most common HCBS services include personal care, adult day care, non-emergent transportation, home-delivered meals and personal emergency response systems. LTSS services are provided for individuals requiring nursing home level of care, receiving waiver services, or entitled to state Medicaid LTSS benefits. The largest groups receiving LTSS, by spending, are older individuals and individuals with physical disabilities, followed by individuals with intellectual and developmental disabilities, those with serious mental illness and/or serious emotional disturbance and other populations. States are increasingly turning to managed care as a solution to provide coordinated, holistic care to their LTSS beneficiaries. According to ADvancing States (formerly National Association of States United for Aging and Disabilities), as of November 2020, 25 states utilize some form of managed LTSS, up from eight in 2004.

The majority of youth and children in foster care qualify for Medicaid, most commonly through Title IV-E of the Social Security Act, which provides funding to support safe and stable out-of-home care for children who are removed from their homes. The federal government has enacted legislation establishing guidelines and requirements for state child welfare agencies related to the health and well-being of children in foster care, including the provision of grants and technical assistance to enable states to meet these needs and make explicit connections with state Medicaid. In addition, the ACA requires states to make former foster care children eligible for Medicaid until they reach the age of 26, provided that they turned 18 while in foster care, and were enrolled in Medicaid at that time.

CMS estimated the total Medicaid market to be approximately $649 billion in 2020, and estimates the market will grow to over $1.0 trillion by 2028. Medicaid spending is estimated to have increased by 4.5% in 2020 and is projected to increase at an average annual rate of 5.7% between 2020 and 2028. Due to the timing of the CMS report and highly uncertain nature of the pandemic, the aforementioned projections do not take into account the impact of COVID-19.

A portion of Medicaid beneficiaries are dual-eligible, low-income seniors and people with disabilities who are enrolled in both Medicaid and Medicare. According to CMS, there were approximately 11.0 million dual-eligible enrollees in 2019. These dual-eligible members may receive assistance from Medicaid for benefits, such as nursing home care, HCBS, and/or assistance with Medicare premiums and cost sharing. Dual-eligibles also use more services due to their tendency to have more chronic health issues. We serve dual-eligibles through our ABD, LTSS, Medicare-Medicaid Plans (MMP), Medicare Advantage Dual Special Needs Plan (DSNP) and standard Medicare Advantage lines of business.

While Medicaid programs have directed funds to many individuals who cannot afford or otherwise maintain health insurance coverage, they did not initially address the inefficient and costly manner in which the Medicaid population tends to access healthcare. Medicaid recipients in non-managed care programs typically have not sought preventive care or routine treatment for chronic conditions, such as asthma and diabetes. Rather, they have sought healthcare in hospital emergency departments, which is typically more expensive. As a result, many states without managed care programs have found that the costs of providing Medicaid benefits have increased while the medical outcomes for the recipients remained unsatisfactory.

We believe managed care has improved the quality of care for Medicaid beneficiaries and lowered costs. The majority of states have mandated that their Medicaid recipients enroll in managed care plans. Other states are considering moving to a mandated managed care approach for additional populations and products. As a result, we believe a significant market opportunity exists for managed care organizations with operations and programs focused on the distinct socio-economic, cultural and healthcare needs of the uninsured population and the Medicaid populations.

Medicare

We contract with CMS under the Medicare Advantage program to provide Medicare Advantage products directly to Medicare beneficiaries as well as through employer and union groups. The Medicare program provides health care coverage primarily to individuals age 65 or older, as well as to individuals with certain disabilities.

We provide or arrange healthcare benefits for services normally covered by Medicare, plus a broad range of healthcare benefits for services not covered by traditional Medicare, usually in exchange for a fixed monthly premium per member from CMS that varies based upon the county in which the member resides, demographic factors of the member such as age, gender and institutionalized status, and the health status of the member. Any benefits that are not covered by Medicare may result in an additional monthly premium charged to the enrollee or through portions of payments received from CMS that may be allocated to these benefits, according to CMS regulations and guidance. Many of our Medicare Advantage members pay no monthly premium to us for these additional benefits. As our Medicare Advantage members reach their deductibles and out-of-pocket maximums, our medical costs rise, creating seasonality in the business with a higher percentage of earnings in the first half of the year.

We provide a wide range of Medicare products, including Medicare Advantage plans with and without prescription drug coverage and Medicare supplement products that supplement traditional fee-for-service Medicare coverage. Our subsidiaries have a number of contracts with CMS under the Medicare Advantage program authorized under Title XVIII of the Social Security Act.

CMS developed the Medicare Advantage Star ratings system to help consumers choose among competing plans, awarding between 1.0 and 5.0 stars to Medicare Advantage plans based on performance in certain measures of quality. The Star ratings are used by CMS to award quality bonus payments to Medicare Advantage plans. Beginning with the 2014 Star ratings (calculated in 2013), Medicare Advantage plans are required to achieve a minimum of 4.0 Stars to qualify for a quality bonus payment. The methodology and measures included in the Star ratings system can be modified by CMS annually and Star ratings thresholds are based on performance of Medicare Advantage plans nationally.

CMS estimated the total Medicare market was approximately $859 billion in 2020, and estimates the market will grow to approximately $1.6 trillion by 2028. Medicare spending is estimated to have increased 7.2% in fiscal 2020 and is projected to increase at an average annual rate of 7.7% between 2020 and 2028.

Medicare Prescription Drug Plan

Through our acquisition of WellCare in January 2020, we now offer stand-alone PDP to Medicare beneficiaries. We have contracted with CMS to serve as a plan sponsor, offering stand-alone Medicare Part D PDP plans to Medicare-eligible beneficiaries. We offer PDPs in 50 states and the District of Columbia. Our PDPs offer national in-network prescription drug coverage, including a preferred pharmacy network, subject to limitations in certain circumstances.

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

The Medicare Part D prescription drug benefit is supported by risk sharing with the federal government through risk corridors designed to limit the losses and gains of the participating drug plans and by reinsurance for catastrophic drug costs. The government subsidy is based on the national weighted average monthly bid for this coverage, adjusted for risk factor payments. Additional subsidies are provided for dually-eligible beneficiaries and specified low-income beneficiaries.

Commercial

Established in 2010 and operational in 2014, the ACA created Health Insurance Marketplaces, which are a key component of the ACA and provide an opportunity for individuals and families to obtain health insurance. States have the option of operating

their own Marketplace or partnering with the federal government. States choosing neither option currently default to a federally-facilitated Marketplace. Premium subsidies are available to make coverage more affordable. Access to Marketplaces is limited to U.S. citizens and legal immigrants. Insurers are required to offer a minimum level of benefits with coverage that varies based on premiums and out-of-pocket costs. Premium subsidies are provided to individuals and families without access to other coverage and with incomes generally between 100-400% of the federal poverty level, with some exceptions, to help them purchase insurance through the Marketplaces. These subsidies are offered on a sliding scale basis.

We also offer commercial healthcare products to individuals through large and small employer groups. We offer plans with differing benefit designs and varying levels of co-payments at different premium rates. These plans are offered generally through contracts with participating network physicians, hospitals and other providers. Coverage typically is subject to copays and can be subject to deductibles and coinsurance. As our commercial members reach their deductibles and out-of-pocket maximums, our medical costs rise, creating seasonality in the business with a higher percentage of earnings in the first half of the year.

International

We have a growing international presence in Spain, the United Kingdom (UK) and Slovakia. Our presence in Spain is mainly associated with our subsidiaries operating as part of the Ribera Salud Group, which manages health administration concessions and private hospitals in various regions in Spain. Ribera Salud Group also holds a noncontrolling investment in Slovakia, which provides radiology services in the region. In the UK, our subsidiaries, operating as part of Operose Health Group, represent one of the largest provider networks in the country and deliver medical and community based services in the primary care sector of the National Health Service (NHS), which is the publicly funded, national healthcare system for England. We also have a noncontrolling investment in the UK in Circle Health Group, which includes BMI Healthcare and represents the UK's largest independent hospital operator.

OUR COMPETITIVE STRENGTHS

Our approach is based on the following key competitive strengths:

- *Expertise in Government Sponsored Programs.* For more than 35 years, we have developed a specialized services expertise that has helped us establish and maintain relationships with members, providers and our government customers. We have implemented programs developed to achieve savings for our government customers and support providers with tools and information to improve health outcomes and quality of care for members. We work to assist the states in which we operate in addressing the operating challenges they face.

- *Quality and Innovation.* Our innovative population health management programs focus on improving quality of care in areas that have the greatest impact on our members. We concentrate on serving the whole person to impact outcomes and costs. We recognize the importance of member-focused delivery of quality managed care services and have developed award winning education and outreach programs including the My Health Pays program, Start Smart for Your Baby, Living Well with Sickle Cell, Fluvention and MemberConnections. It is our objective to provide access to the highest quality of care for our members. As a validation of that objective, we pursue accreditation by independent organizations that have been established to promote healthcare quality. We seek the National Committee for Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC) Health Plan Accreditation in eligible states.

- *Innovative Technology and Scalable Systems.* The ability to access data and translate it into meaningful information is essential to operating across a multi-state service area in a cost-effective manner. Our centralized information systems support our core processing functions under a set of integrated databases and are designed to be both replicable and scalable to accommodate organic growth and growth from acquisitions. We continue to enhance our systems in order to leverage the platforms we have developed for our existing states for configuration into new states or health plan acquisitions. We believe our predictive modeling technology enables our population health management operations to proactively case and disease manage specific high risk members. It can recommend medical care opportunities using a mix of company defined algorithms and evidence based medical guidelines. Interventions are determined by the clinical indicators, the ability to improve health outcomes, and the risk profile of members. We believe our integrated approach helps to assure that consistent sources of claim and member information are provided across all of our health plans. Our membership and claims processing systems are capable of expanding to support additional members in an efficient manner.

- *Financial Strength and Scale.* We are a large healthcare enterprise with $111.1 billion in revenue and $5.5 billion in operating cash flow in 2020. Our strong historical operating performance, size, and scale allow us to continue to grow, diversify and invest in our businesses through strategic acquisitions and investments in technology and other resources that support our business, allowing us to navigate the changing healthcare landscape. We are a leader in the four largest Medicaid states. We seek to continue to increase our Medicaid, Medicare and Health Insurance Marketplace membership through alliances with key providers, outreach efforts, development and implementation of community-specific products and acquisitions. In 2020, we expanded our Health Insurance Marketplace footprints in several existing markets, and we completed the WellCare Acquisition, further expanding our scale and presence. In addition, in 2019 a nationally recognized statistical rating organization raised our long-term issuer credit rating to an investment grade rating.

- *Diversified Business Lines.* We continue to broaden our service offerings to address areas that we believe have been traditionally under-served by Medicaid and Medicare managed care organizations. In addition to our Medicaid and Medicare services, our service offerings include commercial programs, PDP, correctional healthcare services, government-sponsored care under federal contracts with the Department of Defense (DoD), and other various specialty services. Through the utilization of a multi-business line approach, we are able to improve the quality of care, improve outcomes, diversify our revenues and help control our medical costs. In 2020, we served members in all 50 states through approximately 450 product solutions. We are constantly evaluating new opportunities for expansion both domestically and abroad.

- *Localized Approach with Centralized Support Infrastructure.* We take a localized approach to managing our subsidiaries, including provider and member services. This approach enables us to facilitate access by our members to high quality, culturally sensitive healthcare services. Our systems and procedures have been designed to address these community-specific challenges through outreach, education, transportation and other member support activities. For example, our community outreach programs work with our members and their communities to promote health and self-improvement through education on how best to access care. We complement this localized approach with a centralized infrastructure of support functions such as finance, information systems and claims processing, which allows us to minimize selling, general and administrative (SG&A) expenses and to integrate and realize synergies from acquisitions. We believe this combined approach allows us to efficiently integrate new business opportunities in both Managed Care and Specialty Services, while maintaining our local accountability and improved access.

MANAGED CARE

Benefits to Customers

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

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

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

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

- *Managed care expertise in government subsidized programs.* Our expertise in Medicaid has helped us establish and maintain strong relationships with our constituent communities of members, providers and state governments. We

provide access to services through local providers and staff that focus on the cultural norms of their individual communities. To that end, systems and procedures have been designed to address community-specific challenges through outreach, education, transportation and other member support activities.

- *Improved quality and medical outcomes.* We have implemented programs to enhance the ability of providers to improve the quality of healthcare delivered to our members. This is demonstrated through health plan accreditations and program awards.

- *Timely payment of provider claims.* We are committed to ensuring that our information systems and claims payment systems meet or exceed state requirements. We continuously endeavor to update our systems and processes to improve the timeliness of our provider payments.

- *Provider outreach and programs.* Our health plans have adopted a physician-driven approach where network providers are actively engaged in developing and implementing healthcare delivery policies and strategies. We prepare provider comparisons on a severity adjusted basis. This approach is designed to eliminate unnecessary costs, improve services to members and simplify the administrative burdens placed on providers.

- *Care management for complex populations.* Through our experience with Medicaid populations and long-time presence in states with experience in long-term care for children and adolescents in the foster care system, we have developed care management, service coordination and crisis prevention/response programs that increase opportunities for successful outcomes for members. This experience has led to partnerships with specialized networks and community advocates as states transition to managed care programs for vulnerable and complex populations.

- *Responsible collection and dissemination of utilization data.* We gather utilization data from multiple sources, allowing for an integrated view of our members' utilization of services. These sources include medical, vision and behavioral health claims and encounter data, pharmacy data, dental vendor claims and authorization data from the authorization and case management system utilized by us to coordinate care.

- *Timely and accurate reporting.* Our information systems have reporting capabilities which have been instrumental in identifying the need for new and/or improved healthcare and specialty programs. For state agencies, our reporting capability is important in demonstrating an auditable program.

- *Fraud, waste and abuse prevention.* We have several systems in place to help identify, detect and investigate potential fraud, waste, and abuse, including pre- and post-payment review software. We collaborate with state and federal agencies and assist with investigation requests. We use nationally recognized standards to benchmark our processes.

Member Programs and Services

We recognize the importance of member-focused delivery of quality managed care services. Our locally-based staff assists members in accessing care, coordinating referrals to related health and social services and addressing member concerns and questions. While covered healthcare benefits vary from customer to customer and program to program, our health plans generally provide the following services:

- primary and specialty physician care;
- inpatient and outpatient hospital care;
- emergency and urgent care;
- prenatal and postpartum care;
- laboratory and x-ray services;
- home-based primary care;
- transportation assistance;
- vision care;
- dental care;
- telehealth services;
- immunizations;
- prescriptions and limited over-the-counter drugs;
- specialty pharmacy;
- provision of durable medical equipment;
- behavioral health and substance abuse services;

- 24-hour nurse advice line;
- therapies;
- social work services; and
- care coordination.

We also provide a comprehensive set of education and outreach programs to inform, assist and incentivize members to access quality, appropriate healthcare services in an efficient manner. Many of these programs have been recognized with awards for their excellence in education, outreach and/or case management techniques. These awards include Case In Point, Hermes Awards, U.S. Environmental Protection Agency and National Health Information Awards.

- *Start Smart for Your Baby,* or Start Smart, is our award winning prenatal and infant health program designed to increase the percentage of pregnant people receiving early prenatal care, reduce the incidence of low-birth-weight and pre-term babies, identify high-risk pregnancies, increase participation in the federal Women, Infant and Children program, prevent hospital admissions in the first year of life and increase well-child visits. The Neonatal Admissions program is an extension of the Start Smart for Your Baby program with a focus on newborns who have a hospital stay longer than standard after delivery, including those with admissions to the Newborn Intensive Care Unit (NICU). The program strives for timely identification of neonatal admissions to coordinate care and provide member education, resources and member-specific care plans to keep both birth parent and baby safe and healthy in the home environment upon discharge from the hospital.

- *Readmission Reduction* aims to reduce preventable readmissions by ensuring optimal transitional care from acute and non-acute settings. The program focuses on post-hospitalization outreach (PHO), calls to members to verify they understand their discharge instructions, follow up with a Primary Care Physician (PCP), receive medication reconciliation, and, for the highest-risk members, are linked with a Community Health Worker.

- *Chronic Conditions* aims to improve the health and quality of life for members with diabetes, asthma, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), coronary artery disease (CAD), and/or hypertension. The program focuses on reducing emergent utilization and inpatient admissions by increasing treatment adherence, removing barriers to care, and enhancing self-management skills.

- *Fall Prevention* seeks to decrease the number and severity of older adult falls. The program also aims to support members in maintaining their safety, stability, and independence as long as possible. The program leverages an evidence-based falls prevention toolkit to identify members at risk of falling and provide education and interventions to reduce fall risk.

- *Compassionate Connections (Palliative Care)* works to identify members with at least one serious illness and provide necessary services to both members and those individuals close to them. Potential services may include detailed advanced care planning, a multi-team home visit and home health services, and additional social support. Providing palliative care services works to help alleviate members' suffering, and in turn, provide a better quality of life.

- *Emergency Department Diversion* strives to identify members' reasons for visiting the emergency department and connect them with the right care, at the right time, in the right place in the future. The program also identifies opportunities for members to better manage their chronic conditions with the help of PCPs and Care Managers.

- *Fluvention* works to decrease the spread of the flu by increasing the number of members that receive a timely annual flu vaccination. This multi-layered campaign is designed to promote vaccinations as the key to flu prevention. Centene works to address these issues by utilizing enterprise-wide member and provider marketing and education, as well as increasing access to facilities that provide flu vaccinations.

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

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

- *Hepatitis C Care Management Program* seeks to empower patients towards Hepatitis C virus treatment success through a series of telephonic interventions. Goals of the program include preventing premature treatment discontinuation due to medication side effects and access to therapy. Through its family of companies, Envolve clinicians and AcariaHealth patient care coordinators collaborate throughout a patient's treatment course to ensure appropriate therapy management and regimen access.

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

- *OpiEnd Youth Challenge* is a targeted curriculum for adolescents ages 9 through 14 to raise awareness about opioid misuse and prevention. As part of the challenge, teachers and students discuss significant attributes of addiction and opioid misuse, and students then show their understanding by developing and submitting campaign messaging that depicts ways to prevent misuse.

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

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

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

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

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

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

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

- *Outcomes Improvement Central (OIC)* is a highly collaborative initiative that empowers partners across the organization to develop evidence-based clinical programs to promote best practice information sharing, and to establish measurable outcomes for clinical studies. The OIC also serves as a repository of enterprise pilots and programs intended to improve the members' health outcomes.

- *Promotores Health Network (PHN)* is a volunteer-driven community health network designed to improve the community's health through health education specific to health conditions impacting their community and providing guidance and linkage to healthcare services and local resources. PHN provides face-to-face education to members where they live, shop, worship and congregate.

- *myStrength ("The health club for your mind")* is a web and mobile self-help resource to manage depression, anxiety, substance use, and chronic pain. myStrength empowers members to be active participants in their journey to becoming and staying mentally and physically healthy.

- *OpiEnd* is a clinical program designed to identify members at risk for an opioid abuse diagnosis based on a series of critical social and clinical indicators called the Opioid Risk Classification Algorithm (ORCA). Providers will leverage this risk score to flag members for case management and other appropriate interventions. High risk members identified by ORCA will receive educational outreach to provide evidenced-based resources to support pain addiction.

- *Strong Beginnings* addresses the rising US rates of neonatal abstinence syndrome (NAS) and neonatal opioid withdrawal syndrome (NOWS). The program aims to support pregnant people at risk for substance use disorder through case management and care coordination, and to support their providers through incentives and plan of safe care guidance.

Providers

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

Our health plans facilitate access to healthcare services for our members primarily through contracts with our providers. Our contracts with primary and specialty care physicians and hospitals usually are for one to three-year periods and renew automatically for successive one-year terms, but generally are subject to termination by either party upon prior written notice. In the absence of a contract, we typically pay providers at applicable state or federal reimbursement levels, depending on the product (e.g., Medicaid or Medicare). We pay providers under a variety of methods, including fee-for-service, capitation arrangements, and value-based arrangements.

- Under our fee-for-service contracts with providers, we pay a negotiated fee for covered services. This model is characterized as having no financial risk for the provider.

- Under our capitated contracts, providers can be paid a set amount for their services as outlined in their respective provider agreements. A provider group's financial instability or failure to pay secondary providers for services rendered could lead secondary providers to demand payment from us, even though we have made our regular capitated payments to the provider group. Depending on state law and the regulatory environment, it may be necessary for us to pay such claims.

- Under value-based arrangements, providers can be paid under either a capitated or fee-for-service model. The arrangement, however, contains provisions for additional payments to the providers or reimbursement from the providers based upon their performance in cost and quality measures.

In addition, we maintain a network of qualified physicians, facilities, and ancillary providers in the prime service areas of our TRICARE contract. Services are provided on a fee-for-service basis.

We often start our provider relationships in a pay-for-performance arrangement before we transition to a risk-sharing arrangement, which is based on the total cost of care. As we advance along this continuum, it strengthens our partnerships with our providers, enabling the delivery of high quality care.

We work with physicians to help them operate efficiently by providing actionable financial and utilization information, physician and patient educational programs and disease and population health management programs. Our programs are also designed to help physicians coordinate care rendered by other providers.

We believe our local and collaborative approach with physicians and other providers gives us a competitive advantage in entering new markets. Our physicians serve on local committees that assist us in implementing preventive care programs, managing costs and improving the overall quality of care delivered to our members, while also simplifying the administrative

burdens on our providers. This approach has enabled us to strengthen our provider networks through improved physician recruitment and retention that, in turn, has helped to increase our membership base. The following are among the services we provide to support physicians:

- *Provider Engagement Performance Tools and Processes* lead to measurable improvements in quality and health outcomes, healthcare costs, and member satisfaction. High quality and service levels are important as our key customers are increasingly using performance-based measures to select and pay health plans. We have a suite of network performance tools for use by physicians and other providers which monitor the outcomes and care gaps of their individual patient panels. We meet with the providers to review their performance issues and recommend strategies for improvements in their patient panel outcomes. Our tools also allow the physician and others to see where they stand within their value-based contract.

- *Integrated Care Model* is member-centric and managed by one care manager assigned to a member who looks at the total care for the member in a holistic manner. This single care manager will coordinate all care for that member including behavioral health, medical health, and home-based primary care in accordance with an individualized, integrated care plan. This care manager also coordinates meetings with the member's integrated care team to assess and alter the care plan as needed. This results in better outcomes and improvement in member satisfaction.

- *Provider Portal* provides claims and eligibility research, prior authorizations, member panels, care gaps, patient analytics, and provider analytics meant to drive provider engagement and improved patient outcomes. Data and reporting are delivered via a secure, user-friendly web-based provider portal. This is provided through our suite of proprietary technology developed by Interpreta, Apixio and Casenet.

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

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

Quality Management

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

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

- use of nationally recognized InterQual or Milliman criteria to help ensure our members receive the right level of care in the most appropriate setting;

- pre-authorized high-risk medication and services that are commonly over or inappropriately prescribed;

- member education and the provision of appropriate and easily accessed urgent care services to help members avoid unnecessary and costly emergency department visits and improve their healthcare experience;

- emphasis on care management and care coordination where clinicians, such as nurses and social workers who are employed to assist high-risk and other selected members with the coordination of healthcare services that meet their specific needs;

- disease management for chronic illnesses, such as asthma and diabetes through a comprehensive, multidisciplinary and collaborative approach;
- prenatal case management for those with high-risk pregnancies to help them deliver full-term, healthy infants; and
- pharmacy treatment compliance programs driven by evidence-based clinical policies and focused on identifying the appropriate medication in the correct dose, delivered in an efficient format and utilized for the correct duration.

We provide reporting on a regular basis using our data warehouse. State and Health Employer Data and Information Set (HEDIS) reporting constitutes the core of the information base that drives our clinical quality performance efforts. This reporting is monitored by health plan quality improvement committees and our corporate population health management and quality improvement teams.

In an effort to ensure the quality of our provider networks, we verify the credentials and background of our providers using standards that are supported by NCQA.

It is our objective to provide access to the highest quality of care for our members. As a validation of that objective, we pursue accreditation by independent organizations that have been established to promote healthcare quality. NCQA Health Plan Accreditation and URAC Health Plan Accreditation programs provide unbiased, third party reviews to verify and publicly report results on specific quality care metrics. While we have achieved or are pursuing accreditation for all of our plans, accreditation is only one measure of our ability to provide access to quality care for our members. We have achieved accreditation in 30 of 33 eligible states for at least one product (Medicare, Medicaid, or Commercial, including Health Insurance Marketplace).

CMS developed the Medicare Advantage Star ratings system to help consumers choose among competing plans, awarding between 1.0 and 5.0 stars to Medicare Advantage plans based on performance in certain measures of quality.

- For the 2020 Star rating (calculated in 2019 for the quality bonus payment in 2021), two contracts received a 4.5 out of 5.0 Stars, two contracts received 4.0 Stars, four contracts received 3.5 Stars, and seven contracts received 3.0 Stars. In addition, for the 2020 Star rating, we carry a 3.5 Star parent organization rating. Approximately 46% of our Medicare members are in a 4 star or above plan for the 2021 bonus year.
- For the 2021 Star rating (calculated in 2020 for the quality bonus payment in 2022), two contracts received 4.5 out of 5.0 Stars, three contracts received 4.0 Stars, 17 contracts received 3.5 Stars, and 13 contracts received 3.0 Stars. In addition, for the 2021 Star rating, we carry a 3.5 Star parent organization rating. Approximately 30% of our Medicare members are in a 4 star or above plan for the 2022 bonus year.

The parent organization Star rating is used for new Medicare contracts, while existing contracts follow their individual Star ratings to determine bonus payments. We remain committed to our quality initiatives and continue to invest in the programs which we expect to translate into value over the next few years.

SPECIALTY SERVICES

Our specialty services are a key component of our healthcare strategy and complement our core Managed Care business. Our specialty services diversify our revenue stream, enhance the quality of health outcomes for our members and others, and allow Centene to manage costs.

Envolve

Our Envolve brand brings together our extensive portfolio of specialty healthcare solutions. Envolve leverages our collective expertise to provide integrated and comprehensive healthcare for members and other organizations.

- *Pharmacy Solutions.* Envolve Pharmacy Solutions utilizes innovative, flexible solutions and customized care management. We offer traditional pharmacy benefits management as well as comprehensive specialized pharmacy benefit services through our specialty pharmacy businesses, AcariaHealth and PANTHERx. Our traditional pharmacy benefits management program offers progressive pharmacy benefits management services that are specifically designed to improve quality of care while containing costs. This is achieved through a low cost strategy that helps optimize clients' pharmacy benefits. Services that we provide include claims processing, pharmacy network management, benefit design consultation, drug utilization review, formulary and rebate management, online drug

management tools, mail order pharmacy services, home delivery services, analytics and clinical consulting and patient and physician intervention. AcariaHealth offers specialized care management services for complex diseases and enhances the patient care offering through collaboration with providers and the capture of relevant data to measure patient outcomes. PANTHERx serves patients afflicted with rare and devastating conditions through delivering orphan medications to people living with complicated rare diseases.

- *Nurse Advice Line & After-Hours Support* Envolve's Nurse Advice Line brings together our nurse advice, telehealth, and health and wellness programs, allowing for a focus on individual health management through education and empowerment. We offer telehealth services where members engage with customer service representatives and nursing staff who provide health education and triage advice and offer continuous access to health plan functions. Our staff can arrange for urgent pharmacy refills, transportation and qualified behavioral health professionals for crisis stabilization assessments.

- *Vision and Dental Services.* Envolve coordinates benefits beyond traditional medical benefits to offer fully integrated vision and dental health services. Our vision benefit program administers routine and medical surgical eye care benefits through a contracted national network of eye care providers. Through the dental benefit, we are dedicated to improving oral health through a contracted network of dental healthcare providers.

Health Care Enterprises

Our Health Care Enterprises companies aim to improve health outcomes by developing innovative technologies and utilizing efficient care models to reduce healthcare costs.

- *Clinical Healthcare.* Community Medical Group (CMG) provides clinical healthcare, encompassing primary care, access to certain specialty services, and a suite of social and other support services. CMG operates in Florida through an at-risk primary care provider model, focusing on clinical and social care to at-risk beneficiaries.

- *Data Analytics.* Interpreta uses its analytics engine to provide real-time insights to providers, care managers, and payers in the areas of member prioritization, quality management, and risk adjustment. Interpreta's solutions are used by our health plans and available for sale to third parties. Apixio, one of our healthcare analytics companies offers, among other solutions, artificial intelligence (AI) technology which performs retrospective chart reviews for more accurate risk score submission to CMS. Apixio provides services to third party customers as well as our health plans. These businesses continue to digitize the administration of healthcare and accelerate innovation and modernization across the enterprise.

- *Home-Based Primary Care.* U.S. Medical Management (USMM) provides home-based primary care services for high acuity populations and participates as an Accountable Care Organization (ACO) through the CMS Medicare Shared Savings Program.

Other Specialty Companies

Our other specialty companies provide a variety of products and services to complement and expand our business lines.

- *Correctional Healthcare Services.* Centurion provides comprehensive healthcare services to individuals incarcerated in state correctional facilities and detainees in detention facilities in various states. Centurion also provides staffing services to correctional systems and other government agencies.

- *Federal Services.* Health Net Federal Services has a Managed Support Contract in the West Region for the Department of Defense (DoD) TRICARE program. We provide administrative services to Military Health System eligible beneficiaries, which includes eligible active duty service members and their families, retired service members and their families, survivors of retired service members and qualified former spouses.

- *Third Party Administration*. HealthSmart provides customizable and scalable health plan solutions for self-funded employers, universities and colleges, and Native American Tribal Enterprises. Service offerings include plan administration, care management and wellness programs, network, casualty claim, and pharmacy benefit solutions.

We currently have NCQA accreditation and/or URAC accreditation for several of our specialty companies.

CORPORATE COMPLIANCE

Our Ethics and Compliance program assists the organization in developing effective internal controls that promote prevention and detection of fraud, waste and abuse and resolution of instances of conduct that do not conform to federal and state law and private payor healthcare program requirements, as well as our own ethics and business policies. Responsibilities also include the ongoing maintenance of our privacy program and oversight of the Health Insurance Portability and Accountability Act (HIPAA) as they pertain to us and our business units from a compliance, business, and technical perspective.

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

- written standards of conduct;
- designation of compliance officers and compliance committees;
- effective training and education;
- effective lines for reporting and communication;
- enforcement of standards through well-publicized disciplinary guidelines and actions;
- internal monitoring and auditing; and
- prompt response to detected offenses and development of corrective action plans.

The goal of our program is to build a culture of ethics and compliance, which is assessed periodically to measure the values and engagement of the organization. Our Corporate Compliance intranet site, accessible to all employees, contains our Compliance Program description, our Business Ethics and Code of Conduct Policy, and resources for employees to report concerns or ask questions. If needed, employees have access to the contact information for our Board of Directors' Audit Committee Chairman to report concerns. Our Ethics and Compliance Helpline is a toll-free number and web-based reporting tool operated by a third party independent of the Company and allows employees or other persons to report suspected incidents of misconduct, fraud, waste, abuse or other compliance violations anonymously. Furthermore, our Board of Directors has established a Corporate Compliance Committee that, among other things, reviews ethics and compliance reports on a quarterly basis.

ENVIRONMENTAL, SOCIAL, HEALTH, GOVERNANCE AND CORPORATE RESPONSIBILITY

Centene's steadfast commitment to the environment, the health and social well-being of our communities, and our culture of sound and ethical corporate governance extends far beyond individual programs or initiatives. Through the delivery of high-quality healthcare to at-risk populations, our responsibilities to members, stakeholders, and our planet serve as a living expression of our purpose – transforming the health of communities, one person at a time. Continued focus on environmental, social, and governance (ESG) matters remain foundational to supporting our strategy and long-term value creation. These themes were vital as executive leaders from across the enterprise completed an ESG assessment early in 2020. The results of this work led to the development of Centene's Environmental, Social, Health, and Governance (ESHG) Strategic Framework (the Framework), which incorporates our commitment to healthy individuals and healthy communities. Also in 2020, we formed a board-level Environmental and Social Responsibility Committee to oversee implementation of the Framework and formalized a cross-functional work group comprised of executive representatives to advance ESHG initiatives throughout the organization. In December 2020, we issued a Report to the Community to communicate the value of our ESHG efforts. The formalization of Centene’s ESHG Framework enables us to align our business strategy and long-term planning with our commitments to protect our planet, serve our communities, cultivate healthier lives, and live our values. Interested parties can find our December 2020 Environmental, Social, Health and Governance Report within the Investors section of our website, the URL of which is https://www.centene.com/who-we-are/corporate-facts-reports.html. Nothing on our website, including our Environmental, Social, Health and Governance Report or sections thereof, shall be deemed incorporated by reference into this Annual Report.

COMPETITION

We operate in a highly competitive environment in an industry subject to ongoing significant changes, including business consolidations, new strategic alliances, market pressures, and regulatory and legislative reform both at the federal and state level. This includes, but is not limited to, the federal and state healthcare reform legislation described under the heading "Regulation." In addition, changes to the political environment may drive additional changes to the competitive landscape.

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

- *National and Regional Commercial Managed Care Organizations* that focus on providing healthcare services to Medicaid, Medicare and correctional members in addition to members in marketplace and private commercial plans. These organizations consist of national and regional organizations, as well as not-for-profits and organizations that operate in a small geographic location and are owned by providers (primarily hospitals). Some of these organizations offer a range of specialty services including pharmacy benefits management, behavioral health management, population health management, correctional healthcare management, and nurse triage call support centers.

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

- *Accountable Care Organizations* that consist of groups of doctors, hospitals, and other healthcare providers, who come together to provide coordinated high quality care to their patients.

We compete with other Managed Care Organizations and specialty companies for state, county, federal, and commercial contracts. In addition, the impact of the ACA and potential growth in our segment may attract new competitors including technology companies, new joint ventures, financial services firms, consulting firms and other non-traditional competitors. Before granting a contract, state and federal government agencies consider many competitive factors. These factors include quality of care, financial condition, stability and resources, and established or scalable infrastructure with a demonstrated ability to deliver services and establish comprehensive provider networks. Our specialty companies compete with other providers, such as disease management companies, individual health insurance companies, and pharmacy benefits managers for non-governmental contracts.

We also compete to enroll new members and retain existing members. People who wish to enroll in a managed healthcare plan or to change healthcare plans typically choose a plan based on the quality of care and services offered, ease of access to services, a specific provider being part of the network and the availability of supplemental benefits. We believe that the principal competitive features affecting our ability to retain and increase membership include the range and prices of benefit plans offered, size and quality of provider network, quality of service, responsiveness to customer demands, financial stability, comprehensiveness of coverage, diversity of product offerings, market presence and reputation.

We also compete with other managed care organizations in establishing provider networks. When contracting with various health plans, we believe that providers consider existing and potential member volume, reimbursement rates, population health management programs, speed of reimbursement and administrative service capabilities. See "Risk Factors - *Competition may limit our ability to increase penetration of the markets that we serve*."

The relative importance of each of the aforementioned competitive factors and the identity of our key competitors varies by market, including by geography and by product. We believe that we compete effectively against other healthcare industry participants.

REGULATION

Our operations are comprehensively regulated at the local, state, and federal levels. Government regulation of the provision of healthcare products and services is a changing area of law that varies from jurisdiction to jurisdiction. States have implemented National Association of Insurance Commissioners (NAIC) model regulations, requiring governance practices and risk and solvency assessment reporting. States have adopted these or similar measures to enhance regulations relating to corporate governance and internal controls of health maintenance organizations (HMOs) and insurance companies. We are required to maintain a risk management framework and file reports with state insurance regulators.

Regulatory agencies generally have substantial discretion to issue regulations and interpret and enforce laws and rules. Changes in the regulatory environment and applicable laws and rules also may occur periodically, including in connection with changes in political party or administration at the state and federal levels. The ultimate content, timing or effect of any potential future legislation enacted under the new administration remains uncertain.

Our regulated subsidiaries are licensed to operate as HMOs, preferred provider organizations (PPOs), third party administrators, utilization review organizations, pharmacies, direct care providers and/or insurance companies in their respective states. In each of the jurisdictions in which we operate, we are regulated by the relevant insurance, health and/or human services departments,

departments of insurance, boards of pharmacy and other healthcare providers, and departments of health that oversee the activities of managed care organizations and health plans providing or arranging to provide services to enrollees.

The process for obtaining authorization to operate as a managed care organization, health insurance plan, prescription drug plan, pharmacy or provider organization is complex and requires us to demonstrate to the regulators the adequacy of the health plan's organizational structure, financial resources, utilization review, quality assurance programs, proper billing, complaint procedures, and an adequate provider network and procedures for covering emergency medical conditions. For example, under both state managed care organization statutes and insurance laws, our health plan subsidiaries, as well as our applicable specialty companies, must comply with minimum statutory capital and other financial solvency requirements, such as deposit and surplus requirements. Insurance regulations may also require prior state approval of acquisitions of other managed care organization businesses and the payment of dividends, as well as notice for loans or the transfer of funds. Our subsidiaries are also subject to periodic state and federal reporting requirements. In addition, each health plan and individual healthcare provider must meet criteria to secure the approval of state regulatory authorities before implementing certain operational changes, including without limitation changes to existing offerings, the development of new product offerings, certain organizational restructurings and, in some states, the expansion of service areas.

States have adopted a number of regulations that may affect our business and results of operations. These regulations in certain states include:

- premium taxes or similar assessments imposed on us;
- stringent prompt payment laws requiring us to pay claims within a specified period of time;
- disclosure requirements regarding provider fee schedules and coding procedures; and
- programs to monitor and supervise the activities and financial solvency of provider groups.

We are regulated as an insurance holding company and are subject to the insurance holding company acts of the states in which our insurance company and HMO subsidiaries are domiciled. These acts contain certain reporting requirements as well as restrictions on transactions between an insurer or HMO and its affiliates. These holding company laws and regulations generally require insurance companies and HMOs within an insurance holding company system to register with the insurance department of each state where they are domiciled and to file with those states' insurance departments reports describing capital structure, ownership, financial condition, intercompany transactions and general business operations. In addition, depending on the size and nature of the transaction, there are various notice and reporting requirements that generally apply to transactions between insurance companies and HMOs and their affiliates within an insurance holding company structure. Some insurance holding company laws and regulations require prior regulatory approval or, in certain circumstances, prior notice of certain material intercompany transfers of assets as well as certain transactions between insurance companies, HMOs, their parent holding companies and affiliates. Among other provisions, state insurance and HMO laws may restrict the ability of our regulated subsidiaries to pay dividends.

Additionally, the holding company regulations of the states in which our subsidiaries are domiciled restrict the ability of any person to obtain control of an insurance company or HMO without prior regulatory approval. Under those statutes, without such approval or an exemption, no person may acquire any voting security of an insurance holding company, which controls an insurance company or HMO, or merge with such a holding company, if as a result of such transaction such person would "control" the insurance holding company. "Control" is generally defined as the direct or indirect power to direct or cause the direction of the management and policies of a company and is presumed to exist if a person directly or indirectly owns or controls 10% or more of the voting securities of a company.

PPO regulation also varies by state and covers all or most of the subject area referred to above.

Our pharmacies must be licensed to do business as pharmacies in the states in which they are located. Our pharmacies must also register with the U.S. Drug Enforcement Administration and individual state controlled substance authorities to dispense controlled substances. In many of the states where our pharmacies deliver pharmaceuticals, there are laws and regulations that require out-of-state mail order pharmacies to register with that state's board of pharmacy or similar regulatory body. These states generally permit the pharmacy to follow the laws of the state in which the mail order pharmacy is located, although some states require that we also comply with certain laws in that state.

Our healthcare providers must be licensed to practice medicine and do business as care providers in the state in which they are located. In addition, they must be in good standing with the applicable medical board, board of nursing or other applicable entity. Furthermore, they cannot be excluded from participation at either the state or federal levels. Our facilities are periodically reviewed by state departments of health and other regulatory agencies to ensure the environment is safe to provide care.

Federal law has also implemented other health programs that are partially funded by the federal government, such as the Medicaid and Medicare programs. Our Medicaid programs are regulated and administered by various state regulatory bodies. Federal funding remains critical to the viability of these programs. Federal law permits the federal government to oversee and, in some cases, to enact, regulations and other requirements that must be followed by states with respect to these programs. Medicaid is administered at the federal level by CMS. Comprehensive legislation, specifically Title XVIII of the Social Security Act, governs our Medicare program. In addition, our Medicare contracts are subject to regulation by CMS. CMS has the right to audit Medicare contractors and the healthcare providers and administrative contractors who provide certain services on their behalf to determine the quality of care being rendered and the degree of compliance with CMS contracts and regulations.

The ACA transformed the U.S. healthcare system through a series of complex initiatives. Some of the ACA's most significant provisions include the imposition of significant fees, assessments and taxes, including the non-deductible tax (technically called a "fee") on health insurers based on prior year net premiums written (the "health insurer fee" or "HIF"); the establishment of federally-facilitated and state-based Health Insurance Marketplaces where individuals and small groups may purchase health coverage; the implementation of certain premium stabilization programs designed to apportion risk amongst insurers; and the optional Medicaid Expansion. State and federal regulators have continued to provide additional guidance and specificity to the ACA, and we continue to monitor this new information and evaluate its potential impact on our business. In December 2018, a partial summary judgment ruling in Texas v. United States of America held that the ACA's individual mandate requirement was essential to the ACA, and without it, the remainder of the ACA was invalid (i.e., that it was not "severable" from the ACA). That decision was appealed to the Fifth Circuit, which ruled in December 2019 that the individual mandate was unconstitutional after Congress eliminated the individual mandate penalty, and remanded the case to the district court for additional analysis on the question of severability. The Supreme Court heard oral arguments in November 2020 and a ruling is anticipated in 2021. The ACA remains in effect until judicial review of the decision is concluded. For a further discussion of the ACA, see "Risk Factors - *The implementation of the ACA, as well as potential repeal of, changes to, or judicial challenges to the ACA, could materially and adversely affect our results of operations, financial position and cash flows*".

We must also comply with laws and regulations related to the award, administration and performance of U.S. Government contracts. Government contract laws and regulations affect how we do business with our customers and, in some instances, impose added costs on our business. Money laundering is a method of attempting to conceal the origins of money gained through illegal activity and is itself a crime that can result in substantial criminal and civil sanctions including fines and imprisonment. To ensure compliance with anti-money laundering laws and regulations, it is our policy to conduct business only with legitimate customers and counterparties whose funds are derived from legitimate commercial activity. In addition, as a result of our international operations, we are also subject to the U.S. Foreign Corrupt Practices Act (FCPA) and similar worldwide anti-corruption laws, including the U.K. Bribery Act of 2010, which generally prohibit companies and their intermediaries from making improper payments to non-U.S. officials for the purpose of obtaining or retaining business. A violation of specific laws and regulations by us and/or our agents could result in, among other things, the imposition of fines and penalties on us, changes to our business practices, the termination of our contracts or debarment from bidding on contracts.

State and Federal Contracts

In addition to being a licensed insurance company or HMO, in order to be a Medicaid managed care organization in each of the states in which we operate, we generally must operate under a contract with the state's Medicaid agency. States generally either use a formal proposal process, reviewing a number of bidders, or award individual contracts to qualified applicants that apply for entry to the program. Under these state Medicaid program contracts, we receive monthly payments based on specified capitation rates determined on an actuarial basis. These rates differ by membership category and by state depending on the specific benefits and policies adopted by each state. In addition, several of our Medicaid contracts require us to maintain Medicare Advantage special needs plans, which are regulated by CMS, for dual eligible individuals within the state.

We provide Medicare Advantage, PDPs, DSNPs, and MMP which are provided under contracts with CMS and subject to federal regulation regarding the award, administration and performance of such contracts. CMS also has the right to audit our performance to determine our compliance with these contracts, as well as other CMS regulations and the quality of care we provide to Medicare beneficiaries under these contracts. We additionally provide behavioral and other healthcare services to correctional systems under contracts in certain states which are also subject to state regulation.

Our government contracts include government-sponsored managed care and administrative services contracts through the TRICARE program and certain other healthcare-related government contracts.

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

- eligibility, enrollment and dis-enrollment processes;
- covered services;
- eligible providers;
- subcontractors;
- record-keeping and record retention;
- periodic financial and informational reporting;
- quality assurance;
- accreditation;
- health education and wellness and prevention programs;
- timeliness of claims payment;
- financial standards;
- safeguarding of member information;
- fraud, waste and abuse detection and reporting;
- grievance procedures; and
- organization and administrative systems.

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

Our health plans operate through individual state contracts, generally with an initial term of one to five years. The contracts often have renewal or extension terms or are renewable through the state's reprocurement process. The contracts generally are subject to termination for cause, an event of default or lack of funding, among other things.

Marketplace Contracts

We operate in 22 states under federally-facilitated marketplace contracts with CMS and state-based exchanges. Both contract types are renewable on an annual basis.

We operate under a contract with the Arkansas Department of Human Services Division of Medical Services and the Arkansas Insurance Department to participate in the Medicaid expansion model that Arkansas has adopted (referred to as "Arkansas Works").

Privacy Regulations

We are subject to various international, federal, state and local laws and rules regarding the use, security and disclosure of protected health information, personal information, and other categories of confidential or legally protected data that our businesses handle. Such laws and rules include, without limitation, HIPAA, the Federal Trade Commission Act, the Gramm-Leach-Bliley Financial Modernization Act of 1999 (Gramm-Leach-Bliley Act), the General Data Protection Regulation (GDPR) in the European Union (EU), and state privacy and security laws such as the California Confidentiality of Medical Information Act and the California Online Privacy Protection Act. Privacy and security laws and regulations often change due to new or amended legislation, regulations or administrative interpretation. A variety of state and federal regulators enforce these laws, including but not limited to the U.S. Department of Health and Human Services (HHS), the Federal Trade Commission, state attorneys general and other state regulators.

HIPAA is designed to improve the portability and continuity of health insurance coverage, simplify the administration of health insurance through standard transactions and ensure the privacy and security of individual health information. Among the requirements of HIPAA are the Administrative Simplification provisions which include: standards for processing health insurance claims and related transactions (Transactions Standards); requirements for protecting the privacy and limiting the use and disclosure of medical records and other personal health information (Privacy Rule); and standards and specifications for safeguarding personal health information which is maintained, stored or transmitted in electronic format (Security Rule). The Health Information Technology for Economic and Clinical Health (HITECH) Act amended certain provisions of HIPAA and enhanced data security obligations for covered entities and their business associates. HITECH also mandated individual notifications in instances of a data breach, provided enhanced penalties for HIPAA violations, and granted enforcement

authority to states' Attorneys General in addition to the HHS Office for Civil Rights. The HIPAA Omnibus Rule further enhanced the changes under the HITECH Acts and the Genetic Information Nondiscrimination Act of 2008 (GINA) which clarified that genetic information is protected under HIPAA and prohibits most health plans from using or disclosing genetic information for underwriting purposes. These regulations also establish significant criminal penalties and civil sanctions for non-compliance. The preemption provisions of HIPAA provide that the federal standards will not preempt state laws that are more stringent than the related federal requirements.

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

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

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

In addition, we process and maintain personal card data, particularly in connection with our Marketplace business. As a result, we must maintain compliance with the Payment Card Industry (PCI) Data Security Standard, which is a multifaceted security standard intended to optimize the security of credit, debit and cash card transactions and protect cardholders against misuse of their personal information.

Other Fraud, Waste and Abuse Laws

Investigating and prosecuting healthcare fraud, waste and abuse continues to be a top priority for state and federal law enforcement entities. The focus of these efforts has been directed at Medicare, Medicaid, Health Insurance Marketplace and commercial products. The fraud, waste and abuse laws include the federal False Claims Act, which prohibits the known filing of a false claim or the known use of false statements to obtain payment from the federal government. Many states have false claim act statutes that closely resemble the federal False Claims Act. Additional fraud, waste and abuse prohibitions include a wide range of operating activities, such as kickbacks or other inducements for referral of members or for the coverage of products (such as prescription drugs) by a plan, billing for unnecessary medical services by a provider, improper marketing and violation of patient privacy rights. The laws and regulations relating to fraud, waste and abuse and the requirements applicable to health plans, PDPs and providers participating in these programs are complex and change regularly. Compliance with these laws may require substantial resources. We are constantly looking for ways to improve our fraud, waste and abuse detection methods. While we have both prospective and retrospective processes to identify abusive patterns and fraudulent billing, we continue to increase our capabilities to proactively detect inappropriate billing prior to payment.

HUMAN CAPITAL RESOURCES

As the pace of change, complexity and uncertainty in the broader environment accelerates, we continue our strong investment in creating a purpose-driven culture and attracting, developing and retaining top talent. We seek out individuals with ambition for extraordinary impact and believe every employee is a leader and is critical to helping us transform the health of communities for those we serve. Our entrepreneurial spirited workforce is driven by a steadfast commitment to a diverse, inclusive and safe workplace, is enabled through robust talent development programs, is supported by competitive compensation, benefits and health and wellness programs, and is optimized by full alignment with our purpose, values, and strategy through meaningful connections between our employees and their communities.

As of December 31, 2020, we had approximately 71,300 employees. During fiscal 2020, the number of employees increased by approximately 14,700 or 26%, primarily due to the acquisition of WellCare in 2020. During fiscal 2020, our voluntary turnover

rate was less than 10%, which is in line with the insurance industry standard benchmark, which is comprised of certain of our key competitors (AON Salary Increase and Turnover Study – Second Edition (September 2020)).

Diversity and Inclusion

We believe that a diverse workforce and inclusive environment enables competitive advantage and fuels improved service, innovation and performance with all stakeholders. We thoughtfully engage diverse talent across Centene, preparing women and underrepresented employees for leadership roles, and hiring diverse candidates who have a passion for serving our members and ambition for extraordinary impact.

We have a wide range of programs focused on early identification and accelerated development of diverse talent, including our Employee Inclusion Groups (EIGs), which help us further enhance our inclusive workforce culture. These voluntary, employee led groups support the attraction, development and retention of talent at all levels. EIGs provide professional and leadership opportunities, contribute to community engagement initiatives and support business innovation and corporate best practices. Because of their significant value to us, we support EIGs through leadership involvement, work time and space, resources and Executive Mentors. Today, there are over 10,000 participants across all five EIGs providing professional and leadership development opportunities for women, military veterans, individuals with disabilities, LGBTQ+ and multicultural employees. Each EIG offers mentorship programs aligned with our leadership model and bring in unique lived experiences in an effort to ensure we are meeting employees at their level to deliver the best outcomes for their development. EIGs also partake in networking events, training programs, fireside chats and panels addressing current issues and other development opportunities for their members.

Our team of talent advisors are responsible for leading the end-to-end search process, and leveraging our resources, tools and technologies to help our hiring leaders carefully consider the capabilities required to continue to propel our organization forward. Our talent advisors receive Advisory and Certified Diversity Recruiter training which are designed to ensure we consistently attract diverse pools of exceptional talent.

In 2021, we released our inaugural 2020 Diversity & Inclusion Annual Report, which may be reviewed for more detailed information regarding our Human Capital programs and initiatives. Interested parties can find our 2020 Diversity & Inclusion Annual Report within the Investors section of our website, the URL of which is https://www.centene.com/who-we-are/corporate-facts-reports.html. Nothing on our website, including our Diversity and Inclusion Report or sections thereof, shall be deemed incorporated by reference into this Annual Report.

Health, Safety and Well-Being

We provide our employees and their families with access to a variety of health and wellness programs, including benefits that provide protection and security when events arise that may require time away from work or that impact our employees' financial well-being; that support their physical, mental and well-being health; and that offer choice where possible so they can customize their benefits to meet their needs and the needs of their families.

In 2020, when COVID-19 presented an extraordinary threat to the health of our workforce, we responded quickly, equipping nearly 90% of our workforce to work from home within days of the declaration of the pandemic. We also enacted several new benefits, such as: ten days of additional emergency paid sick leave, a technology stipend, in office premium pay, and waived prior authorizations and cost sharing for COVID-19 related employee care. We further supported our workforce by providing assistance to those with school-aged children through a partnership with an online tutoring organization to provide deeply discounted one-on-one tutoring and group and after-school enrichment classes at no cost. We also created an employee resource site to provide well-being resources. Additionally, we established a highly trained, dedicated contact tracing concierge team to support employee's well-being and provide easy access to HR professionals to respond to COVID-related questions.

In addition to workforce benefits and enhanced employee concierge services, we also enacted several new facility modifications and protocols to help ensure the safety of our employees. For instance, while most of our cubicles are already 6x6 feet or larger in dimension, we invested more than $20 million to retrofit with acrylic screens our cubicles, reception and security desks, as well as workstations for additional protection from the spread of respiratory droplets. These protective screens were installed for over 60,000 cubicles across the country. In large campuses, thermal scanning cameras were installed to identify elevated temperatures of all employees and visitors. To promote a healthy distance among colleagues, structured walking paths were created in the hallways of our offices, directional signage has been prepared to guide employees through walking paths, and common areas have been restricted.

In a recent COVID-19 survey focused on employee sentiment and our response to COVID-19, 89% of employees responded favorably (agreed or strongly agreed) to our approach across five key areas: leadership, communications, consistency, care for people, and COVID-19 situation.

Compensation and Benefits

Our compensation and benefits programs are market competitive and designed to attract and retain qualified employees. Our overall compensation philosophy is to pay for performance by linking the achievement of both Company and individual goals to total compensation. In addition to base pay, these programs (which vary by country/region) include annual bonuses, stock awards, an employee stock purchase plan, and a 401(k) plan.

Our benefits cover various aspects of an employee's life to help them live healthy. These include medical, dental and vision insurance, short- and long-term disability, supplemental accidental death and dismemberment and life insurance, wellness program, flexible spending accounts, parental leave and caregiver leave.

We also offer benefits to help employees achieve optimum work-life balance. These include vacation, paid personal and sick time, paid company holidays, paid community volunteer time, an employee assistance program, tuition reimbursement/educational assistance, adoption reimbursement, on-site fitness centers or discount at local fitness centers.

Talent Development

Through our robust talent infrastructure, we continue working to deepen and prepare our talent bench and workforce, which is necessary to support our growth strategy. We believe every employee is a leader and is critical to our success in transforming communities. Our leadership model sets expectations for what it means to lead at Centene and through Centene University, we build skills for how to lead. Centene University is our personalized learning platform and is accessible to all employees, providing both instructor-led and self-directed learning that enables employees to develop their professional and business skills from anywhere and at any time. Our business-led flagship leadership development program, APEX, is a multi-day, instructor-led program, designed to expand mindsets and build capabilities to help our workforce thrive in the future. In 2020, we strengthened our commitment to talent development and activated APEX digital learnings for our full workforce. The asynchronous sessions focused on building skills to thrive in the evolving world of work, including: customer-centricity, digital dexterity, perseverance and resilience, and end-to-end problem solving. We also repositioned our front line leader program to a virtual, instructor-led program, connecting with approximately 5,000 people leaders.

In addition to building new workforce skills, we utilize our ongoing enterprise talent reviews, succession planning, career development planning and comprehensive HR analytics to provide insights to senior leaders to inform actions and drive intentional talent results through our People Plans, the integrated human capital component of our annual operating plans.

Organizational Culture – Meaningful Connections between Employees and the Communities We Serve

We, our health plans, and our subsidiaries have long been leaders in transforming the health of our members and the communities where they live. We believe in local partnerships and value the innovative programs and services that they provide for underserved and at-risk populations. We attract a workforce that is purpose-driven and passionate about transforming communities and we recognize the importance of volunteering and supporting the communities in which we serve. We support our workforce by providing paid time off benefits for employees to participate in individual and work-related community volunteer programs. Additionally, to support our communities during the pandemic, we established an additional emergency volunteer benefit, which provides medical and behavioral health professional employees with paid volunteer time off for up to 3 months.

With a largely remote workforce in 2020, we took additional steps to ensure a highly connected workforce, including new monthly forums for people leaders, new weekly communications for all employees, and new employee programming to engage in transparent dialogue on social issues.

More than 92% of our employees responded to the 2020 Shaping Centene Employee Engagement Survey and 88% of employees reported strong engagement, which surpassed the 75th percentile of Fortune 100 benchmark companies. Based on their responses, employees were strongly aligned with our strategy, with 96% understanding our mission and 92% understanding our objectives.

Information about our Executive Officers

The following table sets forth information regarding our executive officers, including their ages, at February 19, 2021:

Name	Age	Position
Michael F. Neidorff	78	Chairman, President and Chief Executive Officer
Mark J. Brooks	51	Executive Vice President and Chief Information Officer
Brandy L. Burkhalter	48	Executive Vice President, Chief Operating Officer
Jesse N. Hunter	45	Executive Vice President and Chief Strategy Officer
Christopher R. Isaak	54	Senior Vice President, Corporate Controller and Chief Accounting Officer
Christopher A. Koster	56	Senior Vice President, General Counsel and Secretary
Brent D. Layton	53	Executive Vice President, Markets, Products, International, and Chief Business Development Officer
Sarah M. London	40	Senior Vice President, Technology, Innovation and Moderation
Jeffrey A. Schwaneke	45	Executive Vice President, Chief Financial Officer
David P. Thomas	55	Executive Vice President, Markets

Michael F. Neidorff. Mr. Neidorff has served as our Chairman, President and Chief Executive Officer since April 2019. From November 2017 to April 2019, he served as our Chairman and Chief Executive Officer. From May 2004 to November 2017, he served as Chairman, President and Chief Executive Officer. From May 1996 to May 2004, he served as President, Chief Executive Officer and as a member of our Board of Directors.

Mark J. Brooks. Mr. Brooks has served as our Executive Vice President and Chief Information Officer since November 2017. From April 2016 to November 2017, he served as Senior Vice President and Chief Information Officer. Prior to joining Centene, he served as the Chief Information Officer at Health Net from 2012 to 2016.

Brandy L. Burkhalter. Ms. Burkhalter has served as our Executive Vice President, Chief Operating Officer since June 2018. From December 2015 to June 2018, she served as Executive Vice President, Internal Audit & Risk Management.

Jesse N. Hunter. Mr. Hunter has served as our Executive Vice President and Chief Strategy Officer since November 2017. From January 2016 to November 2017, he served as Executive Vice President, Products.

Christopher R. Isaak. Mr. Isaak has served as our Senior Vice President, Corporate Controller and Chief Accounting Officer since April 2016. Prior to joining Centene, he served as Vice President, Corporate Controller at TTM Technologies from 2015 to 2016 and Vice President, Corporate Controller at Viasystems Group, Inc. from 2006 to 2015 and served as Chief Accounting Officer from 2010 to 2015.

Christopher A. Koster. Mr. Koster has served as Senior Vice President, Secretary and General Counsel since February 2020. From February 2017 to February 2020, he served as Senior Vice President, Corporate Services. Prior to joining Centene, Mr. Koster served as Missouri Attorney General for eight years.

Brent D. Layton. Mr. Layton has served as our Executive Vice President, Markets, Products, International, and Chief Business Development Officer since January 2021. From July 2016 to December 2020, he served as Executive Vice President and Chief Business Development Officer. From September 2011 to June 2016, he served as Senior Vice President, Business Development.

Sarah M. London. Ms. London has served as our Senior Vice President, Technology and Modernization since September 2020. Prior to joining Centene, she served as both Senior Principal and Partner for Optum Ventures from May 2018 to March 2020 and Chief Product Officer of Optum from March 2016 to May 2018. From March 2014 to March 2016, she served as Vice President, Client Management and Operations for Humedica.

Jeffrey A. Schwaneke. Mr. Schwaneke has served as our Executive Vice President, Chief Financial Officer since March 2016 and was also our Treasurer from March 2016 to July 2020. From July 2008 to March 2016, he served as our Senior Vice President, Corporate Controller and served as our Chief Accounting Officer from September 2008 to March 2016.

David P. Thomas. Mr. Thomas has served as our Executive Vice President of Markets since October 2019. From January 2019 through October 2019, he served as President and Chief Executive Officer of Fidelis Care. From May 2018 to December 2018, he served as President of Fidelis Care. He also previously served as Chief Operating Officer for Fidelis Care from January 2012 through April 2018.

Available Information

We are subject to the reporting and information requirements of the Securities Exchange Act of 1934, as amended (Exchange Act) and, as a result, we file periodic reports and other information with the Securities and Exchange Commission, or SEC. We make these filings available on our website free of charge, the URL of which is https://www.centene.com, as soon as reasonably practicable after we electronically file such material with, or furnish it to, the SEC. The SEC maintains a website (https://www.sec.gov) that contains our annual, quarterly and current reports and other information we file electronically with the SEC. Information on our website does not constitute part of this Annual Report on Form 10-K.

ITEM 1A. ***Risk Factors.***

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. Unless the context otherwise requires, the terms the "Company," "we," "us," "our" or similar terms and "Centene" (i) prior to the closing of the Magellan Acquisition, refer to Centene Corporation, together with its consolidated subsidiaries, without giving effect to the Magellan Acquisition, and (ii) upon and after the closing of the Magellan Acquisition, refer to us, after giving effect to the Magellan Acquisition.

Risks Relating to Our Business

Our business could be adversely affected by the effects of widespread public health pandemics, such as the spread of COVID-19.

Public health pandemics or widespread outbreaks of contagious diseases could adversely impact our business. In December 2019, a novel strain of coronavirus (COVID-19) emerged, which has now spread globally, including throughout the United States. The extent to which COVID-19 continues to impact our business will depend on future developments, which are highly uncertain and cannot be predicted with confidence. Factors that may determine the severity of the impact include the duration and scale of the outbreak, new information which may emerge concerning the severity of COVID-19, (including new strains, which may be more contagious, more severe or less responsive to treatment or vaccines), the costs of prevention and treatment of COVID-19 and the potential that we will not receive state and federal government reimbursement of additional expenses incurred by our members who contract or require testing for COVID-19 or who experience other health impacts as a result of the pandemic, employee mobility, productivity and utilization of leave and other benefits, financial and other impacts on the healthcare provider community, disruptions or delays in the supply chain for testing and treatment supplies, protective equipment and other products and services, and the actions to contain COVID-19 or address its impact (including federal, state and local laws, regulations and emergency orders, including directives to remain at home, physically distance or forced business closures as well as the timing and scope of vaccine distribution), among others. Additionally, the spread of COVID-19 has led to disruption and volatility in the global capital markets, which could adversely impact our access to capital, and a decline in interest rates which could reduce our investment income. Finally, the impact of the above items on our state and federal partners could result in program changes or delays or reduced capitation payments to us. We cannot at this time predict the ultimate impact of the COVID-19 pandemic, but it could adversely affect our business, including our financial position, results of operations and/or cash flows.

Our Medicare programs are subject to a variety of unique 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 negative outcomes from program audits, sanctions, penalties or other actions; if we do not submit adequate bids in our existing markets or any expansion markets; if our existing contracts are modified or 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. For example, in October 2020, the Centers for Medicare and Medicaid Services (CMS) published updated Medicare Star quality ratings for the 2021 rating year. Approximately 30% of our Medicare members are in a 4 star or above plan for the 2022 bonus year, compared to 46% for the 2021 bonus year and 86% for the 2020 bonus year. Our quality bonus and rebates may be negatively impacted in 2021 and 2022 and the attractiveness of our Medicare Advantage plans may be reduced.

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.

Although we do not anticipate that a single-payer national health insurance system will be enacted by the current Congress, members of Congress have proposed several legislative initiatives over various sessions of Congress that would establish some

form of a single public or quasi-public agency that organizes healthcare financing, but under which healthcare delivery would remain private. Additionally, the potential impact of the change of administration on healthcare reform efforts is unknown. We are unable to predict the nature and success of these or other initiatives or political changes, which could have an adverse effect on our business.

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

Our profitability depends to a significant degree 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 expenses exceed our estimates, our Health Benefits Ratio (HBR), or our expenses related to medical services as a percentage of premium revenues, 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 diseases (such as COVID-19), 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. Also, member behavior could continue to be influenced by the uncertainty surrounding the ACA, including ongoing legal challenges to the ACA including the case originally captioned Texas v. United States, which is currently pending before the Supreme Court.

Our medical expenses include 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 expenses 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 or region or launch a new 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.

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.

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

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

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

Government customers have performed and continue to perform audits of selected plans to validate the provider coding practices under the risk adjustment model used to calculate the premium paid for each member. In 2018, CMS proposed the removal of the fee for service adjuster from the risk adjustment data validation audit methodology. If adopted, this proposal, or any similar CMS rule making initiative, could increase our audit error scores. We anticipate that CMS will continue to conduct audits of our Medicare contracts and contract years on an on-going basis. An audit may result in the refund of premiums to CMS. It is likely that a payment adjustment could occur as a result of these audits; and any such adjustment could have a material adverse effect on our results of operations, financial condition and cash flows.

Any failure to adequately price products offered or any reduction in products offered in the Health Insurance Marketplaces may have a negative impact on our results of operations, financial position and cash flow.

Due to among other things, the elimination of the individual mandate penalty in the Tax Cuts and Jobs Act (TCJA), we may be adversely selected by individuals who have higher acuity levels than those individuals who selected us in the past and healthy individuals may decide to opt out of the pool altogether. In addition, the risk adjustment 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, are subject to a high degree of estimation and variability, and are affected by our members' acuity relative to the membership acuity of other insurers. Further, 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, or require us to increase premium rates. Any significant variation from our expectations regarding acuity, enrollment levels, adverse selection, 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.

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

A significant portion of our PDP membership is obtained from the auto-assignment of beneficiaries in CMS-designated regions where our PDP premium bids are below benchmarks of other plans' bids. In general, our premium bids are based on assumptions regarding PDP membership, utilization, drug costs, drug rebates and other factors for each region. Our 2021 PDP bids resulted in 33 of the 34 CMS regions in which we were below the benchmarks, and within the de minimis range in the remaining region, compared with our 2020 PDP bids in which we were below the benchmarks in 32 regions, and within the de minimis range in the remaining two regions. For those regions in which we are within the de minimis range, we will not be eligible to have new members auto-assigned to us, but we will not lose our existing auto-assigned membership.

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

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

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

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

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 an additional specified number of years if the contracting entity or its agent elects to do so. When our contracts with government entities 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.

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; lowered quality Star ratings; or required 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 either new programs to determine eligibility or new processes to assign or enroll eligible members into health plans, or when it chooses new subcontractors, there is an increased potential for an unanticipated impact on the overall number of members assigned to managed care plans.

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

Our growth strategy includes, without limitation, the acquisition and expansion 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. We continue to pursue opportunistic acquisitions to expand into new geographies and complementary business lines as well as to augment existing operations, and we may be in discussions with respect to one or multiple targets at any given time. 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 and system migrations, 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, including those related to stay-at-home directives and other impacts of COVID-19. As a result of these factors, start-up operations may decrease our profitability. The timing of operating our new East Coast headquarters in Charlotte, and the expected benefits of its completion, may also be negatively impacted as a result of these factors. In addition, we are planning to further 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, including as a result of the continued impact of COVID-19, our future growth will suffer and our results of operations could be harmed.

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

We are seeking to diversify our business lines into areas that complement our government sponsored health plan business in order to grow our revenue stream and diversify our business. 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.

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. In addition to state corporate law limitations, these subsidiaries are subject to more stringent state insurance and HMO laws and 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 or delay our subsidiaries' requests to pay dividends, the funds available to us would be limited, which could harm our ability to implement our business strategy.

We derive a significant portion of our premium revenues from operations in a limited number of states, and our results of operations, financial position or cash flows could 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 a significant portion 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 revenues 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, as well as technology companies, new joint ventures, financial services firms, consulting firms and other non-traditional competitors. In addition, the administration of the ACA has the potential to shift the competitive landscape in our segment.

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, and access to services, be able to provide effective telehealth services, maintain financial solvency, including due to the impact of COVID-19, 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, our 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, our 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.

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, which may include cyber-attacks by terrorists or other governmental or non-governmental actors. In addition, we may from time to time obtain significant portions of our systems-related or other services or facilities from independent third parties, which may make our operations vulnerable if such third parties fail to perform adequately.

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.

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 prevention and detection 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.

Risks Relating to Regulatory and Legal Matters

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 results of operations, financial position and cash flows.

The majority of our revenues come from government subsidized healthcare programs including Medicaid, Medicare, TRICARE, CHIP, LTSS, 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 approximately 60%. We are therefore exposed to risks associated with federal 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 governments to terminate or modify contracts with them, 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; 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; and other regulatory, legislative or judicial actions that may have an impact on the operations of government subsidized healthcare programs including ongoing litigation involving the ACA. 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, CHIP, LTSS, 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, which was extended by the Bipartisan Budget Act of 2019 through 2029. The Coronavirus Aid, Relief, and Economic Security Act of 2020 temporarily suspended the Medicare sequestration for the period of May 1, 2020 through December 31, 2020, while also extending the mandatory sequestration policy by an additional one year, through 2030. The Bipartisan-Bicameral Omnibus COVID Relief Deal passed in December 2020 further extended the suspension of the Medicare sequestration until March 31, 2021.

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 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 one or more contracts for the convenience of the government, may materially and adversely affect our results of operations, financial position and cash flows. In addition, if another federal government shutdown were to occur for a prolonged period of time, federal government payment obligations, including its obligations under Medicaid, Medicare, TRICARE, CHIP, LTSS, 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.

Payments from government payors may be delayed 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 revenues 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.

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

The enactment of the ACA in March 2010 transformed the U.S. healthcare delivery system through a series of complex initiatives; however, the implementation of the ACA continues to face administrative, judicial and legislative challenges to repeal or change certain of its significant provisions. Changes to, or repeal of, portions or the entirety of the ACA, as well as judicial interpretations in response to constitutional and other legal challenges, as well as the uncertainty generated by such actual or potential challenges, 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 under the current administration, a future administration or members of Congress could continue to propose changes impacting implementation of the ACA, which could materially and adversely affect our financial position or operations.

Among the most significant of the ACA's provisions was the establishment of the Health Insurance Marketplace for individuals and small employers to purchase health insurance coverage that included a minimum level of benefits and restrictions on coverage limitations and premium rates, as well as the expansion of Medicaid coverage to all individuals under age 65 with incomes up to 138% of the federal poverty level beginning January 1, 2014, subject to each state's election. The HHS additionally indicated that it would consider a limited number of premium assistance demonstration proposals from states that want to privatize Medicaid expansion. Arkansas was 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 on January 1, 2014. Several states have obtained Section 1115 waivers to implement the ACA's Medicaid expansion in ways that extend beyond the flexibility provided by the federal law, with additional states pursuing Section 1115 waivers regarding eligibility criteria, benefits, and cost-sharing, and provider payments across their Medicaid programs. Litigation challenging Section 1115 waiver activity for both new and previously approved waivers is expected to continue both through administrative actions and the courts.

There have been significant administrative efforts to repeal, or limit implementation of, certain provisions of the ACA through changes in regulations. Such initiatives include repeal of the individual mandate effective in 2019, as well as easing the regulatory restrictions placed on short-term health plans and association health plans (AHPs), which plans often provide fewer benefits than the traditional ACA insurance benefits.

Additionally, the U.S. Department of Labor issued a final rule on June 19, 2018 which expanded flexibility regarding the regulation and formation of AHPs provided by small employer groups and associations. On June 13, 2019, the HHS, the U.S. Department of Labor and the U.S. Treasury issued a final rule allowing employers of all sizes that do not offer a group coverage plan to fund a new kind of health reimbursement arrangement (HRA), known as an individual coverage HRA (ICHRA). Beginning January 1, 2020, employees became able to use employer-funded ICHRAs to buy individual-market insurance, including insurance purchased on the public exchanges formed under the ACA.

In addition to administrative efforts to expand the flexibility of other insurance plan options that are not required to meet ACA requirements, there have also been efforts to address the ACA's non-deductible tax imposed on health insurers based on prior year net premiums written (the "health insurer fee" or "HIF"). The ACA imposed HIF was $8.0 billion in 2014, and $11.3 billion in each of 2015 and 2016, with increasing annual amounts thereafter. The HIF payable in 2017 was suspended by the Consolidated Appropriations Act for fiscal year 2016; however, a $14.3 billion payment occurred in 2018. Collection of the HIF for 2019 was also suspended, but resumed in 2020 with a $15.5 billion payment. Congress passed a spending bill in December 2019, which would repeal the health insurance tax indefinitely, effective in 2021. If we are not reimbursed by the states for the cost of the HIF (including the associated tax impact), or if we are unable to otherwise adjust our business model to address the current assessment, our results of operations, financial position and cash flows may be materially adversely affected.

The constitutionality of the ACA itself continues to face judicial challenge. In December 2018, a partial summary judgment ruling in Texas v. United States of America held that the ACA's individual mandate requirement was essential to the ACA, and without it, the remainder of the ACA was invalid (i.e., that it was not "severable" from the ACA). That decision was appealed to the Fifth Circuit, which ruled in December 2019 that the individual mandate was unconstitutional after Congress set the individual mandate penalty to $0 and remanded the case to the district court for additional analysis on the question of severability. In March 2020, the U.S. Supreme Court agreed to hear the case to review whether the individual mandate is constitutional and, if the individual mandate is unconstitutional, the severability issue. In June 2020, Noel J. Francisco, the then Solicitor General of the United States, together with multiple U.S. Department of Justice colleagues, submitted a brief to the U.S. Supreme Court supporting the argument that the individual mandate is unconstitutional and that the remaining provisions of the ACA are not severable. The U.S. Supreme Court heard oral arguments in November 2020 and a ruling is anticipated in 2021. The ACA remains in effect until judicial review of the decision is concluded. The ultimate content, timing or effect of any potential future legislation or the outcome of the lawsuit cannot be predicted and may be delayed as a result of court closures and reduced court dockets as a result of the COVID-19 pandemic.

These changes and other potential changes involving the functioning of the Health Insurance Marketplace as a result of new legislation, regulation, executive action or litigation could impact our business and results of operations.

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 or federal level in the United States or internationally 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 premiums back to the state in the event profits exceed established levels or HBR does not meet the minimum requirement. Factors that may impact the amount of premium returned to the state include transparent pharmacy pricing and rebate initiatives. Other states may require us to meet certain performance and quality metrics in order to maintain our contract or receive additional or full contractual revenue.

The governmental healthcare programs in which we participate are subject to the satisfaction of certain regulations and performance standards. Regulators require numerous steps for continued implementation of the ACA, including the promulgation of a substantial number of potentially more onerous federal regulations. 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. 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.

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. CMS subsequently issued a Notice of Proposed Rulemaking on November 8, 2018, advancing CMS' efforts to streamline the Medicaid and CHIP managed care regulatory framework and to pursue a broader strategy to relieve regulatory burdens, support state flexibility and local leadership, and promote transparency, flexibility, and innovation in the delivery of care. On November 13, 2020, CMS finalized revisions to the Medicaid managed care regulations, many of which became effective in December 2020. While not a wholesale revision of the 2016 regulations, the November 2020 final rule adopts changes in areas including network adequacy, beneficiary protections, quality oversight, and the establishment of capitation rates and payment policies. 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, either of 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 (FCPA). Any 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 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 pharmacy benefit management (PBM) and specialty pharmacy services, including through our Envolve Pharmacy Solutions product. These businesses are subject to federal and state laws that, among other requirements, 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 and regulators 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 structuring of rebates and 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.

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 healthcare, 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, protests and appeals related to Medicaid procurement awards, employment-related disputes, including wage and hour claims, submissions to state agencies related to payments or state false claims acts 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.

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, state and international laws, regulations, rules and contractual requirements regarding the use and disclosure of confidential member information, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, the Gramm-Leach-Bliley Act, and the European Union's General Data Protection Regulation, 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. For example, in January 2021, we learned that Accellion, a third-party data transfer provider with whom we contract, had a system vulnerability that resulted in unauthorized access to certain sensitive data of our customers, including protected health information, over a period of several days in January 2021 as well as unauthorized access to the data of several of Accellion’s other clients. This incident is still under investigation, but we currently do not believe that it will have a material adverse effect on our business, reputation, results of operations, financial position and cash flows. However, there can be no assurance that the January 2021 incident and other privacy or security breaches will not require us to expend significant resources to remediate any damage, interrupt our operations and damage our business or reputation, subject us to state, federal, or international agency review, and result in enforcement actions, material fines and penalties, litigation or other actions which could have a material adverse effect on our business, reputation, results of operations, financial position and cash flows.

In addition, HIPAA broadened the scope of fraud, waste and abuse laws applicable to healthcare companies and established enforcement mechanisms to combat fraud, waste 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 the amount or application of 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.

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

We, along with other companies involved in public healthcare programs, are the subject of federal and state fraud, waste and abuse investigations. The regulations and contractual requirements applicable to participants in these public sector programs are complex and subject to change. Violations of fraud, waste 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, and other federal healthcare programs and federally funded state health programs. Fraud, waste and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, incorrect and unsubstantiated billing or billing for unnecessary medical services, improper marketing and violations of patient privacy rights. These fraud, waste and abuse laws include the federal False Claims Act, which prohibits the known filing of a false claim or the known use of false statements to obtain payment from the federal government, 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 fraud, waste and abuse laws, including 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 (private parties acting on the government's behalf). Federal and state governments have made investigating and prosecuting healthcare fraud, waste and abuse a priority. In the event we fail to comply with the extensive federal and state fraud, waste and abuse laws, our business, reputation, results of operations, financial position and cash flows could be materially and adversely affected.

Risks Relating to Conditions in the Financial Markets and Economy

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. Furthermore, COVID-19 has impacted, and may continue to impact, the global economy resulting in significant market volatility and fluctuating interest rates. 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.

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, which has increased due to the effects of COVID-19. 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 one or any 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.

We have substantial indebtedness outstanding and may incur additional indebtedness in the future. Such indebtedness could reduce our agility and may adversely affect our financial condition.

As of December 31, 2020, we had consolidated indebtedness of $16,779 million. We intend to incur additional indebtedness to finance a portion of the consideration for the Magellan Acquisition, and we may further increase our indebtedness in the future.

This may 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 and term loan facility (collectively, the Company Credit Facility) and the indentures governing our notes require us to comply with various covenants that impose restrictions on our operations,

including our ability to incur additional indebtedness, create liens, pay dividends, make certain investments or other restricted payments, sell or otherwise dispose of substantially all of our assets and engage in other activities. Our Company Credit Facility also requires us to comply with a maximum debt-to-EBITDA 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 our 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.

Changes in the method pursuant to which the LIBOR rates are determined and potential phasing out of LIBOR after 2021 may affect the value of the financial obligations to be held or issued by us that are linked to LIBOR or our results of operations or financial condition.

As of December 31, 2020, borrowings under our Company Credit Facility bear interest based upon various reference rates, including LIBOR. On July 27, 2017, the Financial Conduct Authority (the authority that regulates LIBOR) announced that it intends to stop compelling banks to submit rates for the calculation of LIBOR after 2021. On November 30, 2020, ICE Benchmark Administration (IBA), the administrator of LIBOR, announced plans to consult on ceasing the publication of certain U.S. dollar LIBOR rates on December 31, 2021 and to extend the transition for other U.S. dollar LIBOR rates to June 2023. The U.S. Federal Reserve concurrently issued a statement advising banks to stop new U.S. dollar LIBOR issuances by the end of 2021. In light of these recent announcements, the future of LIBOR at this time is uncertain and any changes in the methods by which LIBOR is determined or regulatory activity related to the phasing out of LIBOR could cause LIBOR to perform differently than in the past or cease to exist. The U.S. Federal Reserve, in conjunction with the Alternative Reference Rates Committee, a steering committee comprised of large U.S. financial institutions, announced replacement of U.S. dollar LIBOR with a new index calculated by short-term repurchase agreements, backed by U.S. Treasury securities called the Secured Overnight Financing Rate (SOFR). The first publication of SOFR was released in April 2018. Whether or not SOFR attains market traction as a LIBOR replacement tool remains in question and the future of LIBOR at this time is uncertain. As a result, it is not possible to predict the effect of any changes, establishment of alternative references rates or other reforms to LIBOR that may be enacted in the U.K. or elsewhere. The elimination of LIBOR or any other changes or reforms to the determination or supervision of LIBOR could have an adverse impact on the market for or value of any LIBOR-linked securities, loans, and other financial obligations or extensions of credit held by or due to us or on our overall financial condition or results of operations.

Risks Associated with Mergers, Acquisitions, and Divestitures

Mergers and acquisitions may not be accretive and may cause dilution to our earning per share, which may cause the market price of our common stock to decline.

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 acquisitions, including the Magellan Acquisition, if, among other things, we are unable to achieve the expected cost and revenue synergies or growth in earnings, the operational cost savings estimates in connection with the integration of acquired businesses with ours are not realized as rapidly or to the extent anticipated, the transaction costs related to the acquisitions and integrations are greater than expected or if any financing related to the acquisitions is on unfavorable terms. The market price also may decline if we do not achieve the perceived benefits of the acquisitions, including the Magellan Acquisition, as rapidly or to the extent anticipated by financial or industry analysts or if the effect of the acquisitions on our financial position, results of operations or cash flows is not consistent with the expectations of financial or industry analysts.

We may be unable to successfully integrate our existing business with acquired businesses and realize the anticipated benefits of such acquisitions.

The success of acquisitions we make, including the Magellan Acquisition, will depend, in part, on our ability to successfully combine the existing business of Centene with such acquired businesses and realize the anticipated benefits, including synergies, cost savings, growth in earnings, innovation and operational efficiencies, from the combinations. If we are unable to achieve these objectives within the anticipated time frame, or at all, the anticipated benefits may not be realized fully or at all, or may take longer to realize than expected and the value of our common stock may be harmed.

The integration of acquired businesses, including Magellan Health, with our existing business is a complex, costly and time-consuming process. The integration 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 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;
- unforeseen expenses or delays associated with the acquisition and/or integration;
- achieving actual cost savings at the anticipated levels; and
- decreases in premiums paid under government sponsored healthcare programs by any state in which we operate.

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. Our ability to successfully manage the expanded business following any given acquisition, including the Magellan Acquisition, will depend, in part, upon management's ability to design and implement strategic initiatives that address not only the integration of two independent stand-alone companies, but also the increased scale and scope of the combined business with its associated increased costs and complexity. There can be no assurances that we will be successful in managing our expanded operations as a result of acquisitions or that we will realize the expected growth in earnings, operating efficiencies, cost savings and other benefits.

The financing arrangements that we entered into in connection with the WellCare Acquisition may, under certain circumstances, contain restrictions and limitations that could significantly impact our ability to operate our business.

We incurred significant new indebtedness in connection with the WellCare Acquisition. Certain of the agreements governing the indebtedness that we incurred in connection with the WellCare Acquisition contains covenants that, among other things, may, under certain circumstances, place limitations on the dollar amounts paid or other actions relating to:

- payments in respect of, or redemptions or acquisitions of, debt or equity issued by us or our subsidiaries, including the payment of dividends on our common stock;
- incurring additional indebtedness;
- incurring guarantee obligations;
- paying dividends;
- creating liens on assets;
- entering into sale and leaseback transactions;
- making investments, loans or advances;
- entering into hedging transactions;
- engaging in mergers, consolidations or sales of all or substantially all of their respective assets; and
- engaging in certain transactions with affiliates.

In addition, we are required to maintain a minimum amount of excess availability as set forth in these agreements.

Our ability to maintain minimum excess availability in future periods will depend on our ongoing financial and operating performance, which in turn will be subject to economic conditions and to financial, market and competitive factors, many of which are beyond our control. The ability to comply with this covenant in future periods will also depend on our ability to successfully implement its overall business strategy and realize the anticipated benefits of the WellCare Acquisition, including synergies, cost savings, innovation and operational efficiencies.

Various risks, uncertainties and events beyond our control could affect our ability to comply with the covenants contained in our financing agreements. Failure to comply with any of the covenants in our existing or future financing agreements could result in a default under those agreements and under other agreements containing cross-default provisions. A default would permit lenders to accelerate the maturity of the debt under these agreements and to foreclose upon any collateral securing the debt. Under these circumstances, we might not have sufficient funds or other resources to satisfy all of its obligations. In addition, the limitations imposed by financing agreements on our ability to incur additional debt and to take other actions might significantly impair its ability to obtain other financing.

Additional Risks Associated with the Magellan Acquisition

The merger with Magellan Health is subject to conditions, some or all of which may not be satisfied, or completed on a timely basis, if at all. Failure to complete the merger with Magellan Health could have adverse effects on our business.

The completion of the merger is subject to a number of conditions, including, among others, the receipt of U.S. federal antitrust clearance and certain other required state regulatory approvals, which make the completion of the Magellan Acquisition and timing thereof uncertain. Also, either we or Magellan Health may terminate the merger agreement (Merger Agreement) if the Magellan Acquisition is not consummated by October 4, 2021 (subject to an automatic extension to January 4, 2022 in certain circumstances), except that this right to terminate the Merger Agreement will not be available to any party whose failure to perform, in any material respect, any obligation under the Merger Agreement has been the proximate cause of the failure of the merger to be consummated on or before that date.

If the Magellan Acquisition is not completed, our ongoing business may be adversely affected and, without realizing any of the benefits that we could have realized had the Magellan Acquisition been completed, we will be subject to a number of risks, including the following:

- the market price of our common stock could decline;
- inability to secure financing;
- if the Merger Agreement is terminated and our board of directors (Board) seeks another business combination, our stockholders cannot be certain that we will be able to find a party willing to enter into any transaction on terms equivalent to or more attractive than the terms that we and Magellan Health have agreed to in the Merger Agreement;
- time and resources committed by our management to matters relating to the Magellan Acquisition could otherwise have been devoted to pursuing other beneficial opportunities;
- we may experience negative reactions from the financial markets or from our customers or employees; and
- we will be required to pay our costs relating to the Magellan Acquisition, such as legal, accounting, financial advisoryand printing fees, whether or not the Magellan Acquisition is completed.

In addition, if the Magellan Acquisition is not completed, we could be subject to litigation related to any failure to complete the Magellan Acquisition or related to any enforcement proceeding commenced against us to perform our obligations under the Merger Agreement. If any such risk materializes, it could adversely impact our ongoing business.

Similarly, delays in the completion of the Magellan Acquisition could, among other things, result in additional transaction costs, loss of revenue or other negative effects associated with uncertainty about completion of the Magellan Acquisition and cause us not to realize some or all of the benefits that we expect to achieve if the Magellan Acquisition is successfully completed within its expected timeframe. We cannot assure you that the conditions to the closing of the Magellan Acquisition will be satisfied or waived or that the Magellan Acquisition will be consummated.

Centene and Magellan Health may be targets of securities class action and derivative lawsuits that could result in substantial costs and may delay or prevent the Magellan Acquisition from being completed.

Securities class action lawsuits and derivative lawsuits are often brought against public companies that have entered into merger agreements. Even if the lawsuits are without merit, defending against these claims can result in substantial costs and divert management time and resources. An adverse judgment could result in monetary damages, which could have a negative impact on Centene's and Magellan Health's respective liquidity and financial condition. Additionally, if a plaintiff is successful in obtaining an injunction prohibiting completion of the Magellan Acquisition, then that injunction may delay or prevent the Magellan Acquisition from being completed, or from being completed within the expected timeframe, which may adversely affect Centene's business, financial position and results of operation. Currently, Centene is not aware of any securities class action lawsuits or derivative lawsuits having been filed in connection with the Magellan Acquisition.

Completion of the Magellan Acquisition may trigger change in control or other provisions in certain agreements to which Magellan Health or its subsidiaries are a party, which may have an adverse impact on the combined company's business and results of operations.

The completion of the Magellan Acquisition may trigger change in control and other provisions in certain agreements to which Magellan Health or its subsidiaries are a party. If we and Magellan Health are unable to negotiate waivers of those provisions, the counterparties may exercise their rights and remedies under the agreements, potentially terminating the agreements or seeking monetary damages. Even if we and Magellan Health are able to negotiate waivers, the counterparties may require a fee

for such waivers or seek to renegotiate the agreements on terms less favorable to Magellan Health or the combined company. Any of the foregoing or similar developments may have an adverse impact on the combined company's business and results of operations.

General Risk Factors

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 may 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 team 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.

Future issuances and sales of additional shares of preferred or common stock could reduce the market price of our shares of common stock.

We may, from time to time, issue additional securities to raise capital or in connection with acquisitions. We often acquire interests in other companies by using a combination of cash and our common stock or just our common stock. Further, shares of preferred stock may be issued from time to time in one or more series as our Board of Directors may from time to time determine each such series to be distinctively designated. The issuance of any such preferred stock could materially adversely affect the rights of holders of our common stock. Any of these events may dilute your ownership interest in our company and have an adverse impact on the price of our common stock.

Item 1B. ***Unresolved Staff Comments***

None.

Item 2. ***Properties***

We own our corporate office headquarters buildings and land located in St. Louis, Missouri, which is used by each of our reportable segments. We generally lease space in the states where our health plans, specialty companies and claims processing facilities operate. We are required by various insurance and regulatory authorities to have offices in the service areas where we provide benefits. We believe our current facilities and expansion plans are adequate to meet our operational needs for the foreseeable future.

Item 3. ***Legal Proceedings***

A description of the legal proceedings to which we and our subsidiaries are a party is contained in Note 18.*Contingencies* to the consolidated financial statements included in Part II of this Annual Report on Form 10-K, and is incorporated herein by reference.

Item 4. ***Mine Safety Disclosures***

Not applicable.

PART II

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

Market for Common Stock

Our common stock has been traded and quoted on the New York Stock Exchange under the symbol "CNC" since October 16, 2003. The high and low prices, as reported by the NYSE, are set forth below for the periods indicated.

	2021 Stock Price (through February 19, 2021)		2020 Stock Price		2019 Stock Price	
	High	Low	High	Low	High	Low
First Quarter	$ 70.26	$ 57.71	$ 68.64	$ 43.96	$ 69.25	$ 49.56
Second Quarter			74.70	53.83	58.25	45.44
Third Quarter			68.45	53.60	54.89	42.77
Fourth Quarter			72.31	57.56	63.79	41.62

As of February 19, 2021, there were 1,120 holders of record of our common stock.

Issuer Purchases of Equity Securities

In 2009, our Board of Directors extended our stock repurchase program. The initial program authorized the repurchase of up to 6.7 million shares of our common stock from time to time on the open market or through privately negotiated transactions. In October 2019, our Board of Directors approved a $500 million increase to our Company's stock repurchase program, based on the stock price at the close of the WellCare Acquisition. During the first quarter of 2020, we used proceeds from divestitures to repurchase 8.7 million shares of Centene common stock for $500 million through our stock repurchase program. We have approximately 5.5 million available shares remaining under the program for repurchases as of December 31, 2020. In February 2021, our Board of Directors approved an increase in the Company's existing share repurchase program for its common stock. With the increase, the Company is authorized to repurchase up to $1.0 billion of shares of the Company's common stock, inclusive of the previously approved stock repurchase program. No duration has been placed on the repurchase program. We reserve the right to discontinue the repurchase program at any time.

Issuer Purchases of Equity Securities
Fourth Quarter 2020
(shares in thousands)

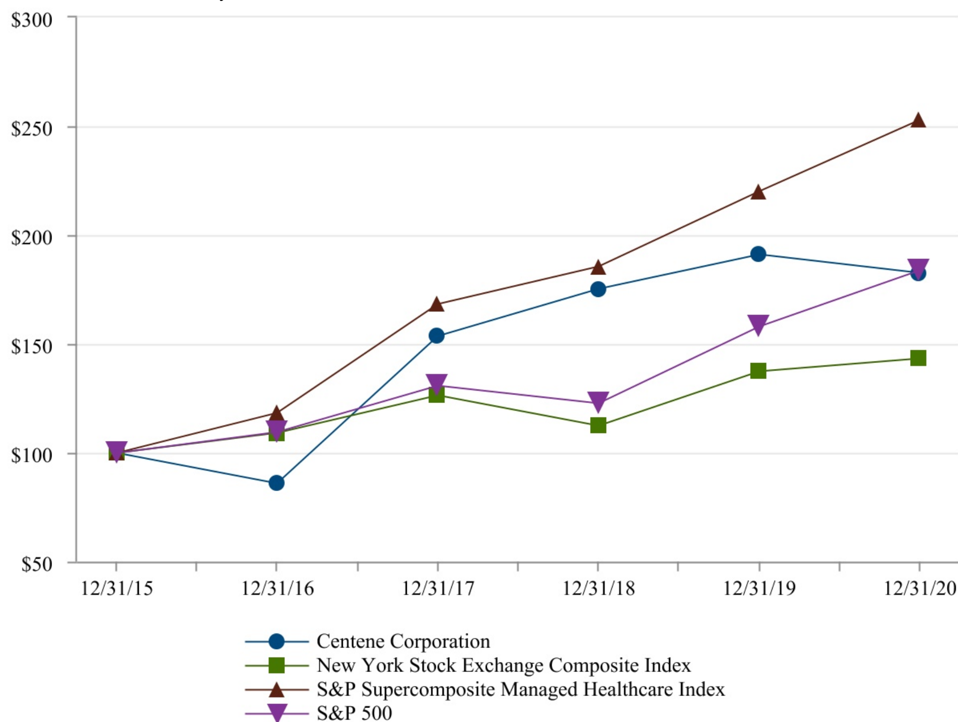
Period	Total Number of Shares Purchased[1]	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number of Shares that May Yet Be Purchased Under the Plans or Programs[2]
October 1 – October 31, 2020	3	$ 65.26	—	5,488
November 1 – November 30, 2020	4	64.40	—	5,488
December 1 – December 31, 2020	867	61.04	—	5,488
Total	874	$ 61.07	—	5,488

(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 14,160 thousand shares. A remaining amount of 5,488 thousand shares are available under the program. No duration has been placed on the repurchase program.

Stock Performance Graph

The graph below compares the cumulative total stockholder return on our common stock for the period from December 31, 2015 to December 31, 2020 with the cumulative total return of the New York Stock Exchange Composite Index, the Standard & Poor's Supercomposite Managed Healthcare Index and the Standard & Poor's 500 over the same period. Standard & Poor's 500 is included because our common stock is within the index. The graph assumes an investment of $100 on December 31, 2015 in our common stock (at the last reported sale price on such day), the New York Stock Exchange Composite Index, the Standard & Poor's Supercomposite Managed Healthcare Index, and the Standard & Poor's 500 and assumes the reinvestment of any dividends.



	December 31,					
	2015	2016	2017	2018	2019	2020
Centene Corporation	$ 100.00	$ 85.87	$ 153.31	$ 175.23	$ 191.09	$ 182.46
New York Stock Exchange Composite Index	100.00	109.01	126.28	112.14	137.16	143.19
S&P Supercomposite Managed Healthcare Index	100.00	118.21	168.16	185.45	220.03	252.75
S&P 500	100.00	109.54	130.81	122.65	158.07	183.77
Centene Corporation closing stock price	$ 32.90	$ 28.25	$ 50.44	$ 57.65	$ 62.87	$ 60.03
Centene Corporation annual stockholder return	26.7 %	(14.1)%	78.5 %	14.3 %	9.1 %	(4.5)%

In accordance with the rules of the SEC, the information contained in the Stock Performance Graph on this page shall not be deemed to be "soliciting material," or to be "filed" with the SEC or subject to the SEC's Regulation 14A, or to the liabilities of Section 18 of the Exchange Act, except to the extent that Centene specifically requests that the information be treated as soliciting material or specifically incorporates it by reference into a document filed under the Securities Act, or the Exchange Act.

Item 6. ***Removed and reserved.***

ITEM 7. Management's Discussion and Analysis of Financial Condition and Results of Operations

The following discussion of our financial condition and results of operations should be read in conjunction with our consolidated financial statements and the related notes included elsewhere in this filing. The discussion contains forward-looking statements that involve known and unknown risks and uncertainties, including those set forth under Part I, Item 1A."Risk Factors" of this Form 10-K. The following discussion and analysis does not include certain items related to the year ended December 31, 2018, including year-to-year comparisons between the year ended December 31, 2019 and the year ended December 31, 2018. For a comparison of our results of operations for the fiscal years ended December 31, 2019 and December 31, 2018, see Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations of our Annual Report on Form 10-K for the year ended December 31, 2019, filed with the SEC on February 18, 2020.

EXECUTIVE OVERVIEW

General

We are a leading multi-national healthcare enterprise that is committed to helping people live healthier lives. We take a local approach - with local brands and local teams - to provide fully integrated, high-quality, and cost-effective services to government-sponsored and commercial healthcare programs, focusing on under-insured and uninsured individuals.

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 premiums 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.

Our insurance subsidiaries are subject to the Affordable Care Act annual health insurer fee (HIF), absent a HIF moratorium or repeal. We recognize revenue for reimbursement of the HIF, including the "gross-up" to reflect the non-deductibility of the HIF. Collectively, this revenue is recorded as premium tax and health insurer fee revenue in the Consolidated Statements of Operations. For certain products, premium taxes, state assessments and the HIF are not pass-through payments and are recorded as premium revenue and premium tax expense or health insurer fee expense in the Consolidated Statements of Operations. A moratorium suspended the HIF for the 2019 calendar year. Due to the size of the health insurer fee, one of the primary drivers of the year-over-year variances discussed throughout this section is related to the reinstatement of the HIF in 2020. The HIF has been repealed beginning in 2021.

WellCare Acquisition

On January 23, 2020, we acquired all of the issued and outstanding shares of WellCare Health Plans, Inc. (WellCare) (the WellCare Acquisition). The transaction was valued at $19.6 billion, including the assumption of $1.95 billion of outstanding debt. The WellCare Acquisition brought a high-quality Medicare platform and further extended our robust Medicaid offerings. The combination enables us to provide access to more comprehensive and differentiated solutions across more markets with a continued focus on affordable, high-quality, culturally-sensitive healthcare services.

Due to the size of the acquisition, one of the primary drivers of the year-over-year variances discussed throughout this section is related to the acquisition of WellCare.

Magellan Acquisition

In January 2021, we announced that we entered into a definitive merger agreement under which we will acquire Magellan Health for $95.00 per share in cash for a total enterprise value of approximately $2.2 billion. The transaction will broaden and deepen our whole health capabilities and establish a leading behavioral health platform. The transaction is subject to clearance under the Hart-Scott Rodino Act, receipt of required state regulatory approvals, the approval of the definitive merger agreement by Magellan Health's stockholders and other customary closing conditions. The transaction is not contingent upon financing. We intend to fund the acquisition primarily through debt financing. The transaction is expected to close in the second half of 2021.

Acquisitions

We continued to execute on our growth strategy through acquisitions during 2020. In the fourth quarter of 2020, we acquired PANTHERx and Apixio. PANTHERx is one of the largest and fastest-growing specialty pharmacies in the United States

specializing in orphan drugs and treating rare diseases. PANTHERx and its management team will continue to operate independently as part of our Envolve Pharmacy Solutions business unit, a total drug management program that includes integrated PBM services and specialty pharmacy solutions to millions of members throughout the United States. Apixio is a healthcare analytics company offering artificial intelligence technology solutions. With this transaction, we will continue to digitize the administration of healthcare and accelerate innovation and modernization across the enterprise. Apixio will remain an operationally independent entity as part of our Health Care Enterprises group to continue bringing value to its clients and the industry, while also realizing the benefits of enhanced scale.

COVID-19 Trends and Uncertainties

The COVID-19 outbreak has created unique and unprecedented challenges. To support our members, providers, employees and the communities we serve, we have taken several actions and made numerous investments related to the COVID-19 crisis. We have extended coverage of COVID-19 screening, testing and treatment services for Medicaid, Medicare and Marketplace members and are waiving all associated member cost share amounts. We are delivering new critical support to Safety Net providers, including Federally Qualified Healthcare Centers (FQHCs), behavioral health providers, and long-term service and support organizations. We continue to address social determinants of health for vulnerable populations during the COVID-19 crisis with a commitment to research and investment in non-medical barriers to achieving quality health outcomes. We developed initiatives designed to support the disability community affected by the pandemic. We created a provider support program to assist our network providers who are seeking benefits from the Small Business Administration (SBA) through the CARES Act. We established a Medical Reserve Leave policy to support clinical employees who want to join a medical reserve force and serve their communities during the COVID-19 pandemic. We are providing additional employee benefits including waiving cost-sharing for COVID-19 related treatment, emergency paid sick leave, and one-time payments to employees in a small number of critical office functions.

We have taken significant steps to support our employees to protect their health and safety, while also ensuring that our business can continue to operate and that services continue without disruption. We have implemented our business continuity plans and have taken actions to support our workforce. We have transitioned the vast majority of our employees to work from home, allowing Centene to continue to operate at close to full capacity, while continuing to maintain our internal control framework. As a result, we have experienced and expect continued incremental costs due to investments and actions we have already taken and continued efforts to protect our members, employees and communities we serve.

The impact on our business in both the short-term and long-term is uncertain. The outlook for 2021 depends on future developments, including but not limited to: the length and severity of the outbreak (including new strains, which may be more contagious, more severe or less responsive to treatment or vaccines), the effectiveness of containment actions, and the timing around the development of treatments and distribution of vaccinations. The pandemic and these future developments have impacted and will continue to affect our membership and medical utilization. From March 31, 2020 through December 31, 2020, our Medicaid membership has increased by 1.7 million members. The pandemic also has the potential to impact the administration of state and federal healthcare programs, premium rates and risk sharing mechanisms. We continue to have active dialogues with our state partners.

Medical utilization continues to normalize as elective procedures and other non-emergent care resume, consistent with our expectations. We have experienced and continue to expect incremental COVID-19 costs as the outbreak continues to spread. In addition, the pandemic has widespread economic impact, driving interest rate decreases and lowering our investment income.

The impact of all these items slightly benefited our 2020 results. We are confident we have the team, systems, expertise and financial strength to continue to effectively navigate this challenging pandemic landscape.

Regulatory Trends and Uncertainties

The United States government, politicians, and healthcare experts continue to discuss and debate various elements of the United States healthcare model. We remain focused on the promise of delivering access to high quality, affordable healthcare to all of our members and believe we are well positioned to meet the needs of the changing healthcare landscape. We have more than three decades of experience, spanning seven presidents from both sides of the aisle, in delivering high-quality healthcare services on behalf of states and the federal government to under-insured and uninsured families, commercial organizations and military families. This expertise has allowed us to deliver cost effective services to our government sponsors and our members. While healthcare experts maintain focus on personalized healthcare technology, we continue to make strategic decisions to accelerate development of new software platforms and analytical capabilities. 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 I, Item 1 *"Business - Regulation"* and Item 1A, "*Risk Factors*."

2020 Highlights

Our financial performance for 2020 is summarized as follows:

- Year-end managed care membership of 25.5 million, an increase of 10.3 million members, or 67% over 2019.
- Total revenues of $111.1 billion, representing 49% growth year-over-year.
- HBR of 86.2% for 2020, compared to 87.3% for 2019.
- SG&A expense ratio of 9.5% for 2020, compared to 9.3% for 2019.
- Adjusted SG&A expense ratio of 8.9% for 2020, compared to 9.2% for 2019.
- Diluted EPS of $3.12 for 2020, compared to $3.14 for 2019.
- Adjusted Diluted EPS of $5.00 for 2020, compared to $4.42 for 2019.
- Operating cash flows of $5.5 billion, or 3.1 times net earnings, for 2020.

A reconciliation from GAAP diluted EPS to Adjusted Diluted EPS is highlighted below, and additional detail is provided under the heading "*Non-GAAP Financial Presentation*":

	Year Ended December 31,	
	2020	2019
GAAP diluted EPS attributable to Centene	$ 3.12	$ 3.14
Amortization of acquired intangible assets	0.95	0.47
Acquisition related expenses	0.86	0.19
Other adjustments [(1)]	0.07	0.62
Adjusted Diluted EPS	$ 5.00	$ 4.42

(1) Other adjustments include the following items:

- 2020 - gain related to the divestiture of certain products of our Illinois health plan of $104 million, or $0.10 per diluted share, net of an income tax expense of $0.08; (b) non-cash impairment of our third-party care management software business of $72 million, or $0.10 per diluted share, net of an income tax benefit of $0.02; and (c) debt extinguishment costs of $61 million, or $0.07 per diluted share, net of an income tax benefit of $0.04; and
- 2019 - non-cash goodwill and intangible asset impairment of $271 million or $0.57 per diluted share, net of an income tax benefit of $0.08 and debt extinguishment costs of $30 million or $0.05 per diluted share, net of an income tax benefit of $0.02.

The following items contributed to our revenue and membership growth in 2020:

- *Arkansas.* In March 2019, our Arkansas subsidiary, Arkansas Total Care, assumed full-risk on a Medicaid special needs population comprised of people with high behavioral health needs and individuals with developmental/intellectual disabilities.

- *Correctional.* In July 2020, Centurion commenced a two-year contract with the Kansas Department of Administration to provide healthcare services in the Department of Corrections’ facilities. In April 2020, Centurion began providing medical services, behavioral healthcare, and substance abuse treatment within four prisons and six community corrections centers across the state of Delaware. In July 2019, Centurion began operating under a contract to provide comprehensive healthcare services to inmates housed in Arizona's state prison system, and also began operating under a re-awarded contract to continue the provision of mental and dental health services to the Georgia Department of

Correction's state prison facilities. In February 2019, Centurion began operating under a new contract to provide comprehensive healthcare services to detainees of the Metropolitan Detention Center located in Albuquerque, New Mexico.

- *Florida.* In December 2018, our Florida subsidiary, Sunshine Health, began providing physical and behavioral healthcare services through Florida's Statewide Medicaid Managed Care Program under its new five year contract which was implemented for all 11 regions by February 2019.

- *Health Insurance Marketplace.* In January 2020, we expanded our offerings in the 2020 Health Insurance Marketplace in ten existing markets: Arizona, Florida, Georgia, Kansas, North Carolina, Ohio, South Carolina, Tennessee, Texas, and Washington.

- *HealthSmart.* In May 2019, we acquired HealthSmart, a third party administrator providing customizable and scalable health plan solutions for self-funded employers, universities and colleges, and Native American Tribal Enterprises. Services include plan administration, care management and wellness programs, network, casualty claim, and pharmacy benefit solutions.

- *Illinois.* In July 2020, our Illinois subsidiary, Meridian Health Plan of Illinois, Inc. (Meridian), began serving Medicaid members in Cook County, Illinois, as a result of a Member Transfer Agreement under which Meridian was assigned 100% of NextLevel Health Partners, Inc.'s approximately 54,000 members who access benefits from the Illinois Department of Healthcare and Family Services' HealthChoice Illinois Program. In February 2020, we began operating in Illinois under an expanded contract for the Medicaid Managed Care Program. The expanded contract includes children who are in need through the Department of Children and Family Services/Youth Care by Illinois Department of Healthcare and Family Services and Foster Care.

- *Iowa.* In July 2019, our Iowa subsidiary, Iowa Total Care, Inc., began operating under a new statewide contract for the IA Health Link Program.

- *Louisiana.* In January 2020, our Louisiana subsidiary, Louisiana HealthCare Connections, began operating under an emergency contract extension in response to protested contract awards. Louisiana's state procurement officer overturned the Louisiana Department of Health's plan to award Medicaid contracts to four health plans, excluding our Louisiana subsidiary. According to the chief procurement officer, the state health department failed to follow state law or its own evaluation and bid guidelines in its award.

- *Medicare.* In January 2020, we expanded our Medicare offerings. We entered Nevada and expanded our footprint in twelve existing markets: Arizona, Arkansas, California, Georgia, Kansas, Louisiana, Missouri, New Mexico, New York, Ohio, Pennsylvania, and Texas.

- *New Hampshire.* In September 2019, our New Hampshire subsidiary, NH Healthy Families, began operating under a new five-year contract to continue to provide service to Medicaid enrollees statewide.

- *Pennsylvania.* In January 2018, our Pennsylvania subsidiary, Pennsylvania Health and Wellness, began serving enrollees in the Community HealthChoices program as part of the statewide contract that was fully implemented in January 2020.

- *QualChoice.* In April 2019, we completed the acquisition of QCA Health Plan, Inc. and QualChoice Life and Health Insurance Company, Inc. The acquisition expands our footprint in Arkansas by adding additional members primarily through commercial products.

- *Spain.* In December 2019, our Spanish subsidiary, Ribera Salud, acquired 93% of Hospital Povisa, S.A., a private hospital in the Vigo region of Spain. In June 2019, Primero Salud, acquired additional ownership in Ribera Salud, increasing our ownership in the Spanish healthcare company from 50% to 90%.

- *Washington.* In January 2019, our Washington State subsidiary, Coordinated Care of Washington, began providing managed care services to Apple Health's Fully Integrated Managed Care beneficiaries in the Greater Columbia, King and Pierce Regions. This integration continued with the addition of the North Sound Region in July 2019.

- *WellCare.* On January 23, 2020, we completed the WellCare Acquisition. The WellCare Acquisition brought a high-quality Medicare platform and further extended our robust Medicaid offerings. The transaction was valued at $19.6 billion, including the assumption of $1.95 billion of outstanding debt.

- In addition, revenue and membership growth was significantly driven by the suspension of eligibility redeterminations and increased unemployment levels as a result of the COVID-19 pandemic, as well as the reinstatement of the health insurer fee in 2020.

The growth items listed above were partially offset by the following items:

- Effective October 2020, we no longer serve members under the correctional contract in Mississippi.

- In September 2020, our Oregon subsidiary, Trillium Community Health Plan, began operating under an expanded contract serving as a coordinated care organization for six counties in the state; however, an additional competitor was added to Lane County. As a result, our membership decreased.

- Effective August 2020, we no longer serve members under the Military & Family Life Counseling Program contract.

- Effective July 2020, we no longer serve members under the state-wide correctional contract in Vermont.

- In January 2020, in connection with the WellCare Acquisition, we completed the divestiture of certain products in our Illinois health plan, including the Medicaid and Medicare Advantage lines of business.

- Effective December 2019, we no longer serve members under the state-wide correctional contract in New Mexico.

- Beginning in January 2019, Health Net of Arizona, Inc. began discontinuing and non-renewing all of its Employer Group plans for small and large business groups in Arizona. The effective date of coverage termination for existing groups is dependent on remaining renewals; however, coverage is no longer provided to any group policyholders and/or members as of December 31, 2019.

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

- We expect to realize the full year benefit in 2021 of acquisitions, investments, and business commenced during 2020, as discussed above.

- In January 2021, Centene announced that its Oklahoma subsidiary, Oklahoma Complete Health, has been selected by the Oklahoma Health Care Authority (OHCA) for statewide contracts to provide managed care for the SoonerSelect and, on a sole source basis, SoonerSelect Specialty Children's Plan (SCP) (foster care) programs. The state expects to commence the SoonerSelect and SoonerSelect SCP Programs on October 1, 2021.

- In January 2021, we began administering the Buckley Prime Service Area Pilot in the Denver, Colorado area, which is a TRICARE pilot program to value-based payment arrangements not currently an option in the fee-for-service T2017 reimbursement model.

- In January 2021, we announced that we entered into a definitive merger agreement under which we will acquire Magellan Health for $95.00 per share in cash for a total enterprise value of approximately $2.2 billion. The transaction is subject to clearance under the Hart-Scott Rodino Act, receipt of required state regulatory approvals, the approval of the definitive merger agreement by Magellan Health's stockholders and other customary closing conditions. The transaction is expected to close in the second half of 2021.

- In January 2021, we expanded our offerings in the Health Insurance Marketplace. We expanded our Marketplace product, branded Ambetter, in nearly 400 new counties across 13 existing states. In addition, Ambetter-branded Marketplace products is now offered in two new states, New Mexico and Michigan.

- In December 2020, we acquired PANTHERx, one of the largest and fastest-growing specialty pharmacies in the United States specializing in orphan drugs and treating rare diseases.

- In December 2020, we acquired Apixio Inc., a healthcare analytics company offering artificial intelligence technology solutions. With this transaction, we will continue to digitize the administration of healthcare and accelerate innovation

and modernization across the enterprise.

- In October 2019, our North Carolina joint venture, Carolina Complete Health, was awarded an additional service area to provide Medicaid managed care services in Region 4. With the addition of this new Region, Carolina Complete Health will provide Medicaid managed care services in three contiguous regions: Region 3, 4 and 5. In February 2019, WellCare was awarded a statewide contract to administer the state's Medicaid Prepaid Health Plans. The new contracts are expected to commence in mid-2021.

The future growth items listed above are partially offset by the following items:

- In October 2020, Centers for Medicare and Medicaid Services (CMS) published updated Medicare Star quality ratings for the 2021 rating year. Approximately 30% of our Medicare members are in a 4 star or above plan for the 2022 bonus year, compared to 46% for the 2021 bonus year. Our quality bonus and rebates may be negatively impacted in 2021 and 2022, if we are unable to utilize mitigation strategies.

- Beginning in 2021, the health insurer fee has been repealed, which will result in a decrease in revenue.

- We expect a decrease in our marketplace membership driven by a reduction in the state of Florida, resulting from price competition in three highly populated counties.

- We expect Medicaid eligibility redeterminations to begin on May 1, 2021, resulting in a decrease in membership.

MEMBERSHIP

From December 31, 2019 to December 31, 2020, we increased our managed care membership by 10.3 million, or 67%. The following table sets forth our membership by line of business:

	December 31,	
	2020	2019
Traditional Medicaid [1]	12,055,400	7,573,600
High Acuity Medicaid [2]	1,554,700	1,110,000
Total Medicaid	13,610,100	8,683,600
Commercial	2,633,600	2,331,100
Medicare [3]	955,400	359,600
Medicare PDP	4,469,400	—
International	597,700	599,800
Correctional	147,200	180,000
Total at-risk membership	22,413,400	12,154,100
TRICARE eligibles	2,877,900	2,860,700
Non-risk membership	231,600	227,000
Total	25,522,900	15,241,800

[1] Membership includes TANF, Medicaid Expansion, CHIP, Foster Care and Behavioral Health
[2] Membership includes ABD, IDD, LTSS and MMP Duals
[3] Membership includes Medicare Advantage and Medicare Supplement

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

	December 31,	
	2020	2019
Dual-eligible [4]	1,066,800	639,200
Health Insurance Marketplace	2,131,600	1,805,200
Medicaid Expansion	2,181,400	1,346,700

[4] Membership that is eligible for both Medicaid and Medicare benefits.

From December 31, 2019 to December 31, 2020, our membership increased as a result of:

- the WellCare Acquisition;
- Medicaid membership growth related to the COVID-19 pandemic;
- membership growth in our Health Insurance Marketplace business; and
- expansions, new programs and growth in many of our states.

RESULTS OF OPERATIONS

The following discussion and analysis is based on our Consolidated Statements of Operations, which reflect our results of operations for years ended December 31, 2020, and 2019, respectively, prepared in accordance with generally accepted accounting principles in the United States ($ in millions, except per share data in dollars):

	2020	2019	% Change 2019-2020
Premium	$ 100,055	$ 67,439	48 %
Service	3,745	2,925	28 %
Premium and service revenues	103,800	70,364	48 %
Premium tax and health insurer fee	7,315	4,275	71 %
Total revenues	111,115	74,639	49 %
Medical costs	86,264	58,862	47 %
Cost of services	3,303	2,465	34 %
Selling, general and administrative expenses	9,867	6,533	51 %
Amortization of acquired intangible assets	719	258	179 %
Premium tax expense	6,332	4,469	42 %
Health insurer fee expense	1,476	—	n.m.
Goodwill and intangible impairment	72	271	(73) %
Earnings from operations	3,082	1,781	73 %
Other income (expense):			
Investment and other income	480	443	8 %
Debt extinguishment costs	(61)	(30)	(103) %
Interest expense	(728)	(412)	(77) %
Earnings before income tax expense	2,773	1,782	56 %
Income tax expense	979	473	107 %
Net earnings	1,794	1,309	37 %
Loss attributable to noncontrolling interests	14	12	17 %
Net earnings attributable to Centene Corporation	$ 1,808	$ 1,321	37 %
Diluted earnings per common share attributable to Centene Corporation:	$ 3.12	$ 3.14	(1) %

n.m.: not meaningful

Year Ended December 31, 2020 Compared to Year Ended December 31, 2019

Total Revenues

The following table sets forth supplemental revenue information for the year ended December 31, ($ in millions):

	2020	2019	% Change 2019-2020
Medicaid	$ 74,785	$ 51,831	44 %
Commercial	17,071	14,747	16 %
Medicare [1]	11,976	4,248	182 %
Medicare PDP	2,403	—	n.m.
Other	4,880	3,813	28 %
Total Revenues	$ 111,115	$ 74,639	49 %

[1] Medicare includes Medicare Advantage and Medicare Supplement
n.m.: not meaningful

Total revenues increased 49% in the year ended December 31, 2020, over the corresponding period in 2019, primarily due to the acquisition of WellCare, growth in the Medicaid and Health Insurance Marketplace businesses, and the reinstatement of the health insurer fee in 2020. Additionally, the net effect of the pandemic increased our revenues due to the suspension of Medicaid eligibility redeterminations. The increase was partially offset by the divestiture of our Illinois health plan. During the twelve months ended December 31, 2020, we received premium rate adjustments which yielded a net 1% composite increase 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 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 premiums received and the medical services provided.

The HBR for the year ended December 31, 2020 was 86.2%, a decrease of 110 basis points over the comparable period in 2019. The HBR decrease was primarily attributable to lower medical utilization trends due to the COVID-19 pandemic, the ACA risk corridor receivable settlement and the reinstatement of the health insurer fee. The decrease was partially offset by performance in the Health Insurance Marketplace business, the implementation of retroactive state premium rate adjustments and risk sharing mechanisms, and higher testing and treatment costs associated with COVID-19.

Cost of Services

Cost of services increased by $838 million in the year ended December 31, 2020, compared to the corresponding period in 2019, primarily attributable to increased volume in our specialty pharmacy business, increased non-specialty pharmacy sales to our recently divested Illinois health plan, and growth from acquired businesses.

The cost of service ratio for the year ended December 31, 2020 was 88.2%, compared to 84.3% in 2019. The increase in the cost of service ratio was driven by the results of lower revenue from the shared savings programs in our physician home health business and higher non-specialty pharmacy sales to our recently divested Illinois health plan, which carries a higher cost of service ratio.

Selling, General & Administrative Expenses

SG&A increased by $3.3 billion in the year ended December 31, 2020, compared to the corresponding period in 2019. The SG&A increase was primarily due to the addition of the WellCare business, expansions, new programs and growth in many of our states in 2020, and $580 million of acquisition related expense in the year ended December 31, 2020.

The SG&A expense ratio was 9.5% for the year ended December 31, 2020, compared to 9.3% for the year ended December 31, 2019. The 2020 SG&A expense ratio increased due to higher acquisition and integration related expenses primarily due to the WellCare acquisition, the $275 million charitable contribution to our foundation and enhanced growth and profitability initiatives for our Medicare and Health Insurance Marketplace businesses (both as a result of the one-time ACA risk corridor settlement). These items were partially offset by leveraging of expenses over higher revenues as a result of the WellCare acquisition.

The Adjusted SG&A expense ratio was 8.9% for the year ended December 31, 2020, compared to 9.2% for the year ended December 31, 2019. The Adjusted SG&A expense ratio benefited from leveraging of expenses over higher revenues as a result of the WellCare acquisition, partially offset by the $275 million charitable contribution to our foundation and enhanced growth and profitability initiatives for our Medicare and Health Insurance Marketplace businesses.

Health Insurer Fee Expense

Health insurer fee expense was $1.5 billion for the year ended December 31, 2020. As a result of the health insurer fee moratorium, which suspended the health insurance provider fee for the 2019 calendar year, we did not record health insurer fee expense for the year ended December 31, 2019.

Impairment

During the first quarter of 2020, we recorded $72 million, or $0.10 per diluted share, of non-cash impairment of our third-party care management software business. In 2019, we recorded $271 million, or $0.57 per diluted share, of non-cash goodwill and intangible asset impairment. Substantially all of the 2019 impairment is associated with our USMM physician home health business and was identified as part of our quarterly review procedures, which included an analysis of new information related to our shared savings programs, slower than expected penetration of the physician home health business model into our Medicaid population, and the related impact to revised forecasts.

Other Income (Expense)

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

	2020	2019
Investment and other income	$ 480	$ 443
Debt extinguishment costs	(61)	(30)
Interest expense	(728)	(412)
Other income (expense), net	$ (309)	$ 1

Investment and other income. Investment and other income increased by $37 million for year ended December 31, 2020 compared to 2019. The increase in investment income in 2020 was due to a $104 million gain related to the divestiture of certain products of our Illinois health plan as part of the previously announced divestiture agreements associated with the WellCare Acquisition as well as overall higher investment balances, partially offset by lower interest rates.

Debt extinguishment costs. In October 2020, we redeemed all of the $1.0 billion 4.75% Senior Notes due 2022 (the 2022 Notes) and the $1.2 billion 5.25% Senior Notes due 2025 (the 2025 Notes). We recognized a pre-tax loss on extinguishment of $17 million on the redemption of the 2022 Notes and the 2025 Notes in the fourth quarter of 2020, including the call premiums and write-off of unamortized debt issuance costs. In February 2020, we redeemed all of our outstanding $1.0 billion 6.125% Senior Notes, due February 15, 2024 (the 2024 Notes) and recognized a pre-tax loss on extinguishment of $44 million. The loss includes the call premium, the write-off of unamortized debt issuance costs and the loss on the termination of the $1.0 billion interest rate swap associated with the 2024 Notes. In October 2019, we redeemed the outstanding principal balance on the $1.4 billion 5.625% Senior Notes due February 15, 2021 (the 2021 Notes). We recognized a pre-tax loss on extinguishment of $30 million on the redemption of the 2021 Notes, including the call premium, the write-off of unamortized debt issuance costs and a loss on the termination of the $600 million interest rate swap agreement associated with the notes.

Interest expense. Interest expense increased by $316 million in the year ended December 31, 2020, compared to the corresponding period in 2019. The increase is driven by an increase in borrowings related to the issuance of an additional $7.0 billion in senior notes in December 2019 to finance the cash consideration of the WellCare Acquisition as well as the $1.9 billion of WellCare Notes assumed upon acquisition. The increase was also driven by incremental interest expense related to our decision to preserve an additional $1.0 billion of liquidity due to the economic environment created by COVID-19.

Income Tax Expense

For the year ended December 31, 2020, we recorded income tax expense of $979 million on pre-tax earnings of $2.8 billion, or an effective tax rate of 35.3%. The effective tax rate for the year ended December 31, 2020 reflects the tax impact associated with the Illinois divestiture and the reinstatement of the health insurer fee in 2020, partially offset by a favorable tax settlement. For the year ended December 31, 2019, we recorded income tax expense of $473 million on pre-tax earnings of $1.8 billion, or an effective tax rate of 26.5%, which reflects the impact of the health insurer fee moratorium, partially offset by the non-deductibility of a portion of our non-cash goodwill and intangible impairment recorded in the third quarter of 2019.

Segment Results

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

	2020	2019	% Change 2019-2020
Total Revenues			
Managed Care	$ 107,296	$ 71,379	50 %
Specialty Services	16,155	13,781	17 %
Eliminations	(12,336)	(10,521)	(17) %
Consolidated Total	$ 111,115	$ 74,639	49 %
Earnings from Operations			
Managed Care	$ 3,031	$ 1,806	68 %
Specialty Services	51	(25)	304 %
Consolidated Total	$ 3,082	$ 1,781	73 %

Managed Care

Total revenues increased 50% in the year ended December 31, 2020, compared to the corresponding period in 2019, primarily due to the acquisition of WellCare, growth in the Medicaid and Health Insurance Marketplace businesses, and the reinstatement of the health insurer fee in 2020. Additionally, the net effect of the pandemic increased our revenues due to the suspension of Medicaid eligibility redeterminations. The increase was partially offset by the divestiture of our Illinois health plan. Earnings from operations increased $1.2 billion between years driven by the acquisition of WellCare, lower medical utilization due to the COVID-19 pandemic, and the reinstatement of the health insurer fee in 2020, partially offset by higher acquisition related expenses, retroactive state premium rate adjustments and risk sharing mechanisms, and higher testing and treatment costs associated with COVID-19, particularly in the Health Insurance Marketplace business.

Specialty Services

Total revenues increased 17% in the year ended December 31, 2020, compared to the corresponding period in 2019, resulting primarily from increased services associated with membership growth in the Managed Care segment, acquisitions and increased volume in our specialty pharmacy business. Earnings from operations increased $76 million between years. Earnings from operations in 2020 was negatively affected by the previously discussed impairment related to our third-party care management software business and the results of the shared savings programs in our physician home health business. Earnings from operations in 2019 were negatively affected by the previously discussed non-cash goodwill and intangible impairment related to our USMM physician home health business.

LIQUIDITY AND CAPITAL RESOURCES

Shown below is a condensed schedule of cash flows for the years ended December 31, 2020 and 2019, used in the discussion of liquidity and capital resources ($ in millions).

	Year Ended December 31,	
	2020	2019
Net cash provided by operating activities	$ 5,503	$ 1,483
Net cash used in investing activities	(6,955)	(1,532)
Net cash provided by financing activities	260	6,832
Effect of exchange rate changes on cash and cash equivalents	18	(2)
Net increase in cash, cash equivalents, and restricted cash and equivalents	$ (1,174)	$ 6,781

Cash Flows Provided by Operating Activities

Normal operations are funded primarily through operating cash flows and borrowings under our Revolving Credit Facility. In 2020, operating activities provided cash of $5.5 billion, or 3.1 times net earnings, compared to $1.5 billion in 2019. Cash flow provided by operations in 2020 was due to net earnings, an increase in medical claims liabilities from growth and expansions, and an increase in other long-term liabilities related to minimum MLR payables and a delay in employer payroll tax payments related to the COVID-19 extensions to payment deadlines.

Cash flows provided by operations in 2019 was primarily due to net earnings and an increase in medical claims liabilities, primarily resulting from growth in the Health Insurance Marketplace business and the commencement or expansion of the Arkansas, Iowa, New Mexico, and Pennsylvania health plans. Operating cash flows were partially offset by an increase in premium and trade receivables due to the timing of payments from our state customers, as discussed below.

Cash flows from operations in each year can be 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.

	Year Ended December 31,	
	2020	2019
(Increase) decrease in premium and trade receivables	$ (52)	$ (1,076)
Increase (decrease) in unearned revenue	(528)	(9)
Net increase (decrease) in operating cash flow	$ (580)	$ (1,085)

Cash Flows Used in Investing Activities

Investing activities used cash of $7.0 billion for the year ended December 31, 2020 and $1.5 billion in 2019. Cash flows used in investing activities in 2020 primarily consisted of our acquisitions of WellCare, PANTHERx and Apixio, partially offset by divestiture proceeds. Cash flows used in investing activities in 2020 also 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.

We spent $869 million and $730 million in the years ended December 31, 2020 and 2019, respectively, on capital expenditures for system enhancements, market growth, and corporate headquarters expansions.

As of December 31, 2020, our investment portfolio consisted primarily of fixed-income securities with a weighted average duration of 3.3 years. We had unregulated cash and investments of $1.9 billion at December 31, 2020, compared to $7.2 billion at December 31, 2019. Unregulated cash as of December 31, 2019 included the net proceeds from our $7.0 billion senior note issuance in advance of the closing of the WellCare Acquisition. Unregulated cash and investments include private equity investments and company owned life insurance contracts.

Cash flows used in investing activities in 2019 primarily consisted of the 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 Provided by Financing Activities

Our financing activities provided cash of $260 million in 2020, compared to providing cash of $6.8 billion in 2019. During 2020, our net financing activities were due to increased borrowings, partially offset by common stock repurchases. During 2019, our net financing activities primarily related to the proceeds from the issuance of $7.0 billion of senior notes in December 2019 in preparation of the WellCare Acquisition.

In connection with the WellCare Acquisition, in January 2020, we completed an exchange offer for $1.2 billion of 5.25% Senior Notes due 2025 and $750 million of 5.375% Senior Notes due 2026 (collectively, the WellCare Notes) issued by WellCare and issued $1.1 billion aggregate principal amount of 5.25% Senior Notes due 2025 and $747 million aggregate principal amount of 5.375% Senior Notes due 2026. Additionally, our wholly owned subsidiary, WellCare Health Plans, Inc., assumed the remaining unexchanged WellCare Notes.

In February 2020, we issued $2.0 billion 3.375% Senior Notes due 2030 (the $2.0 billion 2030 Notes). We used the net proceeds from the $2.0 billion 2030 Notes to redeem all of our outstanding 2024 Notes. We recognized a pre-tax loss on extinguishment of $44 million, including the call premium, the write-off of unamortized debt issuance costs and a loss on the termination of the $1.0 billion interest rate swap associated with the 2024 Notes. We intended to use remaining proceeds to redeem our 2022 Notes. The 2022 Notes were redeemed in the fourth quarter in connection with an additional offering of senior notes as further described below, and we decided to increase liquidity with the remaining proceeds of the $2.0 billion 2030 Notes.

In February 2020, we terminated the interest rate swap agreements associated with the 2022 Notes and the Senior Notes due January 15, 2025, (the 2025 Notes). The interest rate swaps associated with the 2024 Notes were also terminated in connection with the redemption of those notes as discussed above. In total, we terminated three interest rate swap contracts with a notional amount of $2.1 billion.

In May 2020, we completed an exchange offer, whereby we offered to exchange all of the outstanding $2.0 billion 3.375% Senior Notes due February 15, 2030, $1.0 billion 4.75% Senior Notes due 2025, $2.5 billion 4.25% Senior Notes, and $3.5 billion 4.625% Senior Notes due 2029 for identical securities that have been registered under the Securities Act of 1933.

In October 2020, we issued $2.2 billion 3.0% Senior Notes due October 2030 (the $2.2 billion 2030 Notes). We used the net proceeds from the offering, together with cash on hand, to redeem all of the 2022 Notes and the $1.2 billion 5.25% Senior Notes due 2025. We recognized a pre-tax loss on extinguishment of $17 million, including the call premium, and the write-off of unamortized debt issuance costs.

Liquidity Metrics

The credit agreement underlying our Revolving Credit Facility and Term Loan Facility contains customary covenants as well as financial covenants, including a minimum fixed charge coverage ratio and a maximum debt-to-EBITDA ratio. Our maximum debt-to-EBITDA ratio under the credit agreement may not exceed 3.5 to 1.0, which may, under certain circumstances and subject to certain elections made by us, be increased for certain periods to 4.0 to 1.0. As of December 31, 2020, we had $97 million of borrowings outstanding under our Revolving Credit Facility, $1.5 billion of borrowings outstanding under our Term Loan Facility, and we were in compliance with all covenants. As of December 31, 2020, there were no limitations on the availability of our Revolving Credit Facility as a result of the debt-to-EBITDA ratio.

We have a $200 million non-recourse construction loan to fund the expansion of our corporate headquarters. In February 2021, we extended the term of the construction loan for one year. The loan bears interest based on the one month LIBOR plus 2.70% and matures in April 2022. The agreement contains financial and non-financial covenants aligning with the credit agreement governing our Revolving Credit Facility. We have guaranteed completion of the construction project associated with the loan. As of December 31, 2020, we had $180 million in borrowings outstanding under the loan.

We had outstanding letters of credit of $129 million as of December 31, 2020, which were not part of our Revolving Credit Facility. The letters of credit bore weighted interest of 0.6% as of December 31, 2020. In addition, we had outstanding surety bonds of $1.1 billion as of December 31, 2020.

The indentures governing our various maturities of senior notes contain limited restrictive covenants. As of December 31, 2020, we were in compliance with all covenants.

At December 31, 2020, we had working capital, defined as current assets less current liabilities, of $1.8 billion, compared to $7.4 billion at December 31, 2019. Working capital as of December 31, 2019, reflected the net proceeds from our $7.0 billion senior note issuance in advance of the closing of the WellCare Acquisition. We manage our short-term and long-term investments with the goal of ensuring that a sufficient portion is held in investments that are highly liquid and can be sold to fund short-term requirements as needed.

At December 31, 2020, our debt to capital ratio, defined as total debt divided by the sum of total debt and total equity, was 39.3%, compared to 52.0% at December 31, 2019. Excluding $230 million of non-recourse debt, our debt to capital ratio was 39.0% as of December 31, 2020, compared to 51.7% at December 31, 2019. At December 31, 2019, excluding non-recourse debt and the senior notes issued to fund the WellCare Acquisition in advance of closing, our debt to capital was 34.3%. We utilize the debt to capital ratio as a measure, among others, of our leverage and financial flexibility.

We have a stock repurchase program authorizing us to repurchase common stock from time to time on the open market or through privately negotiated transactions. We have 5.5 million available shares remaining under the program for repurchases as of December 31, 2020. No duration has been placed on the repurchase program. We reserve the right to discontinue the repurchase program at any time. In 2020, we used proceeds from divestitures to repurchase 8.7 million shares of Centene common stock for $500 million through our stock repurchase program. We did not make any repurchases under this plan during 2019.

During the year ended December 31, 2020 and 2019, we received dividends of $1.3 billion and $713 million, respectively, from our regulated subsidiaries.

2021 Expectations

During 2021, we expect to receive net dividends of approximately $1.7 billion from our regulated subsidiaries and expect to spend approximately $860 million in capital expenditures primarily associated with system enhancements and market and corporate headquarters expansions. In February 2021, our Board of Directors approved an increase in our existing share repurchase program for our common stock. With the increase, we are authorized to repurchase up to $1.0 billion of shares of our common stock, inclusive of the previously approved stock repurchase program. No duration has been placed on the repurchase program.

In February 2021, we issued $2.2 billion 2.50% Senior Notes due 2031 (the 2031 Notes). In conjunction with the 2031 Notes offering, we completed a tender offer (the Tender Offer) to purchase for cash, subject to certain conditions, any and all of the outstanding aggregate principal amount of the $2.2 billion 4.75% Senior Notes due 2025 (the 2025 Notes). We used the net proceeds from the 2031 Notes, together with available cash on hand, to fund the purchase price for the 2025 Notes accepted for purchase in the Tender Offer (approximately 36% of the aggregate principal amount outstanding) and intend to use the remaining proceeds to redeem any of the 2025 Notes that remain outstanding following the Tender Offer, including all premiums, accrued interest and costs and expenses related to the redemption.

We have material debt, lease, and short-term medical claims obligations. Refer to Note 10. *Debt,* Note 11. *Leases*, and Note 8. *Medical Claims Liability*, respectively, for further information. In addition, we have material commitments as a result of our Fidelis and Health Net acquisitions. Refer to Note 17. *Commitments* for detail.

In the second half of 2021, we expect to complete the merger with Magellan Health, Inc. for $95.00 per share in cash for a total enterprise value of approximately $2.2 billion. We intend to primarily fund the acquisition through debt financing.

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. While we are currently in a strong liquidity position and believe we have adequate access to capital, we may elect to increase borrowings on our Revolving Credit Facility. In addition, 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 or redemption opportunities to extend maturities and/or improve terms of our indebtedness if we believe such opportunities are favorable to us.

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.

As of December 31, 2020, our subsidiaries had aggregate statutory capital and surplus of $14.2 billion, compared with the required minimum aggregate statutory capital and surplus requirements of $5.9 billion. During the year ended December 31, 2020, we received $508 million of net dividends from our regulated subsidiaries. For our subsidiaries that file with the National Association of Insurance Commissioners (NAIC), we estimate our Risk Based Capital (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 healthcare expenditures, excluding capitated amounts. In addition, certain of our California subsidiaries have made certain undertakings to the Department of Managed Health Care 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.

Under the New York State Department of Health Codes, Rules and Regulations Title 10, Part 98, our New York subsidiary must comply with contingent reserve requirements. Under these requirements, net worth based upon admitted assets must equal or exceed a minimum amount based on annual net premium income.

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 December 31, 2020, 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 December 31, 2020, the amount of capital and surplus or net worth that was unavailable for the payment of dividends or return of capital to us was $5.9 billion in the aggregate.

RECENT ACCOUNTING PRONOUNCEMENTS

For this information, refer to Note 2. *Summary of Significant Accounting Policies*, in the Notes to the Consolidated Financial Statements, included herein.

CRITICAL ACCOUNTING POLICIES AND ESTIMATES

Our discussion and analysis of our results of operations and liquidity and capital resources are based on our consolidated financial statements which have been prepared in accordance with GAAP. Our significant accounting policies are more fully described in Note 2. *Summary of Significant Accounting Policies,* to our consolidated financial statements included elsewhere herein. Our accounting policies regarding intangible assets, medical claims liability and revenue recognition are particularly important to the portrayal of our financial position and results of operations and require the application of significant judgment by our management. As a result, they are subject to an inherent degree of uncertainty. We have reviewed these critical accounting policies and related disclosures with the Audit Committee of our Board of Directors.

Goodwill and Intangible Assets

We have made several acquisitions that have resulted in our recording of intangible assets. These intangible assets primarily consist of purchased contract rights and customer relationships, provider contracts, trade names, developed technologies, and goodwill. Key assumptions used in the valuation of these intangible assets include, but are not limited to, member attrition rates, contract renewal probabilities, revenue growth rates, expectations of profitability, and discount and royalty rates. We

allocate the fair value of purchase consideration to the assets acquired and liabilities assumed based on their fair values at the acquisition date. The excess of the fair value of consideration transferred over the fair value of the net assets acquired is recorded as goodwill. Goodwill is generally attributable to the value of the synergies between the combined companies and the value of the acquired assembled workforce, neither of which qualifies for recognition as an intangible asset. At December 31, 2020, we had $18.7 billion of goodwill and $8.4 billion of other intangible assets.

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

Intangible Asset	Amortization Period
Purchased contract rights and customer relationships	3 - 21 years
Provider contracts	4 - 15 years
Trade names	7 - 20 years
Developed technologies	2 - 7 years

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

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

If a reporting unit's carrying amount exceeds its fair value, an entity will record an impairment charge based on that difference. The impairment charge will be limited to the amount of goodwill allocated to that reporting unit. We first assess qualitative factors to determine if a quantitative impairment test is necessary. We generally do not calculate the fair value of a reporting unit unless we determine, based on a qualitative assessment, that it is more likely than not that its fair value is less than its carrying amount. However, in certain circumstances, such as recent acquisitions, we may elect to perform a quantitative assessment without first assessing qualitative factors.

Our specialty clinical healthcare business acquired in 2018, with goodwill of $325 million, has experienced short-term decreased profitability due to short-term rate inadequacies and the effect of the COVID-19 pandemic, coupled with immigration restrictions enacted by policy administrators. However, the goodwill is expected to be recovered and there have been no fundamental changes in the business model since the acquisition date. To the extent rates do not improve in the long-term or the new administration does not reverse the immigration restrictions, the reporting unit could be at risk for impairment.

Medical Claims Liability

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

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

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

illness such as influenza, provider contract changes, changes to fee schedules, and the incidence of high dollar or catastrophic claims.

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

Additionally, we contract with independent actuaries to review our estimates on a quarterly basis. The independent actuaries provide us with a review letter that includes the results of their analysis of our medical claims liability. We do not solely rely on their report to adjust our claims liability. We utilize their calculation of our claims liability only as additional information, together with management's judgment, to determine the assumptions to be used in the calculation of our liability for claims.

Our development of the medical claims liability estimate is a continuous process which we monitor and refine on a monthly basis as additional claims receipts and payment information becomes available. As more complete claims information becomes available, we adjust the amount of the estimates, and include the changes in estimates in medical costs in the period in which the changes are identified. In every reporting period, our operating results include the effects of more completely developed medical claims liability estimates associated with previously reported periods. We consistently apply our reserving methodology from period to period. As additional information becomes known to us, we adjust our actuarial models accordingly to establish medical claims liability estimates.

The paid and received completion factors, claims per member per month and per diem cost trend factors are the most significant factors affecting the IBNR estimate. The following table illustrates the sensitivity of these factors and the estimated potential impact on our operating results caused by changes in these factors based on December 31, 2020 data:

Completion Factors: [(1)]		**Cost Trend Factors:** [(2)]	
(Decrease) Increase in Factors	**Increase (Decrease) in Medical Claims Liabilities**	**(Decrease) Increase in Factors**	**Increase (Decrease) in Medical Claims Liabilities**
	(in millions)		**(in millions)**
(1.00) %	$ 623	(1.00) %	$ (169)
(0.75)	466	(0.75)	(126)
(0.50)	310	(0.50)	(84)
(0.25)	155	(0.25)	(42)
0.25	(154)	0.25	42
0.50	(307)	0.50	84
0.75	(459)	0.75	126
1.00	(610)	1.00	169

(1) Reflects estimated potential changes in medical claims liability caused by changes in completion factors.

(2) Reflects estimated potential changes in medical claims liability caused by changes in cost trend factors for the most recent periods.

While we believe our estimates are appropriate, it is possible future events could require us to make significant adjustments for revisions to these estimates. For example, a 1% increase or decrease in our estimated medical claims liability would have affected net earnings by $80 million for the year ended December 31, 2020, excluding the effect of any return of premium, risk corridor, or minimum MLR programs. The estimates are based on our historical experience, terms of existing contracts, our observance of trends in the industry, information provided by our providers and information available from other outside sources.

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

	Year Ended December 31,		
	2020	2019	2018
Balance, January 1,	$ 7,473	$ 6,831	$ 4,286
Less: reinsurance recoverable	20	27	18
Balance, January 1, net	7,453	6,804	4,268
Acquisitions	3,856	59	1,204
Less: acquired reinsurance recoverable	—	—	8
Incurred related to:			
Current year	86,765	59,539	46,484
Prior years	(501)	(677)	(427)
Total incurred	86,264	58,862	46,057
Paid related to:			
Current year	78,838	52,453	41,161
Prior years	6,320	5,819	3,556
Total paid	85,158	58,272	44,717
Balance, December 31, net	12,415	7,453	6,804
Plus: reinsurance recoverable	23	20	27
Balance, December 31,	$ 12,438	$ 7,473	$ 6,831
Days in claims payable [1]	51	45	48

(1) Days in claims payable is a calculation of medical claims liability at the end of the period divided by average expense per calendar day for the fourth quarter of each year.

Medical claims are usually paid within a few months of the member receiving service from the physician or other healthcare provider. As a result, the liability generally is described as having a "short-tail," which causes less than 5% of our medical claims liability as of the end of any given year to be outstanding the following year. We believe that substantially all the development of the estimate of medical claims liability as of December 31, 2020 will be known by the end of 2021.

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 $86 million, $49 million and $25 million of the "Incurred related to: Prior years" was recorded as a reduction to premium revenues in 2020, 2019 and 2018, respectively. Further, claims processing initiatives yielded increased claim payment recoveries and coordination of benefits related to prior year dates of service. Changes in medical utilization and cost trends and the effect of population health management initiatives may also contribute to changes in medical claim liability estimates. While we have evidence that population health management initiatives are effective on a case by case basis, these initiatives primarily focus on events and behaviors prior to the incurrence of the medical event and generation of a claim. Accordingly, any change in behavior, leveling of care, or coordination of treatment occurs prior to claim generation and as a result, the costs prior to the population health management initiative are not known by us. Additionally, certain population health management initiatives are focused on member and provider education with the intent of influencing behavior to appropriately align the medical services provided with the member's acuity. In these cases, determining whether the population health management initiative changed the behavior cannot be determined. Because of the complexity of our business, the number of states in which we operate, and the volume of claims that we process, we are unable to practically quantify the impact of these initiatives on our changes in estimates of IBNR.

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

- Appropriate leveling of care for neonatal intensive care unit hospital admissions, other inpatient hospital admissions, and observation admissions, in accordance with InterQual or other criteria.
- Management of our pre-authorization list and more stringent review of durable medical equipment and injectibles.
- Emergency department program designed to collaboratively work with hospitals to steer non-emergency care away from the costly emergency department setting (through patient education, on-site alternative urgent care settings, etc.).

- Increased emphasis on case management and clinical rounding where case managers are nurses or social workers who are employed by the health plan to assist selected patients with the coordination of healthcare services in order to meet a patient's specific healthcare needs.
- Incorporation of disease management which is a comprehensive, multidisciplinary, collaborative approach to chronic illnesses such as asthma.
- Prenatal and infant health programs utilized in our *Start Smart For Your Baby* outreach service.

Revenue Recognition

Our health plans generate revenues primarily from premiums received from the states in which we operate health plans, premiums received from our members and CMS for our Medicare product, and premiums from members of our commercial health plans. In addition to member premium payments, our Marketplace contracts also generate revenues from subsidies received from CMS. We generally receive a fixed premium per member per month pursuant to our contracts and recognize premium revenues during the period in which we are obligated to provide services to our members at the amount reasonably estimable. In some instances, our base premiums are subject to an adjustment, or risk score, based on the acuity of its membership. Generally, the risk score is determined by the State or CMS analyzing submissions of processed claims data to determine the acuity of our membership relative to the entire state's membership. We estimate the amount of risk adjustment based upon the processed claims data submitted and expected to be submitted to CMS and record revenues on a risk adjusted basis. Some contracts allow for additional premiums related to certain supplemental services provided such as maternity deliveries.

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, including commercial plans, our plans may be required to return premium to the state or policyholders in the event profits exceed established levels. We estimate the effect of these programs and recognize reductions in revenue in the current period. Other states may require us to meet certain performance and quality metrics in order to receive additional or full contractual revenue. For performance-based contracts, we do not recognize revenue subject to refund until data is sufficient to measure performance.

Revenues are recorded based on membership and eligibility data provided by the states or CMS, which is adjusted on a monthly basis by the states or CMS for retroactive additions or deletions to membership data. These eligibility adjustments are estimated monthly and subsequent adjustments are made in the period known. We continuously review and update those estimates as new information becomes available. It is possible that new information could require us to make additional adjustments, which could be significant, to these estimates.

Our Medicare Advantage contracts are with CMS. CMS deploys a risk adjustment model which apportions premiums paid to all health plans according to health severity and certain demographic factors. The CMS risk adjustment model pays more for members whose medical history would indicate that they are expected to have higher medical costs. Under this risk adjustment methodology, CMS calculates the risk adjusted premium payment using diagnosis data from hospital inpatient, hospital outpatient, physician treatment settings as well as prescription drug events. We and the healthcare providers collect, compile and submit the necessary and available diagnosis data to CMS within prescribed deadlines. We estimate risk adjustment revenues based upon the diagnosis data submitted and expected to be submitted to CMS and record revenues on a risk adjusted basis.

For qualifying low income PDP members, CMS pays for some, or all, of the member's monthly premium. We receive certain Part D prospective subsidy payments from CMS for our PDP members as a fixed monthly per member amount, based on the estimated costs of providing prescription drug benefits over the plan year, as reflected in our bids. Approximately nine to ten months subsequent to the end of the plan year, or later in the case of the coverage gap discount subsidy, a settlement payment is made between CMS and our plans based on the difference between the prospective payments and actual claims experience.

Our specialty services generate revenues under contracts with state and federal programs, healthcare organizations and other commercial organizations, as well as from our own subsidiaries. Revenues are recognized when the related services are provided or as ratably earned over the covered period of services. For performance-based measures in our contracts, revenue is recognized as data sufficient to measure performance is available. We recognize revenue related to administrative services under the TRICARE government-sponsored managed care support contract for the DoD's TRICARE program on a straight-line basis over the option period, when the fees become fixed and determinable. The TRICARE contract includes various performance-based measures. For each of the measures, an estimate of the amount that has been earned is made at each interim date, and revenue is recognized accordingly.

Some states enact premium taxes, similar assessments and provider pass-through payments, collectively premium taxes, and these taxes are recorded as a separate component of both revenues and operating expenses. Additionally, our insurance subsidiaries are subject to the Affordable Care Act annual HIF. The ACA imposed the HIF in 2014, 2015, 2016, 2018 and 2020. The HIF was suspended in 2017 and 2019. Beginning in 2021, the HIF was permanently repealed. If we are able to negotiate reimbursement of portions of these premium taxes or the HIF, we recognize revenue associated with the HIF on a straight-line basis when we have binding agreements for such reimbursements, including the "gross-up" to reflect the HIFs non-tax deductible nature. Collectively, this revenue is recorded as premium tax and health insurer fee revenue in the Consolidated Statements of Operations. For certain products, premium taxes, state assessments and the HIF are not pass-through payments and are recorded as premium revenue and premium tax expense or health insurer fee expense in the Consolidated Statements of Operations.

Some states require state directed payments that have minimal risk, but are administered as a premium adjustment. These payments are recorded as premium revenue and medical costs at close to a 100% HBR. We have little visibility to the timing of these payments until they are paid by the state.

ITEM 7A. *Quantitative and Qualitative Disclosures About Market Risk*

INVESTMENTS AND DEBT

As of December 31, 2020, we had short-term investments of $1.6 billion and long-term investments of $13.9 billion, including restricted deposits of $1.1 billion. 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, equity securities and private equity investments and have maturities greater than one year. Restricted deposits consist of investments required by various state statutes to be deposited or pledged to state agencies. Due to the nature of the states' requirements, these investments are classified as long-term regardless of the contractual maturity date. Substantially all of our investments are subject to interest rate risk and will decrease in value if market rates increase. Assuming a hypothetical and immediate 1% increase in market interest rates at December 31, 2020, the fair value of our fixed income investments would decrease by approximately $319 million. Declines in interest rates over time, including those that have occurred as markets experienced volatility related to the COVID-19 pandemic, will reduce our investment income.

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.*"

Item 8. ***Financial Statements and Supplementary Data***

Report of Independent Registered Public Accounting Firm

To the Stockholders and Board of Directors
Centene Corporation:

Opinion on the Consolidated Financial Statements

We have audited the accompanying consolidated balance sheets of Centene Corporation and subsidiaries (the Company) as of December 31, 2020 and 2019, the related consolidated statements of operations, comprehensive earnings, stockholders' equity, and cash flows for each of the years in the three-year period ended December 31, 2020, and the related notes (collectively, the consolidated financial statements). In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Company as of December 31, 2020 and 2019, and the results of its operations and its cash flows for each of the years in the three-year period ended December 31, 2020, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2020, based on criteria established in *Internal Control - Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission, and our report dated February 22, 2021 expressed an unqualified opinion on the effectiveness of the Company's internal control over financial reporting.

Basis for Opinion

These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the consolidated financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. We believe that our audits provide a reasonable basis for our opinion.

Critical Audit Matters

The critical audit matters communicated below are matters arising from the current period audit of the consolidated financial statements that were communicated or required to be communicated to the audit committee and that: (1) relate to accounts or disclosures that are material to the consolidated financial statements and (2) involved our especially challenging, subjective, or complex judgments. The communication of critical audit matters does not alter in any way our opinion on the consolidated financial statements, taken as a whole, and we are not, by communicating the critical audit matters below, providing separate opinions on the critical audit matters or on the accounts or disclosures to which they relate.

Evaluation of acquisition-date fair value of purchased contract rights and customer relationships intangible assets acquired in the WellCare Health Plans, Inc. business combination

As discussed in Note 3 to the consolidated financial statements, the Company acquired WellCare Health Plans, Inc. (WellCare) in a business combination on January 23, 2020. In connection with the transaction, the Company recorded purchased contract rights and customer relationships intangible assets associated with the generation of future income from WellCare's existing contracts and customers. The acquisition-date fair value for the purchased contract rights and customer relationships assets was $5,737 million.

We identified the evaluation of the acquisition-date fair value of purchased contract rights and customer relationships intangible assets acquired in the WellCare business combination as a critical audit matter. There was a higher degree of

auditor judgment involved in evaluating certain of management's assumptions used in determining the fair value of these intangible assets. Specifically, the assumptions for the contract renewal probabilities for Medicaid contracts and member attrition rates for Medicare and Prescription Drug Plans were challenging to assess as there was limited observable market information. The determination of the fair value of the purchased contract rights and customer relationships assets was sensitive to possible changes in the assumptions used in the forecast for contract renewal probabilities and member attrition rates.

The following are the primary procedures we performed to address this critical audit matter. We evaluated the design and tested the operating effectiveness of certain internal controls related to the critical audit matter. This included controls related to the Company's acquisition-date fair value process and the development of the relevant assumptions identified above. We evaluated the estimated contract renewal probabilities for Medicaid contracts by comparing to the historical managed care contract renewal results of the Company and certain internal and external factors. We evaluated the estimated member attrition rates for Medicare and Prescription Drug Plans by comparing to the historical Medicare and Prescription Drug Plans member attrition rates of WellCare. We also compared the member attrition rates to previous acquisitions made by the Company and certain internal and external factors. We performed sensitivity analyses over the contract renewal probabilities and member attrition rate assumptions to assess their impact on the Company's determination of the fair value of the purchased contract rights and customer relationships assets. We involved valuation professionals with specialized skills and knowledge, who compared the models used by the Company to calculate the contract renewal probabilities and member attrition rate assumptions to generally accepted valuation practices.

Evaluation of the estimated medical claims liability

As discussed in Note 2 to the consolidated financial statements, the Company's medical claims liability includes claims reported but not yet paid, estimates for claims incurred but not reported, and estimates for the costs necessary to process unpaid claims. As discussed in Note 8 to the consolidated financial statements, the balance at December 31, 2020 was $12,438 million.

We identified the evaluation of the estimated medical claims liability as a critical audit matter. The Company estimates its medical claims liability using actuarial methods. Specialized skills were required to evaluate these actuarial methods, which include analyzing historical claims data in order to estimate the medical claims liability. The medical claims liability included an estimate for medical claims developing under moderately adverse conditions, which represents the risk of adverse deviation in the Company's actuarial methods of reserving, which required auditor judgment to evaluate.

The following are the primary procedures we performed to address this critical audit matter. We evaluated the design and tested the operating effectiveness of certain internal controls related to the critical audit matter. This included controls over the Company's process to evaluate the estimate of the medical claims liability including the results of the Company's independent actuaries' analysis. We involved actuarial professionals with specialized skills and knowledge who evaluated the actuarial methods used by the Company to estimate the medical claims liability. With the assistance of the actuarial professionals, we challenged the Company's estimate of the medical claims liability, including the effects of moderately adverse conditions, by developing an independent estimate for certain health plans using the Company's medical claims data, and relative range. We assessed the potential for management bias by evaluating the Company's position and movement within the actuarial professionals' relative range.

Evaluation of the estimated Affordable Care Act risk adjustment accruals

As discussed in Note 2 to the consolidated financial statements, the Affordable Care Act (ACA) established a permanent risk adjustment program. This program transfers funds from qualified individual and small group insurance plans with below average risk scores to those insurance plans with above average risk scores within each state. The final settlement of the December 31, 2020 ACA risk adjustment accruals is scheduled to be determined by the Centers for Medicare and Medicaid Services (CMS) in June 2021, based on data submitted by insurance companies through April 2021. As discussed in Note 9, the Company recorded an estimated asset and liability (the ACA risk adjustment accruals) of $340 million, and $1,224 million, respectively at December 31, 2020.

We identified the evaluation of the estimated ACA risk adjustment accruals as a critical audit matter. Specialized skills and a higher degree of auditor judgment were required to evaluate the Company's estimates. The Company's estimates are based on its analysis of member data, claims data, and projections of claims data expected to be submitted by the Company, and other insurance plans, to CMS for settlement.

The following are the primary procedures we performed to address this critical audit matter. We evaluated the design and tested the operating effectiveness of certain internal controls over the Company's process to develop the estimated ACA risk adjustment accruals. We involved actuarial professionals with specialized skills and knowledge who assisted in evaluating the Company's methodology used in estimating the ACA risk adjustment accruals for consistency with the federally developed risk adjustment methodology. Additionally, the actuarial professionals assisted in evaluating the projections of claims data utilized to estimate the ACA risk adjustment accruals, and assessed the methodologies utilized by the Company for consistency with industry practice. We assessed the Company's process to estimate the ACA risk adjustment accruals, in order to consider the potential for management bias, by performing a retrospective review of the prior period ACA risk adjustment accruals and assessing the consistency of those estimated balances with the subsequent settlement.

/s/ KPMG LLP

We have served as the Company's auditor since 2005.

St. Louis, Missouri
February 22, 2021

CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED BALANCE SHEETS
(In millions, except shares in thousands and per share data in dollars)

	December 31, 2020	December 31, 2019
ASSETS		
Current assets:		
Cash and cash equivalents	$ 10,800	$ 12,123
Premium and trade receivables	9,696	6,247
Short-term investments	1,580	863
Other current assets	1,317	1,090
Total current assets	23,393	20,323
Long-term investments	12,853	7,717
Restricted deposits	1,060	658
Property, software and equipment, net	2,774	2,121
Goodwill	18,652	6,863
Intangible assets, net	8,388	2,063
Other long-term assets	1,599	1,249
Total assets	$ 68,719	$ 40,994
LIABILITIES, REDEEMABLE NONCONTROLLING INTERESTS AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims liability	$ 12,438	$ 7,473
Accounts payable and accrued expenses	7,069	4,164
Return of premium payable	1,458	824
Unearned revenue	523	383
Current portion of long-term debt	97	88
Total current liabilities	21,585	12,932
Long-term debt	16,682	13,638
Deferred tax liability	1,534	189
Other long-term liabilities	2,956	1,543
Total liabilities	42,757	28,302
Commitments and contingencies		
Redeemable noncontrolling interests	77	33
Stockholders' equity:		
Preferred stock, $0.001 par value; authorized 10,000 shares; no shares issued or outstanding at December 31, 2020 and December 31, 2019	—	—
Common stock, $0.001 par value; authorized 800,000 shares; 598,249 issued and 581,479 outstanding at December 31, 2020, and 421,508 issued and 415,048 outstanding at December 31, 2019	1	—
Additional paid-in capital	19,459	7,647
Accumulated other comprehensive earnings	337	134
Retained earnings	6,792	4,984
Treasury stock, at cost (16,770 and 6,460 shares, respectively)	(816)	(214)
Total Centene stockholders' equity	25,773	12,551
Noncontrolling interest	112	108
Total stockholders' equity	25,885	12,659
Total liabilities, redeemable noncontrolling interests and stockholders' equity	$ 68,719	$ 40,994

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

CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF OPERATIONS
(In millions, except shares in thousands and per share data in dollars)

	Year Ended December 31,		
	2020	**2019**	**2018**
Revenues:			
Premium	$ 100,055	$ 67,439	$ 53,629
Service	3,745	2,925	2,806
Premium and service revenues	103,800	70,364	56,435
Premium tax and health insurer fee	7,315	4,275	3,681
Total revenues	111,115	74,639	60,116
Expenses:			
Medical costs	86,264	58,862	46,057
Cost of services	3,303	2,465	2,386
Selling, general and administrative expenses	9,867	6,533	6,043
Amortization of acquired intangible assets	719	258	211
Premium tax expense	6,332	4,469	3,252
Health insurer fee expense	1,476	—	709
Impairment loss	72	271	—
Total operating expenses	108,033	72,858	58,658
Earnings from operations	3,082	1,781	1,458
Other income (expense):			
Investment and other income	480	443	253
Debt extinguishment costs	(61)	(30)	—
Interest expense	(728)	(412)	(343)
Earnings before income tax expense	2,773	1,782	1,368
Income tax expense	979	473	474
Net earnings	1,794	1,309	894
Loss attributable to noncontrolling interests	14	12	6
Net earnings attributable to Centene Corporation	$ 1,808	$ 1,321	$ 900
Net earnings per common share attributable to Centene Corporation:			
Basic earnings per common share	$ 3.17	$ 3.19	$ 2.31
Diluted earnings per common share	$ 3.12	$ 3.14	$ 2.26
Weighted average number of common shares outstanding:			
Basic	570,722	413,487	390,248
Diluted	579,135	420,409	398,506

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

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

	Year Ended December 31,		
	2020	2019	2018
Net earnings	$ 1,794	$ 1,309	$ 894
Reclassification adjustment, net of tax	(3)	(5)	2
Change in unrealized gain (loss) on investments, net of tax	191	203	(52)
Defined benefit pension plan net gain (loss), net of tax	—	(6)	1
Foreign currency translation adjustments	15	(2)	(4)
Other comprehensive earnings (loss)	203	190	(53)
Comprehensive earnings	1,997	1,499	841
Comprehensive loss attributable to noncontrolling interests	14	12	6
Comprehensive earnings attributable to Centene Corporation	$ 2,011	$ 1,511	$ 847

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

CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
(In millions, except shares in thousands and per share data in dollars)

	Centene Stockholders' Equity								
	Common Stock					Treasury Stock			
	$0.001 Par Value Shares	Amt	Additional Paid-in Capital	Accumulated Other Comprehensive Earnings (Loss)	Retained Earnings	$0.001 Par Value Shares	Amt	Non controlling Interest	Total
Balance, December 31, 2017	360,758	$ —	$ 4,349	$ (3)	$ 2,748	13,884	$ (244)	$ 14	$ 6,864
Net earnings (loss)	—	—	—	—	900	—	—	(2)	898
Other comprehensive loss, net of $(15) tax	—	—	—	(53)	—	—	—	—	(53)
Common stock issued for acquisitions	—	—	331	—	—	(9,787)	176	—	507
Common stock issued for stock offering	53,207		2,779	—	—	—	—	—	2,779
Common stock issued for employee benefit plans	3,730	—	17	—	—	—	—	—	17
Common stock repurchases	—	—	—	—	—	1,120	(71)	—	(71)
Stock compensation expense	—	—	145	—	—	—	—	—	145
Cumulative-effect of adopting new accounting guidance	—	—	—	—	15	—	—	—	15
Purchase of noncontrolling interest	—	—	(172)	—	—	—	—	(15)	(187)
Acquisition resulting in noncontrolling interest	—	—	—	—	—	—	—	99	99
Balance, December 31, 2018	417,695	$ —	$ 7,449	$ (56)	$ 3,663	5,217	$ (139)	$ 96	$ 11,013
Net earnings (loss)	—	—	—	—	1,321	—	—	(9)	1,312
Other comprehensive earnings, net of $ 59 tax	—	—	—	190	—	—	—	—	190
Common stock issued for employee benefit plans	3,813	—	21	—	—	—	—	—	21
Common stock repurchases	—	—	—	—	—	1,243	(75)	—	(75)
Stock compensation expense	—	—	177	—	—	—	—	—	177
Contribution from noncontrolling interest	—	—	—	—	—	—	—	21	21
Balance, December 31, 2019	421,508	$ —	$ 7,647	$ 134	$ 4,984	6,460	$ (214)	$ 108	$ 12,659
Net earnings (loss)	—	—	—	—	1,808	—	—	(24)	1,784
Other comprehensive earnings, net of $ 60 tax	—	—	—	203	—	—	—	—	203
Common stock issued for acquisitions	171,225	1	11,526	—	—	—	—	—	11,527
Common stock issued for employee benefit plans	5,923	—	29	—	—	—	—	—	29
Common stock repurchases	(407)	—	(24)	—	—	10,310	(602)	—	(626)
Stock compensation expense	—	—	281	—	—	—	—	—	281
Contribution from noncontrolling interest	—	—	—	—	—	—	—	28	28
Balance, December 31, 2020	598,249	$ 1	$ 19,459	$ 337	$ 6,792	16,770	$ (816)	$ 112	$ 25,885

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

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

	Year Ended December 31,		
	2020	**2019**	**2018**
Cash flows from operating activities:			
Net earnings	$ 1,794	$ 1,309	$ 894
Adjustments to reconcile net earnings to net cash provided by operating activities			
Depreciation and amortization	1,259	643	495
Stock compensation expense	281	177	145
Impairment	72	271	—
Loss on debt extinguishment	57	30	—
Deferred income taxes	(51)	55	(129)
Gain on divestiture	(104)	—	—
Changes in assets and liabilities			
Premium and trade receivables	(52)	(1,076)	(1,173)
Other assets	(30)	(234)	(38)
Medical claims liabilities	1,117	578	1,325
Unearned revenue	(528)	(9)	(52)
Accounts payable and accrued expenses	585	(421)	(533)
Other long-term liabilities	1,078	185	258
Other operating activities, net	25	(25)	42
Net cash provided by operating activities	5,503	1,483	1,234
Cash flows from investing activities:			
Capital expenditures	(869)	(730)	(675)
Purchases of investments	(7,402)	(2,575)	(3,846)
Sales and maturities of investments	4,921	1,809	1,991
Acquisitions, net of cash acquired	(4,049)	(36)	(2,055)
Divestiture proceeds, net of divested cash	466	—	—
Other investing activities, net	(22)	—	—
Net cash used in investing activities	(6,955)	(1,532)	(4,585)
Cash flows from financing activities:			
Proceeds from the issuance of common stock	—	—	2,779
Proceeds from long-term debt	5,107	24,721	6,077
Payments of long-term debt	(4,067)	(17,803)	(4,083)
Common stock repurchases	(626)	(75)	(71)
Payments for debt extinguishment	(81)	(23)	—
Debt issuance costs	(120)	(25)	(25)
Other financing activities, net	47	37	(65)
Net cash provided by financing activities	260	6,832	4,612
Effect of exchange rate changes on cash, cash equivalents, and restricted cash	18	(2)	—
Net increase (decrease) in cash, cash equivalents, and restricted cash and equivalents	(1,174)	6,781	1,261
Cash, cash equivalents, and restricted cash and cash equivalents, beginning of period	12,131	5,350	4,089
Cash, cash equivalents, and restricted cash and cash equivalents, end of period	$ 10,957	$ 12,131	$ 5,350
Supplemental disclosures of cash flow information:			
Interest paid	$ 725	$ 374	$ 323
Income taxes paid	$ 1,191	$ 612	$ 448
Equity issued in connection with acquisitions	$ 11,526	$ —	$ 507

The following table provides a reconciliation of cash, cash equivalents, and restricted cash and cash equivalents reported within the Consolidated Balance Sheets to the totals above:

	2020	**2019**	**2018**
Cash and cash equivalents	$ 10,800	$ 12,123	$ 5,342
Restricted cash and cash equivalents, included in restricted deposits	157	8	8
Total cash, cash equivalents, and restricted cash and cash equivalents	$ 10,957	$ 12,131	$ 5,350

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

CENTENE CORPORATION AND SUBSIDIARIES
NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS

1. Organization and Operations

Centene Corporation, or the Company, is a leading multi-national healthcare enterprise that is committed to helping people live healthier lives. The Company takes a local approach - with local brands and local teams - to provide fully integrated, high-quality, and cost-effective services to government-sponsored and commercial healthcare programs, focusing on under-insured and uninsured individuals. The Company operates in two segments: Managed Care and Specialty Services. The Managed Care segment provides health plan coverage to individuals through government subsidized programs, including Medicaid, the State Children's Health Insurance Program (CHIP), Long-Term Services and Supports (LTSS), Foster Care, Medicare-Medicaid Plans (MMP), which cover beneficiaries who are dually eligible for Medicaid and Medicare, the Supplemental Security Income Program, also known as the Aged, Blind or Disabled Program (ABD), Medicare (including Medicare Prescription Drug Plans), and the Health Insurance Marketplace. The Company also offers a variety of individual, small group, and large group commercial healthcare products, both to employers and directly to members in the Managed Care segment. The Specialty Services segment consists of the Company's specialty companies offering auxiliary healthcare services and products to state programs, correctional facilities, healthcare organizations, employer groups and other commercial organizations, as well as to the Company's own subsidiaries. The Specialty Services segment also includes the government contracts business which includes the Company's government-sponsored managed care support contract with the U.S. Department of Defense (DoD) under the TRICARE program and other healthcare related government contracts.

On January 23, 2020, the Company acquired all of the issued and outstanding shares of WellCare. The transaction was valued at approximately $19,555 million, including the assumption of $1,950 million of outstanding debt. The WellCare Acquisition brought a high-quality Medicare platform and further extended the Company's robust Medicaid offerings. The combination enables the Company to provide access to more comprehensive and differentiated solutions across more markets with a continued focus on affordable, high-quality, culturally-sensitive healthcare services.

2. Summary of Significant Accounting Policies

Basis of Presentation

The accompanying consolidated financial statements include the accounts of Centene Corporation and all majority owned subsidiaries and subsidiaries over which the Company exercises the power and control to direct activities significantly impacting financial performance. All material intercompany balances and transactions have been eliminated.

Certain amounts in the consolidated financial statements and notes have been reclassified to conform to the 2020 presentation. These reclassifications have no effect on net earnings, cash flow, or stockholders' equity as previously reported.

Use of Estimates

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

Business Combinations

Business combinations are accounted for using the acquisition method of accounting. The Company allocates the fair value of purchase consideration to the assets acquired and liabilities assumed based on their fair values at the acquisition date. The excess of the fair value of consideration transferred over the fair value of the net assets acquired is recorded as goodwill. Goodwill is generally attributable to the value of the synergies between the combined companies and the value of the acquired assembled workforce, neither of which qualifies for recognition as an intangible asset.

The Company uses its best estimates and assumptions to value assets acquired and liabilities assumed at the acquisition date; however, these estimates are sometimes preliminary and, in some instances, all information required to value the assets acquired and liabilities assumed may not be available or final as of the end of a reporting period subsequent to the business combination. If the accounting for the business combination is incomplete, provisional amounts are recorded. The provisional amounts are updated during the period determined, up to one year from the acquisition date. The Company includes the results of operations of acquired businesses in the Company's consolidated results prospectively from the date of acquisition.

Acquisition related expenses and post-acquisition restructuring costs are recognized separately from the business combination and are expensed as incurred.

Cash and Cash Equivalents

Investments with original maturities of three months or less are considered to be cash equivalents. Cash equivalents consist of money market funds, bank certificates of deposit and savings accounts.

The Company maintains amounts on deposit with various financial institutions, which may exceed federally insured limits. However, management periodically evaluates the credit-worthiness of those institutions, and the Company has not experienced any losses on such deposits.

Investments

Short-term investments include securities with maturities greater than three months to one year. Long-term investments include securities with maturities greater than one year.

Short-term and long-term investments are generally classified as available-for-sale and are carried at fair value. Certain equity investments are recorded using the fair value or equity method. The Company monitors the difference between the carrying value and fair value of its available-for-sale debt investments and whether declines in fair value are credit related. Unrealized gains and losses on debt investments available-for-sale are excluded from earnings and reported in accumulated other comprehensive earnings (loss), a separate component of stockholders' equity, net of income tax effects. If a loss is deemed to be credit related, the Company recognizes an allowance through earnings. 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 recorded in earnings through investment and other income. Premiums and discounts are amortized or accreted over the life of the related security using the effective interest method. To calculate realized gains and losses on the sale of investments, the Company uses the specific amortized cost of each investment sold. Realized gains and losses are recorded in investment and other income.

The Company uses the equity method to account for investments in entities that it does not control but has the ability to exercise significant influence over operating and financial policies. Generally, under the equity method, original investments in these entities are recorded at cost and subsequently adjusted by the Company's share of equity in income or losses after the date of acquisition as well as capital contributions to and distributions from these companies.

Restricted Deposits

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

Fair Value Measurements

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

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

- Available-for-sale investments and restricted deposits: The carrying amount is stated at fair value, based on quoted market prices, where available. For securities not actively traded, fair values were estimated using values obtained from independent pricing services or quoted market prices of comparable instruments.
- Senior unsecured notes: Estimated based on third-party quoted market prices for the same or similar issues.
- Variable rate debt: The carrying amount of the Company's floating rate debt approximates fair value since the interest rates adjust based on market rate adjustments.
- Contingent consideration: Estimated based on expected achievement of metrics included in the acquisition agreement considering circumstances that exist as of the acquisition date.

Property, Software and Equipment

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

Fixed Asset	Depreciation Period
Buildings and improvements	5 - 40 years
Computer hardware and software	3 - 5 years
Furniture and equipment	3 - 10 years
Land improvements	10 - 20 years
Leasehold improvements	1 - 20 years

The carrying amounts of all long-lived assets are evaluated to determine if adjustment to the depreciation and amortization period or to the unamortized balance is warranted. Such evaluation is based principally on the expected utilization of the long-lived assets.

The Company retains fully depreciated assets in property and accumulated depreciation accounts until it removes them from service. In the case of sale, retirement, or disposal, the asset cost and related accumulated depreciation balance is removed from the respective account, and the resulting net amount, less any proceeds, is included as a component of earnings from operations in the Consolidated Statements of Operations.

Goodwill and Intangible Assets

Intangible assets represent assets acquired in purchase transactions and consist primarily of purchased contract rights and customer relationships, provider contracts, trade names, developed technologies and goodwill. Intangible assets are amortized using the straight-line method over the following periods:

Intangible Asset	Amortization Period
Purchased contract rights and customer relationships	3 - 21 years
Provider contracts	4 - 15 years
Trade names	7 - 20 years
Developed technologies	2 - 7 years

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

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

The Company first assesses qualitative factors to determine whether it is necessary to perform the quantitative goodwill impairment test. The Company generally does not calculate the fair value of a reporting unit unless it determines, based on a qualitative assessment, that it is more likely than not that its fair value is less than its carrying amount.

If the quantitative test is deemed necessary, the Company determines an appropriate valuation technique to estimate a reporting unit's fair value as of the testing date. The Company utilizes either the income approach or the market approach, whichever is most appropriate for the respective reporting unit. The income approach is based on an internally developed discounted cash flow model that includes many assumptions related to future growth rates, discount factors, future tax rates and other various assumptions. The market approach is based on financial multiples of comparable companies derived from current market data. The Company then compares the fair value of the reporting unit calculated using the income approach or market approach with its carrying amount and recognizes an impairment charge for the amount by which the carrying amount exceeds fair value. The impairment charge is limited to the total amount of goodwill allocated to the reporting unit. Changes in economic and operating conditions impacting assumptions used in the Company's analyses could result in goodwill impairment in future periods.

Medical Claims Liability

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

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

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

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

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

Revenue Recognition

The Company's health plans generate revenues primarily from premiums received from the states in which it operates health

plans, premiums received from its members and the Centers for Medicare and Medicaid Services (CMS) for its Medicare product, and premiums from members of its commercial health plans. In addition to member premium payments, its Marketplace contracts also generate revenues from subsidies received from CMS. The Company generally receives a fixed premium per member per month pursuant to its contracts and recognizes premium revenues during the period in which it is obligated to provide services to its members at the amount reasonably estimable. In some instances, the Company's base premiums are subject to an adjustment, or risk score, based on the acuity of its membership. Generally, the risk score is determined by the State or CMS analyzing submissions of processed claims data to determine the acuity of the Company's membership relative to the entire state's membership. The Company estimates the amount of risk adjustment based upon the processed claims data submitted and expected to be submitted to CMS and records revenues on a risk adjusted basis. Some contracts allow for additional premiums related to certain supplemental services provided such as maternity deliveries.

The Company's contracts with states may require us to maintain a minimum health benefits ratio (HBR) or may require us to share profits in excess of certain levels. In certain circumstances, including commercial plans, its plans may be required to return premium to the state or policyholders in the event profits exceed established levels. The Company estimates the effect of these programs and recognizes reductions in revenue in the current period. Other states may require us to meet certain performance and quality metrics in order to receive additional or full contractual revenue. For performance-based contracts, the Company does not recognize revenue subject to refund until data is sufficient to measure performance.

Revenues are recorded based on membership and eligibility data provided by the states or CMS, which is adjusted on a monthly basis by the states or CMS for retroactive additions or deletions to membership data. These eligibility adjustments are estimated monthly and subsequent adjustments are made in the period known. The Company reviews and updates those estimates as new information becomes available. It is possible that new information could require us to make additional adjustments, which could be significant, to these estimates.

The Company's Medicare Advantage contracts are with CMS. CMS deploys a risk adjustment model which apportions premiums paid to all health plans according to health severity and certain demographic factors. The CMS risk adjustment model pays more for members whose medical history would indicate that they are expected to have higher medical costs. Under this risk adjustment methodology, CMS calculates the risk adjusted premium payment using diagnosis data from hospital inpatient, hospital outpatient, physician treatment settings as well as prescription drug events. The Company and the healthcare providers collect, compile and submit the necessary and available diagnosis data to CMS within prescribed deadlines. The Company estimates risk adjustment revenues based upon the diagnosis data submitted and expected to be submitted to CMS and records revenues on a risk adjusted basis.

For qualifying low income PDP members, CMS pays for some, or all, of the member's monthly premium. The Company receives certain Part D prospective subsidy payments from CMS for the its PDP members as a fixed monthly per member amount, based on the estimated costs of providing prescription drug benefits over the plan year, as reflected in the its bids. Approximately nine to ten months subsequent to the end of the plan year, or later in the case of the coverage gap discount subsidy, a settlement payment is made between CMS and the Company's plans based on the difference between the prospective payments and actual claims experience.

The Company's specialty services generate revenues under contracts with state and federal programs, healthcare organizations and other commercial organizations, as well as from its own subsidiaries. Revenues are recognized when the related services are provided or as ratably earned over the covered period of services. The Company recognizes revenue related to administrative services under the TRICARE government-sponsored managed care support contract for the DoD's TRICARE program on a straight-line basis over the option period, when the fees become fixed and determinable. The TRICARE contract includes various performance-based measures. For each of the measures, an estimate of the amount that has been earned is made at each interim date, and revenue is recognized accordingly.

Some states enact premium taxes, similar assessments and provider pass-through payments, collectively premium taxes, and these taxes are recorded as a separate component of both revenues and operating expenses. Additionally, the Company's insurance subsidiaries are subject to the Affordable Care Act annual health insurer fee (HIF), absent a HIF moratorium. The ACA imposed the HIF in 2014, 2015, 2016, 2018 and 2020. The HIF was suspended in 2017 and 2019. Beginning in 2021, the HIF was permanently repealed. If the Company is able to negotiate reimbursement of portions of these premium taxes or the HIF, it recognizes revenue associated with the HIF on a straight-line basis when the Company has binding agreements for such reimbursements, including the "gross-up" to reflect the HIFs non-tax deductible nature. Collectively, this revenue is recorded as premium tax and health insurer fee revenue in the Consolidated Statements of Operations. For certain products, premium taxes, state assessments and the HIF are not pass-through payments and are recorded as premium revenue and premium tax expense or health insurer fee expense in the Consolidated Statements of Operations.

Some states require state directed payments that have minimal risk, but are administered as a premium adjustment. These payments are recorded as premium revenue and medical costs at close to a 100% HBR. The Company has little visibility to the timing of these payments until they are paid by the state.

Affordable Care Act

The Affordable Care Act (ACA) established risk spreading premium stabilization programs as well as minimum medical loss ratio (MLR) and cost sharing reductions.

The Company's accounting policies for the programs are as follows:

Risk Adjustment

The permanent risk adjustment program established by the ACA transfers funds from qualified individual and small group insurance plans with below average risk scores to those plans with above average risk scores within each state. The Company estimates the receivable or payable under the risk adjustment program based on its estimated risk score compared to the state average risk score. The Company may record a receivable or payable as an adjustment to premium revenues to reflect the year-to-date impact of the risk adjustment based on its best estimate. The Company refines its estimate as new information becomes available.

Minimum Medical Loss Ratio

Additionally, the ACA established a minimum MLR for the Health Insurance Marketplace. The risk adjustment program described above is taken into consideration to determine if the Company's estimated annual medical costs are less than the minimum MLR and require an adjustment to premium revenues to meet the minimum MLR.

Cost Sharing Reductions (CSRs)

The ACA directs issuers to reduce the Company's members' cost sharing for essential health benefits for individuals with Federal Poverty Levels (FPLs) between 100% and 250% who are enrolled in a silver tier product; eliminate cost sharing for Indians/Alaska Natives with a FPL less than 300% and eliminate cost sharing for Indians/Alaska Natives regardless of FPL when services are provided by an Indian Health Service. In order to compensate issuers for reduced cost sharing provided to enrollees, CMS pays an advance CSR payment to the Company each month based on the Company's certification data provided at the time of the qualified health plan application. After the close of the benefit year, the Company is required to provide CMS with data on the value of the CSRs provided to enrollees based on either a 'simplified' or 'standard' approach. A reconciliation will occur in order to calculate the difference between the Company's CSR advance payments received and the value of CSRs provided to enrollees. This reconciliation will produce either a payable or receivable to/from CMS. The Company has elected the standard methodology approach. In October 2017, the Trump Administration issued an executive order that immediately ceased payments of CSRs to issuers, and beginning in 2018 premium rates for Health Insurance Marketplace were set without factoring in the cost sharing subsidy payments from the federal government.

Premium and Trade Receivables and Unearned Revenue

Premium and service revenues collected in advance are recorded as unearned revenue. For performance-based contracts, the Company does not recognize revenue subject to refund until data is sufficient to measure performance. Premiums and service revenues due to the Company are recorded as premium and trade receivables and are recorded net of an allowance based on historical trends and management's judgment on the collectibility of these accounts. As the Company generally receives payments during the month in which services are provided, the allowance is typically not significant in comparison to total revenues and does not have a material impact on the presentation of the financial condition or results of operations. Amounts receivable under federal contracts are comprised primarily of contractually defined billings, accrued contract incentives under the terms of the contract and amounts related to change orders for services not originally specified in the contract.

Activity in the allowance for uncollectible accounts for the years ended December 31, is summarized below ($ in millions):

	2020	2019	2018
Allowances, beginning of year	$ 157	$ 123	$ 24
Amounts charged to expense	121	76	134
Write-offs of uncollectible receivables	(35)	(42)	(35)
Allowances, end of year	$ 243	$ 157	$ 123

Significant Customers

The Company receives the majority of its revenues under contracts or subcontracts with state Medicaid managed care programs.Customers where the aggregate annual contract revenues exceeded 10% of total annual revenues included the state of California, where the percentage of the Company's total revenue was 11% and 13% for the years ended December 31, 2019 and 2018, respectively; the state of New York, where the percentage of the Company's total revenue was 11% and 15% for the years ended December 31, 2020 and 2019, respectively, and the state of Texas, where the percentage of the Company's total revenue was 10% for the year ended December 31, 2018.

Other Income (Expense)

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

Income Taxes

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

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

Contingencies

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

Stock Based Compensation

Stock based compensation expense is recognized at grant date fair value over the period during which an employee is required to provide service in exchange for the award. Excess tax benefits related to stock compensation are presented as a cash inflow from operating activities. The Company accounts for forfeitures when they occur.

Foreign Currency Translation

The Company is exposed to foreign currency exchange risk through its international subsidiaries whose functional currencies include the Euro and British Pound. The assets and liabilities of the Company's subsidiaries are translated into United States dollars at the balance sheet date. The Company translates its proportionate share of earnings using average rates during the year. The resulting foreign currency translation adjustments are recorded as a separate component of accumulated other comprehensive earnings (loss).

Recently Adopted Accounting Guidance

In June 2016, the Financial Accounting Standards Board (FASB) issued an Accounting Standards Update (ASU) which changes how entities measure credit losses for most financial assets and certain other investments that are not measured at fair value through net income. The ASU is intended to improve financial reporting by requiring timelier recording of credit losses on loans and other financial instruments held by financial institutions and other organizations. The amended guidance requires the measurement of all expected credit losses for financial assets (or groups of financial assets) and available-for-sale debt securities held at the reporting date over the remaining life based on historical experience, current conditions, and reasonable and supportable forecasts. The guidance is effective for annual and interim periods beginning after December 15, 2019. The Company adopted the new guidance in the first quarter of 2020. The majority of the Company's receivables and other financial instruments are with government entities and, therefore, the adoption did not have a material impact on its receivables and other financial instruments. The Company evaluated its investment portfolio under the new available-for-sale debt securities impairment model guidance. The vast majority of the Company's investment portfolio are low risk, investment grade securities. The impact of the Company's evaluation of the investment portfolio resulted in an immaterial decrease to retained earnings at January 1, 2020. The Company evaluates available-for-sale debt securities on a regular basis and records an allowance for credit losses, if necessary. The comparative information has not been restated and continues to be reported under the accounting standards in effect for those periods. The new guidance did not have a material impact on the Company's consolidated financial position, results of operations or cash flows.

In August 2018, the FASB issued an ASU which aligns the requirements for capitalizing implementation costs incurred in a hosting arrangement that is a service contract with the requirements for capitalizing implementation costs incurred to develop or obtain internal-use software (and hosting arrangements that include an internal use software license). The accounting for the service element of a hosting arrangement that is a service contract is not affected by the amendments in this update. The amendments in this ASU require an entity that is the customer in a hosting arrangement to follow the guidance on internal-use software to determine which implementation costs to capitalize and which costs to expense. The standard also requires an entity that is the customer to expense the capitalized implementation costs of a hosting arrangement over the term of the hosting arrangement. The new guidance requires an entity to present the expense related to the capitalized implementation costs in the same line item in the statement of income as the fees associated with the hosting element of the arrangement and classify payments for capitalized implementation costs in the statement of cash flows in the same manner as payments made for fees associated with the hosting element. The entity is also required to present the capitalized implementation costs in the statement of financial position in the same line item that a prepayment for the fees of the associated hosting arrangement would be presented. The guidance is effective for annual and interim periods beginning after December 15, 2019. The Company adopted the new guidance in the first quarter of 2020. The new guidance did not have a material impact on the Company's consolidated financial position, results of operations or cash flows.

Recent Accounting Guidance Not Yet Adopted

In December 2019, the FASB issued an ASU which simplifies the accounting for income taxes by removing certain exceptions to the general principles in ASC Topic 740. The ASU also clarifies and amends certain areas of ASC Topic 740 to improve consistent application of and simplify the generally accepted accounting principles within Topic 740. The guidance is effective for annual and interim periods beginning after December 15, 2020. The Company adopted the new guidance in the first quarter of 2021. The new guidance did not have a material impact on the Company's consolidated financial position, results of operations and cash flows.

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

3. Acquisitions

WellCare Acquisition

On January 23, 2020, the Company acquired all of the issued and outstanding shares of WellCare. The transaction was valued at $19,555 million, including the assumption of debt. The WellCare Acquisition brought a high-quality Medicare platform and further extended the Company's robust Medicaid offerings. The WellCare Acquisition also enables the Company to provide access to more comprehensive and differentiated solutions across more markets with a continued focus on affordable, high-quality, culturally-sensitive healthcare services. With the WellCare Acquisition, the Company further broadened its product offerings by adding a Medicare prescription drug plan (PDP) to its existing business lines.

Total consideration paid for the acquisition was $17,605 million, consisting of Centene common shares valued at $11,431 million (based on Centene's stock price of $66.76), $6,079 million in cash, and $95 million related to the fair value of replacement equity awards associated with pre-combination service. Each WellCare share was converted into 3.38 shares of validly issued, fully paid, non-assessable Centene common stock and $120.00 in cash. In total, 171 million shares of Centene common stock were issued to the WellCare stockholders. The cash portion of the acquisition was funded through the issuance of long-term debt as further discussed in Note 10. Debt. The Company recognized $602 million of acquisition related costs, primarily related to WellCare, that are included in the Consolidated Statements of Operations for the year ended December 31, 2020.

The acquisition of WellCare was accounted for as a business combination using the acquisition method of accounting that requires assets acquired and liabilities assumed to be recognized at fair value as of the acquisition date. The valuation of all assets acquired and liabilities assumed was finalized in the fourth quarter of 2020.

The Company's allocation of the fair value of assets acquired and liabilities assumed as of the acquisition date of January 23, 2020 is as follows ($ in millions):

Assets acquired and liabilities assumed		
Cash and cash equivalents	$	2,947
Premium and related receivables		3,699
Short-term investments		355
Other current assets		1,205
Long-term investments		2,725
Restricted deposits		320
Property, software and equipment		237
Intangible assets [a]		6,632
Other long-term assets		338
Total assets acquired		18,458
Medical claims liability		4,122
Accounts payable and accrued expenses		3,035
Return of premium payable		192
Unearned revenue		657
Long-term debt [b]		2,055
Deferred tax liabilities [c]		1,428
Other long-term liabilities		475
Total liabilities assumed		11,964
Total identifiable net assets		6,494
Goodwill [d]		11,111
Total assets acquired and liabilities assumed	$	17,605

Significant fair value adjustments are noted as follows:

(a) The identifiable intangible assets acquired are to be measured at fair value as of the completion of the acquisition. The fair value of intangible assets is determined primarily using variations of the income approach, which is based on the present value of the future after tax cash flows attributable to each identified intangible asset. Other valuation methods, including the market approach and cost approach, were also considered in estimating the fair value. The Company has estimated the fair value of intangible assets to be $6,632 million with a weighted average life of 14 years. The identifiable intangible assets include purchased contract rights and customer relationships, provider contracts, trade names and developed technologies.

The fair values and weighted average useful lives for identifiable intangible assets acquired are as follows:

	Fair Value	Weighted Average Useful Life (in years)
Purchased contract rights and customer relationships	$ 5,737	14
Provider contracts	227	15
Trade names	561	16
Developed technologies	107	3
Total intangible assets acquired	$ 6,632	14

(b) Debt is required to be measured at fair value under the acquisition method of accounting. The fair value of WellCare's aggregate principle of $1,950 million Senior Notes assumed in the acquisition was $2,055 million. The $105 million increase is amortized as a reduction to interest expense over the remaining life of the debt.

(c) The deferred tax liabilities are presented net of $355 million of deferred tax assets.

(d) The acquisition resulted in $11,111 million of goodwill primarily related to synergies expected from the acquisition and the assembled workforce of WellCare. Substantially all of the goodwill has been assigned to the Managed Care segment. The majority of the goodwill is not deductible for income tax purposes.

Divestitures

Immediately prior to the closing of the WellCare Acquisition, Anthem, Inc. acquired WellCare's Missouri Medicaid health plan, a WellCare Missouri Medicare Advantage health plan, and WellCare's Nebraska Medicaid health plan. CVS Health Corporation acquired portions of Centene's Illinois Medicaid and Medicare Advantage health plans as part of previously announced divestiture agreements. The Company recorded $104 million in pre-tax gains for the year ended December 31, 2020, as a result of the Illinois divestiture, which is included in investment and other income on the Consolidated Statements of Operations.

Statement of Operations

From the acquisition date through December 31, 2020, the Company's Consolidated Statement of Operations include total WellCare revenues of $30,709 million. It is impracticable for the Company to determine the effect on net income resulting from the WellCare acquisition for the year ended December 31, 2020, as the Company immediately began integrating WellCare into its ongoing operations.

Unaudited Pro Forma Financial Information

The following table presents supplemental pro forma information for the year ended December 31, 2019 ($ in millions, except per share data):

	Year Ended December 31, 2019
Total revenues	$ 102,379
Net earnings attributable to common stockholders	1,496
Diluted earnings per share	$ 2.53

The unaudited pro forma total revenues for the year ended December 31, 2020 was $112,905 million. It is impracticable for the Company to determine the pro forma earnings information for the year ended December 31, 2020 due to the nature of obtaining that information as the Company immediately began integrating WellCare into its ongoing operations.

The unaudited pro forma financial information reflects the historical results of Centene and WellCare adjusted as if the acquisition had occurred on January 1, 2019, primarily for the following:

- Interest expense associated with debt incurred to finance the transaction.
- Elimination of historical WellCare intangible asset amortization expense and addition of amortization expense based on the fair value of identifiable intangible assets of approximately $6,632 million.

- Issuance of 171 million shares of Centene common stock in connection with the per share common stock consideration.
- Elimination of acquisition related costs.
- Adjustments to income tax expense related to pro forma adjustments and increased income tax expense related to IRS Regulation 162(m)(6).

The pro forma results do not reflect any anticipated synergies, efficiencies, or other cost savings of the acquisition. Accordingly, the unaudited pro forma financial information is not indicative of the results if the acquisition had been completed on January 1, 2019 and is not a projection of future results. The unaudited pro forma financial information does not reflect the previously discussed divestitures as the impact would be impracticable to quantify.

Magellan Acquisition

In January 2021, the Company announced that it entered into a definitive merger agreement under which it will acquire Magellan Health for $95.00 per share in cash for a total enterprise value of approximately $2,200 million.

The transaction is subject to clearance under the Hart-Scott Rodino Act, receipt of required state regulatory approvals, the approval of the definitive merger agreement by Magellan Health's stockholders and other customary closing conditions. The transaction is not contingent upon financing. The Company intends to fund the acquisition primarily through debt financing. The transaction is expected to close in the second half of 2021.

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

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

	December 31, 2020				December 31, 2019			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
Debt securities:								
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ 907	$ 4	$ —	$ 911	$ 211	$ 1	$ —	$ 212
Corporate securities	6,560	262	(8)	6,814	3,629	108	(4)	3,733
Restricted certificates of deposit	105	—	—	105	482	—	—	482
Restricted cash equivalents	157	—	—	157	8	—	—	8
Short-term time deposits	53	—	—	53	—	—	—	—
Municipal securities	2,970	129	(2)	3,097	2,320	69	(1)	2,388
Asset-backed securities	1,154	13	(3)	1,164	741	5	(2)	744
Residential mortgage-backed securities	1,068	27	—	1,095	464	8	(1)	471
Commercial mortgage- backed securities	748	30	(5)	773	380	9	(1)	388
Equity securities [1]	318	—	—	318	—	—	—	—
Private equity investments	838	—	—	838	664	—	—	664
Life insurance contracts	168	—	—	168	148	—	—	148
Total	$ 15,046	$ 465	$ (18)	$ 15,493	$ 9,047	$ 200	$ (9)	$ 9,238

(1) Investments in equity securities primarily consists of exchange traded funds in fixed income securities.

The Company's investments are debt securities classified as available-for-sale with the exception of equity securities, certain private equity investments and life insurance contracts. 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 December 31, 2020, 97% of the Company's investments in rated securities carry an investment grade rating by nationally recognized statistical rating organizations. At December 31, 2020, the Company held certificates of deposit, equity securities, private equity investments and life insurance contracts, which did not carry a credit rating. Accrued interest income on available-for-sale debt securities was $86 million and $62 million at December 31, 2020 and 2019, respectively, and is included in other current assets on the Consolidated Balance Sheet.

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 years at December 31, 2020.

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

	December 31, 2020				December 31, 2019			
	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
Corporate securities	$ (7)	$ 953	$ (1)	$ 24	$ (2)	$ 192	$ (2)	$ 48
Municipal securities	(2)	238	—	—	(1)	185	—	11
Asset-backed securities	(2)	302	(1)	105	(1)	153	(1)	151
Residential mortgage- backed securities	—	59	—	2	—	44	(1)	81
Commercial mortgage- backed securities	(5)	147	—	13	(1)	118	—	21
Total	$ (16)	$ 1,699	$ (2)	$ 144	$ (5)	$ 692	$ (4)	$ 312

As of December 31, 2020, the gross unrealized losses were generated from967 positions out of a total of 6,327 positions. The change in fair value of available-for-sale debt 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 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, the Company did not record an impairment for these securities.

In addition, the Company monitors available-for-sale debt securities for credit losses. 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 allowance when evidence demonstrates that the decline in fair value is credit related. Evidence of a credit related loss may include rating agency actions, adverse conditions specifically related to the security, or failure of the issuer of the security to make scheduled payments.

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

	December 31, 2020				December 31, 2019			
	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	$ 1,407	$ 1,414	$ 817	$ 818	$ 750	$ 752	$ 550	$ 550
One year through five years	4,748	4,937	221	223	3,034	3,106	106	108
Five years through ten years	3,460	3,639	18	19	2,162	2,257	—	—
Greater than ten years	81	87	—	—	48	50	—	—
Asset-backed securities	2,970	3,032	—	—	1,585	1,603	—	—
Total	$ 12,666	$ 13,109	$ 1,056	$ 1,060	$ 7,579	$ 7,768	$ 656	$ 658

Actual maturities may differ from contractual maturities due to call or prepayment options. Equity securities, private equity investments and life insurance contracts are excluded from the table above because they do not have a contractual maturity. 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.

5. 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 December 31, 2020, 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	$ 10,800	$ —	$ —	$ 10,800
Investments:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ 165	$ —	$ —	$ 165
Corporate securities	—	6,789	—	6,789
Municipal securities	—	3,070	—	3,070
Short-term time deposits	—	53	—	53
Asset-backed securities	—	1,164	—	1,164
Residential mortgage-backed securities	—	1,095	—	1,095
Commercial mortgage-backed securities	—	773	—	773
Equity securities	316	2	—	318
Total investments	$ 481	$ 12,946	$ —	$ 13,427
Restricted deposits:				
Cash and cash equivalents	$ 157	$ —	$ —	$ 157
Certificates of deposit	—	105	—	105
Corporate securities	—	25	—	25
Municipal securities	—	27	—	27
U.S. Treasury securities and obligations of U.S. government corporations and agencies	746	—	—	746
Total restricted deposits	$ 903	$ 157	$ —	$ 1,060
Total assets at fair value	$ 12,184	$ 13,103	$ —	$ 25,287

The following table summarizes fair value measurements by level at December 31, 2019, 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	$ 12,123	$ —	$ —	$ 12,123
Investments:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ 73	$ —	$ —	$ 73
Corporate securities	—	3,713	—	3,713
Municipal securities	—	2,379	—	2,379
Asset-backed securities	—	744	—	744
Residential mortgage-backed securities	—	471	—	471
Commercial mortgage-backed securities	—	388	—	388
Total investments	$ 73	$ 7,695	$ —	$ 7,768
Restricted deposits:				
Cash and cash equivalents	$ 8	$ —	$ —	$ 8
Certificates of deposit	—	482	—	482
Corporate securities	—	20	—	20
Municipal securities	—	9	—	9
U.S. Treasury securities and obligations of U.S. government corporations and agencies	139	—	—	139
Total restricted deposits	$ 147	$ 511	$ —	$ 658
Other long-term assets:				
Interest rate swap agreements	$ —	$ 10	$ —	$ 10
Total assets at fair value	$ 12,343	$ 8,216	$ —	$ 20,559
Liabilities				
Other long-term liabilities:				
Interest rate swap agreements	$ —	$ 11	$ —	$ 11
Total liabilities at fair value	$ —	$ 11	$ —	$ 11

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. In addition, the aggregate carrying amount of the Company's private equity investments and life insurance contracts, which approximates fair value, was $1,006 million and $812 million as of December 31, 2020, and December 31, 2019, respectively.

6. Property, Software and Equipment

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

	2020	2019
Computer software	$ 1,465	$ 1,018
Building	891	778
Furniture and office equipment	600	457
Leasehold improvements	532	390
Computer hardware	525	378
Land	238	202
Property, software and equipment, at cost	4,251	3,223
Less: accumulated depreciation	(1,477)	(1,102)
Property, software and equipment, net	$ 2,774	$ 2,121

Depreciation expense for the years ended December 31, 2020, 2019 and 2018 was $487 million, $342 million and $237 million, respectively.

7. Goodwill and Intangible Assets

The following table summarizes the changes in goodwill by operating segment ($ in millions):

	Managed Care	Specialty Services	Total
Balance as of December 31, 2018	$ 5,686	$ 1,329	$ 7,015
Acquisitions and purchase accounting adjustments	61	47	108
Impairment	(16)	(243)	(259)
Translation impact	(1)	—	(1)
Balance as of December 31, 2019	5,730	1,133	6,863
Acquisitions and purchase accounting adjustments	11,114	756	11,870
Divestitures	(68)	(5)	(73)
Reallocation	197	(197)	—
Impairment	—	(9)	(9)
Translation impact	1	—	1
Balance as of December 31, 2020	$ 16,974	$ 1,678	$ 18,652

The majority of the increase in the managed care segment goodwill in 2020 was related to the acquisition and fair value allocations related to the WellCare acquisition discussed in Note 3. *Acquisitions*. The majority of the increase in the specialty services segment goodwill related to the acquisitions of Apixio and PANTHERx. As part of the sale of certain products of the Illinois health plan due to the WellCare acquisition, the Company allocated goodwill of $68 million to the Illinois health plan as part of the divestiture. The Company reallocated goodwill of $197 million from the Specialty Services segment to the Managed Care segment related to its pharmacy benefit management business based on the completion of the shift to transparent pricing. During the first quarter of 2020, the Company recorded $9 million of non-cash goodwill impairment related to its third-party care management software business in the Specialty Services segment.

During the third quarter of 2019, the Company recorded $271 million of non-cash goodwill ($259 million) and intangible asset ($12 million) impairment, substantially all associated with the Company's U.S. Medical Management (USMM) physician home health business in the Specialty Services segment. The impairment was identified as part of the Company's quarterly review procedures, which included an analysis of new information related to its shared savings demonstration programs, slower than expected penetration of the physician home health business model into its Medicaid population, and the related impact to revised forecasts. The Company conducted an impairment analysis of the identifiable intangible assets and goodwill of the reporting unit using the income approach, in which fair value is derived based on the present value of discounted expected cash flows.

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

	2020	2019	Weighted Average Life in Years 2020	Weighted Average Life in Years 2019
Purchased contract rights and customer relationships	$ 8,102	$ 2,026	13.4	12.0
Provider contracts	526	299	13.5	12.4
Trade names	939	361	13.8	15.2
Developed technologies	336	179	4.8	5.2
Other intangibles	—	5	—	2.7
Intangible assets	9,903	2,870	13.1	12.0
Less accumulated amortization:				
Purchased contract rights and customer relationships	(1,046)	(497)		
Provider contracts	(152)	(115)		
Trade names	(140)	(80)		
Developed technologies	(177)	(111)		
Other intangibles	—	(4)		
Total accumulated amortization	(1,515)	(807)		
Intangible assets, net	$ 8,388	$ 2,063		

Amortization expense was $719 million, $258 million and $211 million for the years ended December 31, 2020, 2019 and 2018, respectively.Estimated total amortization expense related to the December 31, 2020 intangible assets for each of the five succeeding fiscal years is as follows ($ in millions):

Year	Expense
2021	$ 768
2022	762
2023	727
2024	718
2025	710

8. Medical Claims Liability

The Specialty Services segment 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.

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

	Year Ended December 31,		
	2020	2019	2018
Balance, January 1	$ 7,473	$ 6,831	$ 4,286
Less: Reinsurance recoverable	20	27	18
Balance, January 1, net	7,453	6,804	4,268
Acquisitions and divestitures	3,856	59	1,204
Less: Acquired reinsurance recoverable	—	—	8
Incurred related to:			
Current year	86,765	59,539	46,484
Prior years	(501)	(677)	(427)
Total incurred	86,264	58,862	46,057
Paid related to:			
Current year	78,838	52,453	41,161
Prior years	6,320	5,819	3,556
Total paid	85,158	58,272	44,717
Balance at December 31, net	12,415	7,453	6,804
Plus: Reinsurance recoverable	23	20	27
Balance, December 31	$ 12,438	$ 7,473	$ 6,831

Reinsurance recoverables related to medical claims are included in premium and trade 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, the Company recorded approximately $86 million, $49 million, and $25 million of the "Incurred related to: Prior years" as a reduction to premium revenues in 2020, 2019, and 2018, respectively. Further, claims processing initiatives yielded increased claim payment recoveries and coordination of benefits related to prior year dates of service. Changes in medical utilization and cost trends and the effect of population health management initiatives may also contribute to changes in medical claim liability estimates. While the Company has evidence that population health management initiatives are effective on a case by case basis, population health management initiatives primarily focus on events and behaviors prior to the incurrence of the medical event and generation of a claim. Accordingly, any change in behavior, leveling of care, or coordination of treatment occurs prior to claim generation and as a result, the costs prior to the population health management initiative are not known by the Company. Additionally, certain population health management initiatives are focused on member and provider education with the intent of influencing behavior to appropriately align the medical services provided with the member's acuity. In these cases, determining whether the population health management initiative changed the behavior cannot be determined. Because of the complexity of its business, the number of states in which it operates, and the volume of claims that it processes, the Company is unable to practically quantify the impact of these initiatives on its changes in estimates of IBNR.

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

Information about incurred and paid claims development as of December 31, 2020 is included in the table below and is inclusive of claims incurred and paid related to the WellCare and Fidelis Care businesses prior and subsequent to the acquisition date. The claims development information for all periods preceding the most recent reporting period is considered required supplementary information. Incurred and paid claims development as of December 31, 2020 is as follows ($ in millions):

	Cumulative Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance		
	For the Years Ended December 31,		
Claim Year	2018 (unaudited)	2019 (unaudited)	2020
2018	$ 71,013	$ 70,023	$ 69,999
2019		84,027	83,329
2020			88,206
		Total incurred claims	$ 241,534

	Cumulative Paid Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance		
	For the Years Ended December 31,		
Claim Year	2018 (unaudited)	2019 (unaudited)	2020
2018	$ 61,851	$ 69,523	$ 69,807
2019		73,889	82,690
2020			76,722
		Total payment of incurred claims	$ 229,219
		All outstanding liabilities prior to 2018, net of reinsurance	100
		Medical claims liability, net of reinsurance	$ 12,415

Incurred claims and allocated claim adjustment expenses, net of reinsurance, total IBNR plus expected development on reported claims and cumulative claims data as of December 31, 2020 are included in the following table and are inclusive of the acquired WellCare and Fidelis Care businesses. For claims frequency information summarized below, a claim is defined as the financial settlement of a single medical event in which remuneration was paid to the servicing provider. 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. The Company estimates its 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. Information is summarized as follows (in millions):

	December 31, 2020		
	Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance	Total IBNR Plus Expected Development on Reported Claims	Cumulative Paid Claims
2018	$ 69,999	$ 3	469.7
2019	83,329	81	515.7
2020	88,206	8,364	542.9

9. Affordable Care Act

The Affordable Care Act established risk spreading premium stabilization programs as well as a minimum annual MLR and cost sharing reductions.

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

	December 31, 2020	December 31, 2019
Risk adjustment receivable	$ 340	$ 245
Risk adjustment payable	(1,224)	(1,239)
Risk corridor receivable	—	4
Minimum medical loss ratio	(238)	(367)
Cost sharing reduction receivable	101	73
Cost sharing reduction payable	(1)	(1)

In April 2020, the U.S. Supreme Court ruled that the federal government was required to pay health insurers for payments due under the risk corridor program, originally established under the Affordable Care Act (ACA). In the third quarter of 2020, the Company recorded a pre-tax net benefit related to the ACA risk corridor receivable settlement of $398 million (net of minimum medical loss ratio payback and related expenses). The Company collected the risk corridor receivable in 2020.

In July 2020, CMS announced the final risk adjustment transfers for the 2019 benefit year. As a result of the announcement, the Company reduced its risk adjustment net payables by $94 million from December 31, 2019. After consideration of minimum MLR, estimated Risk Adjustment Data Validation (RADV) audit results, and other related impacts, the net pre-tax benefit recognized of $63 million was recorded in the second quarter of 2020.

10. Debt

Debt consists of the following ($ in millions):

	December 31, 2020	December 31, 2019
$1,000 million 4.75% Senior Notes, due May 15, 2022	$ —	$ 1,004
$1,000 million 6.125% Senior Notes, due February 15, 2024	—	1,000
$2,200 million 4.75% Senior Notes, due January 15, 2025	2,230	2,228
$1,800 million 5.375% Senior Notes, due June 1, 2026	1,800	1,800
$750 million 5.375% Senior Notes, due August 15, 2026	794	—
$2,500 million 4.25% Senior Notes, due December 15, 2027	2,482	2,479
$3,500 million 4.625% Senior Notes, due December 15, 2029	3,500	3,500
$2,000 million 3.375% Senior Notes, due February 15, 2030	2,000	—
$2,200 million 3.00% Senior Notes due October 15, 2030	2,200	—
Fair value of interest rate swap agreements	—	(1)
Total senior notes	15,006	12,010
Term loan credit facility	1,450	1,450
Revolving credit agreement	97	93
Mortgage notes payable	50	54
Construction loan payable	180	140
Finance leases and other	153	122
Debt issuance costs	(157)	(143)
Total debt	16,779	13,726
Less current portion	(97)	(88)
Long-term debt	$ 16,682	$ 13,638

Senior Notes

In February 2021, the Company issued $2,200 million 2.50% Senior Notes due 2031 (the 2031 Notes). In conjunction with the 2031 Notes offering, the Company completed a tender offer (the Tender Offer) to purchase for cash, subject to certain conditions, any and all of the outstanding aggregate principal amount of the $2,200 million 4.75% Senior Notes due 2025 (the 2025 Notes). The Company used the net proceeds from the 2031 Notes, together with available cash on hand, to fund the purchase price for the 2025 Notes accepted for purchase in the Tender Offer (approximately 36% of the aggregate principal

amount outstanding) and intends to use the remaining proceeds to redeem any of the 2025 Notes that remain outstanding following the Tender Offer, including all premiums, accrued interest and costs and expenses related to the redemption.

In October 2020, the Company issued $2,200 million 3.0% Senior Notes due October 2030 (the $2,200 million 2030 Notes). The Company used the net proceeds from the offering, together with cash on hand, to redeem all of the $1,000 million 4.75% Senior Notes due May 15, 2022 (the 2022 Notes) and the $1,200 million 5.25% Senior Notes due 2025, including all premiums, accrued interest and expenses related to the redemptions. The Company recognized a pre-tax loss on extinguishment of $17 million on the redemption of the 2022 Notes and the $1,200 million 5.25% Senior Notes due 2025 in the fourth quarter of 2020, including the call premium and write-off of unamortized debt issuance costs.

In May 2020, the Company completed an exchange offer, whereby it exchanged substantially all of the outstanding $2,000 million 3.375% Senior Notes due February 15, 2030, $1,000 million 4.75% Senior Notes due January 15, 2025, $2,500 million 4.25% Senior Notes due December 15, 2027, and $3,500 million 4.625% Senior Notes due December 15, 2029 for identical securities that have been registered under the Securities Act of 1933.

In February 2020, the Company issued $2,000 million 3.375% Senior Notes due February 15, 2030 (the $2,000 million 2030 Notes). The Company used the net proceeds from the $2,000 million 2030 Notes to redeem and all of its outstanding $1,000 million 6.125% Senior Notes, due February 15, 2024 (the 2024 Notes). The Company recognized a pre-tax loss on extinguishment of $44 million, including the call premium, the write-off of unamortized debt issuance costs and the loss on the termination of the $1,000 million interest rate swap associated with the 2024 Notes. The Company intended to use remaining proceeds to redeem the 2022 Notes. However, as a result of the spread of COVID-19 and the resulting disruption and volatility in the global capital markets, the Company deferred the redemption of the 2022 Notes. The 2022 Notes were redeemed in the fourth quarter of 2020 in connection with an additional offering of senior notes as further described above, and the Company decided to increase liquidity with the remaining proceeds of the $2,000 million 2030 Notes.

In connection with the WellCare Acquisition, in January 2020, the Company completed an exchange offer for up to $1,200 million of 5.25% Senior Notes due April 1, 2025 and $750 million of 5.375% Senior Notes due August 15, 2026 (collectively, the WellCare Notes) issued by WellCare and issued $1,146 million aggregate principal amount of 5.25% Senior Notes due April 1, 2025 and $747 million aggregate principal amount of 5.375% Senior Notes due August 15, 2026. Additionally, the Company's wholly owned subsidiary, WellCare Health Plans, Inc., assumed the remaining unexchanged WellCare Notes. The WellCare Notes were recorded at the acquisition date fair value of $ 2,055 million. The Company redeemed the $1,200 million of 5.25% Senior Notes due April 1, 2025 in October 2020.

In December 2019, the Company issued approximately $1,000 million 4.75% Senior Notes due 2025 (the Additional 2025 Notes), $2,500 million 4.25% Senior Notes due 2027 (the 2027 Notes), and $3,500 million 4.625% Senior Notes due 2029 (the 2029 Notes). The Company used the net proceeds of the 2027 Notes and the 2029 Notes and a portion of the net proceeds of the Additional 2025 Notes to fund the cash consideration of the WellCare acquisition, which closed on January 23, 2020.

In October 2019, the Company redeemed the outstanding principal balance on the $1,400 million 5.625% Senior Notes due February 15, 2021, plus applicable premium for early redemption and accrued and unpaid interest through the redemption date. The Company recognized a pre-tax loss on extinguishment of $30 million on the redemption of the $1,400 million 5.625% Senior Notes in the fourth quarter of 2019, including the call premium, the write-off of unamortized debt issuance costs and a loss on the termination of the $600 million interest rate swap agreement associated with the notes.

The indentures governing the senior notes listed in the table above contain restrictive covenants of Centene Corporation. At December 31, 2020, the Company was in compliance with all covenants.

Interest Rate Swaps

In February 2020, the Company terminated the interest rate swap agreements associated with the 2022 Notes and $2,200 million 4.75% Senior Notes, due January 15, 2025, (the 2025 Notes). The interest rate swaps associated with the 2024 Notes were also terminated in connection with the redemption of those notes as discussed above. In total, the Company terminated three interest rate swap contracts with a notional amount of $2,100 million. The swaps effectively converted $2,100 million of fixed rate notes to floating rates. As a result of the interest rate swap terminations, the Company received $9 million in cash.

Revolving Credit Facility and Term Loan Credit Facility

The Company has (i) unsecured $2,000 million multi-currency revolving credit facility (the Revolving Credit Facility), which includes a $300 million sub-limit for letters of credit and a $200 million sub-limit for swingline loans and (ii) a $1,450 million unsecured delayed-draw term loan facility (the Term Loan Facility, and, together with the Revolving Credit Facility, the Company Credit Facility). Borrowings under the Revolving Credit Facility bear interest, at the Company's option, at LIBOR, EURIBOR, CDOR, BBR or base rates plus, in each case, an applicable margin based on total debt to EBITDA ratio. Borrowings under the Term Loan Facility bear interest, at the Company's option, at LIBOR or base rates plus, in each case, an applicable margin based on the total debt to EBITDA ratio. The Company has an uncommitted option to increase its Company Credit Facility by an additional $500 million plus certain additional amounts based on its total debt to EBITDA ratio.

The Company Credit Facility contains financial covenants including maintenance of a minimum fixed charge coverage ratio and a restriction on the Company's maximum total debt to EBITDA ratio not to exceed 3.5 to 1.0, except under certain circumstances and subject to certain elections made by the Company, the maximum total debt to EBITDA ratio may be increased for certain periods to 4.0 to 1.0. It also contains certain non-financial covenants including: limitations on incurrence of additional indebtedness; restrictions on incurrence of liens; restrictions on dividends and other restricted payments; restrictions on investments, mergers, consolidations and asset sales; and limitations on transactions with affiliates. As of December 31, 2020, the Company was in compliance with all financial and non-financial covenants under the Company Credit Facility.

As of December 31, 2020, the Company had $97 million of borrowings outstanding under the Revolving Credit Facility, with a weighted average interest rate of 1.25%. In October 2019, the Company borrowed $1,450 million under the Term Loan Facility. The proceeds of the Term Loan Facility were used to fund the redemption of certain senior notes discussed below and pay fees and expenses in connection therewith, with any remaining proceeds to be used for general corporate purposes.

The Revolving Credit Facility will mature on May 7, 2024. The Term Loan Facility will mature on September 11, 2022.

Mortgage Notes Payable

The Company has a non-recourse mortgage note of $50 million at December 31, 2020 collateralized by its corporate headquarters building. The mortgage note was paid January 1, 2021 and bore a 5.14% interest rate. The collateralized property had a net book value of $130 million at December 31, 2020.

Construction Loan

The Company has a $200 million non-recourse construction loan to fund the expansion of the Company's corporate headquarters. In February 2021, the Company extended the term of the construction loan for one year. The loan bears interest based on the one month LIBOR plus 2.70% and matures in April 2022. The agreement contains financial and non-financial covenants aligning with the Company Credit Facility. The Company has guaranteed completion of the construction project associated with the loan. As of December 31, 2020, the Company had $180 million in borrowings outstanding under the loan.

Letters of Credit & Surety Bonds

The Company had outstanding letters of credit of $129 million as of December 31, 2020, which were not part of the Revolving Credit Facility. The letters of credit bore interest at 0.6% as of December 31, 2020. The Company had outstanding surety bonds of $1,114 million as of December 31, 2020.

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

2021	$ 97
2022	1,674
2023	34
2024	113
2025	2,212
Thereafter	12,750
Total	$ 16,880

The fair value of outstanding debt was approximately $17,717 million and $14,160 million at December 31, 2020 and 2019, respectively.

11. Leases

The Company records right of use (ROU) assets and lease liabilities for non-cancelable operating leases primarily for real estate and equipment. Leases with an initial term of 12 months or less are not recorded on the balance sheet. Expense related to leases is recorded on a straight-line basis over the lease term, including rent holidays. The Company recognized operating lease expense of $341 million and $203 million during the years ended December 31, 2020 and 2019, respectively.

The following table sets forth the ROU assets and lease liabilities ($ in millions):

	December 31, 2020	December 31, 2019
Assets		
ROU assets (recorded within other long-term assets)	$ 1,311	$ 661
Liabilities		
Short-term (recorded within accounts payable and accrued expenses)	$ 204	$ 161
Long-term (recorded within other long-term liabilities)	1,334	622
Total lease liabilities	$ 1,538	$ 783

Cash paid for amounts included in the measurement of lease liabilities, recorded as operating cash flows in the Consolidated Statements of Cash Flows, was $276 million and $227 million during the years ended December 31, 2020 and 2019, respectively. New operating leases commenced resulting in the recognition of ROU assets and lease liabilities of $349 million and $162 million during the years ended December 31, 2020 and 2019, respectively. As of December 31, 2020, the Company had additional operating leases that have not yet commenced of $19 million. These operating leases will commence in 2021 with lease terms of five to seven years. In connection with the WellCare acquisition, the Company acquired $297 million of ROU assets and $298 million of lease liabilities.

The weighted average remaining lease term of the Company's operating leases was 9.3 years and 6.6 as of December 31, 2020 and 2019, respectively. The lease liabilities reflect a weighted average discount rate of 3.1% and 4.2% as of December 31, 2020 and 2019, respectively. Lease payments over the next five years and thereafter are as follows ($ in millions):

	December 31, 2020
2021	$ 293
2022	238
2023	209
2024	186
2025	150
Thereafter	778
Total lease payments	1,854
Less: imputed interest	(316)
Total lease liabilities	$ 1,538

12. Stockholders' Equity

The Company has 10 million authorized shares of preferred stock at $.001 par value. At December 31, 2020, there were no preferred shares outstanding.

The Company's Board of Directors has authorized a stock repurchase program of the Company's common stock from time to time on the open market or through privately negotiated transactions. The initial program, which was extended in 2009, authorized the repurchase of up to 16.0 million shares. In October 2019, the Company's Board of Directors approved a $500 million increase to the program based on the closing stock price on the date of the WellCare Acquisition. Based on the stock price of $66.76, an additional 7.5 million shares were approved. As of December 31, 2020, 5.5 million remaining shares are available under the program for repurchase. In February 2021, the Company's Board of Directors approved an increase in the Company's existing share repurchase program for its common stock. With the increase, the Company is authorized to

repurchase up to $1,000 million of shares of the Company's common stock, inclusive of the previously approved stock repurchase program. No duration has been placed on the repurchase program. The Company reserves the right to discontinue the repurchase program at any time. During the first quarter of 2020, the Company used proceeds from divestitures to repurchase 8.7 million shares of Centene common stock for $500 million through the Company's stock repurchase program. During the year ended December 31, 2019, the Company did not repurchase any shares through this publicly announced program.

As a component of the employee stock compensation plan, employees can use shares of stock which have vested to satisfy statutory tax withholding obligations. As part of this plan, the Company repurchased 1.6 million shares at an aggregate cost of $102 million in 2020 and 1 million shares at an aggregate cost of $75 million in 2019. These shares are included in the Company's treasury stock. In addition, in 2020, 407 thousand shares were withheld at an aggregate cost of $24 million to meet applicable tax withholding requirements related to the vesting of shares assumed in connection with the WellCare acquisition. Although these withheld shares are not issued or considered common stock repurchases under a stock repurchase program, they are treated as common stock repurchases as they reduce the number of shares that would have been issued upon vesting.

In January 2020, the Company issued 171 million shares of Centene common stock with a fair value of $11,431 million and paid $6,079 million in cash in exchange for all the outstanding shares of WellCare common stock. In addition, the Company recorded $95 million related to the fair value of replacement equity awards associated with pre-combination service.

13. Statutory Capital Requirements and Dividend Restrictions

Various state laws require Centene's regulated subsidiaries to maintain minimum capital levels specified by each state and restrict the amount of dividends that may be paid without prior regulatory approval. At December 31, 2020 and 2019, Centene's subsidiaries had aggregate statutory capital and surplus of $14,163 million and $8,725 million, respectively, compared with the required minimum aggregate statutory capital and surplus of $5,945 million and $3,407 million, respectively. As of December 31, 2020, the amount of capital and surplus or net worth that was unavailable for the payment of dividends or return of capital to the Company was $5,945 million in the aggregate.

14. Income Taxes

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

	2020	2019	2018
Current provision			
Federal	$ 959	$ 381	$ 498
State and local	152	41	107
International	4	—	—
Total current provision	1,115	422	605
Deferred provision	(136)	51	(131)
Total income tax expense	$ 979	$ 473	$ 474

The reconciliation of the tax provision at the U.S. federal statutory rate to income tax expense for the years ended December 31 is as follows ($ in millions):

	2020	2019	2018
Earnings before income tax expense	$ 2,773	$ 1,782	$ 1,368
Loss (earnings) attributable to flow through noncontrolling interest	9	11	4
Earnings less noncontrolling interest before income tax expense	2,782	1,793	1,372
Tax provision at the U.S. federal statutory rate	584	377	288
State income taxes, net of federal income tax benefit	106	49	52
Nondeductible compensation	54	42	33
ACA Health Insurer Fee	316	—	149
Audit settlement	(71)	—	—
Valuation Allowance	(11)	—	(28)
Nondeductible goodwill	16	30	—
Other, net	(15)	(25)	(20)
Income tax expense	$ 979	$ 473	$ 474

The tax effects of temporary differences which give rise to deferred tax assets and liabilities are presented below for the years ended December 31 ($ in millions):

	2020	2019
Deferred tax assets:		
Medical claims liability	$ 107	$ 66
Nondeductible liabilities	145	97
Net operating loss and tax credit carryforwards	124	83
Compensation accruals	205	113
Premium and trade receivables	161	78
Operating lease liability	386	186
Other	69	46
Deferred tax assets	1,197	669
Valuation allowance	(73)	(66)
Net deferred tax assets	$ 1,124	$ 603
Deferred tax liabilities:		
Goodwill and intangible assets	$ 1,805	$ 346
Prepaid assets	33	26
Fixed assets	351	187
Right of use asset	337	171
Unrealized gain/loss	105	45
Other	27	17
Deferred tax liabilities	2,658	792
Net deferred tax assets (liabilities)	$ (1,534)	$ (189)

Valuation allowances are provided when it is considered more likely than not that deferred tax assets will not be realized. The valuation allowances primarily relate to future tax benefits on certain federal, state and foreign net operating loss and tax credit carryforwards. The $7 million increase in valuation allowance relates to tax losses in multiple jurisdictions, offset by releases of certain valuation allowances.

Federal net operating loss and credit carryforwards of $46 million expire beginning in 2021 through 2040; state net operating loss and tax credit carryforwards of $58 million expire beginning in 2021 through 2040. Substantially all of the non-U.S. tax loss carryforwards of $20 million have indefinite carryforward periods.

The Company maintains a reserve for uncertain tax positions that may be challenged by a tax authority. A rollforward of the beginning and ending amount of uncertain tax positions, exclusive of related interest and penalties, is as follows:

	Year Ended December 31,	
	2020	2019
Gross unrecognized tax benefits, beginning of period	$ 305	$ 277
Gross increases:		
Current year tax positions	31	39
Acquired reserves	118	—
Prior year tax positions	7	14
Gross decreases:		
Settlements	(96)	(16)
Prior year tax positions	(11)	(8)
Statute of limitation lapses	—	(1)
Gross unrecognized tax benefits, end of period	$ 354	$ 305

Uncertain tax positions increased by $49 million primarily due to the acquisition of WellCare, offset by the release of a 2014 position acquired in the Health Net transaction due to audit settlement. As of December 31, 2020, $310 million of unrecognized tax benefits would impact the Company's effective tax rate in future periods, if recognized. The Company believes it is reasonably possible that its liability for unrecognized tax benefits will decrease in the next twelve months by $13 million as a result of the expiration of statutes of limitations and projected audit settlements in certain jurisdictions.

The table above excludes interest and penalties, net of related tax benefits, which are treated as income tax expense (benefit) under the Company's accounting policy. The Company recognized net interest expense and penalties related to uncertain positions of $2 million benefit and $2 million expense for the years ended December 31, 2020 and 2019, respectively. The Company had $42 million and $16 million of accrued interest and penalties for uncertain tax positions as of December 31, 2020 and 2019, respectively including a $27 million increase for positions acquired in the WellCare transaction.

The Company files tax returns for federal as well as numerous state and international tax jurisdictions. As of December 31, 2020, WellCare is under federal examination for its 2019 federal return as part of the Compliance Assurance Process program. Additionally, Centene's tax returns are under federal examination for tax years 2014 through 2017.

15. Stock Incentive Plans

The Company's stock incentive plans allow for the granting of restricted stock or restricted stock unit awards and options to purchase common stock. Both incentive stock options and nonqualified stock options can be awarded under the plans. However, an immaterial amount of options were granted, exercised, or outstanding in 2020. The plans have 16 million shares available for future awards, however, 10 million shares relate to legacy WellCare shares and based on the terms of the WellCare acquisition, these shares are only available for awards to legacy WellCare employees and new Centene employees. Compensation expense for stock options and restricted stock unit awards is recognized on a straight-line basis over the vesting period, generally three to five years for stock options and one to three years for restricted stock or restricted stock unit awards. Vesting is accelerated by one year for individuals who qualify under the Company's retirement eligible provisions. Certain restricted stock unit awards contain performance-based as well as service-based provisions. Certain awards provide for accelerated vesting if there is a change in control as defined in the plans. The total compensation cost that has been charged against income for the stock incentive plans was $281 million, $177 million and $145 million for the years ended December 31, 2020, 2019 and 2018, respectively. The total income tax benefit recognized in the Statements of Operations for stock-based compensation arrangements was $34 million, $22 million and $34 million for the years ended December 31, 2020, 2019 and 2018, respectively.

A summary of the Company's non-vested restricted stock and restricted stock unit shares as of December 31, 2020, and changes during the year ended December 31, 2020, is presented below (shares in thousands):

	Shares	Weighted Average Grant Date Fair Value
Non-vested balance as of December 31, 2019	6,987	$ 56.19
Granted	3,633	53.30
Converted [1]	3,762	66.76
Vested	(6,098)	52.34
Forfeited	(599)	60.16
Non-vested balance as of December 31, 2020	7,685	$ 62.74

(1) WellCare awards converted in connection with the acquisition.

The total fair value of restricted stock and restricted stock units vested during the years ended December 31, 2020, 2019 and 2018, was $364 million, $202 million and $209 million, respectively.

As of December 31, 2020, there was $246 million of total unrecognized compensation cost related to non-vested share-based compensation arrangements granted under the plans; that cost is expected to be recognized over a weighted-average period of 2.0 years.

The Company maintains an employee stock purchase plan and issued 487 thousand shares, 416 thousand shares, and 256 thousand shares in 2020, 2019 and 2018, respectively.

16. Retirement Plan

Centene has a defined contribution plan which covers substantially all employees who are at least 21 years of age. Under the plan, eligible employees may contribute a percentage of their base salary, subject to certain limitations. Centene may elect to match a portion of the employee's contribution. Company expense related to matching contributions to the plan was $91 million, $64 million and $53 million during the years ended December 31, 2020, 2019 and 2018, respectively.

17. Commitments

In connection with obtaining regulatory approval of the Fidelis Care acquisition, the Company entered into certain undertakings with the New York State Department of Health in 2018. These undertakings contain various commitments by the Company effective upon completion of the Fidelis Care acquisition. One of the undertakings includes a $340 million contribution by the Company to the State of New York to be paid over a five-year period for initiatives consistent with the Company's mission of providing high quality healthcare to vulnerable populations within New York State. As a result of the closing of the Fidelis Care acquisition, the present value of the $ 340 million contribution to the State of New York, approximately $328 million, was expensed during 2018. As of December 31, 2020, the Company has paid $204 million.

The Company also committed to certain undertakings with the California Department of Insurance and the California Department of Managed Health Care in connection with obtaining regulatory approval of the Health Net acquisition in 2016 The Health Net commitments related to the undertakings are as follows:

- invest an additional $30 million through the California Organized Investment Network over the five years following completion of the acquisition, and the Company fulfilled this undertaking in 2020;
- build a service center in an economically distressed community in California, investing $200 million over 10 years and employing at least 300 people, of which the Company has incurred $80 million through 2020;
- contribute $65 million to improve enrollee health outcomes ($10 million over five years), support locally-based consumer assistance programs ($5 million over five years) and strengthen the healthcare delivery system ($50 million over five years), of which the Company has contributed $34 million through 2020, and;
- invest $75 million of its investment portfolio in vehicles supporting California's healthcare infrastructure, of which the Company has invested $48 million through 2020.

18. Contingencies

Overview

The Company is 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, submissions to state agencies related to payments or state false claims acts, 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 and other federal and state fraud, waste and abuse laws;

- litigation arising out of general business activities, such as tax matters, disputes related to healthcare 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 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.

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 proceeding 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.

California

On October 20, 2015, the Company's California subsidiary, Health Net of California, Inc. (Health Net California), was 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, Dave Jones, Insurance Commissioner of the State of California, Betty T. Yee, Controller of the State of California, 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 2015 filing of the complaint. This lawsuit is being coordinated with similar lawsuits filed against other entities (collectively, "Related Actions"). In March 2018, the Court overruled the Company's demurrer seeking to dismiss the complaint and denied the Company's motion to strike allegations seeking retroactive relief. In August 2018, the trial court stayed all the Related Actions pending determination of a writ of mandate by the California Court of Appeals in two of the Related Actions. In March 2019, the California Court of Appeals denied the writ of mandate. The defendants in those Related Actions sought review by the California Supreme Court, which declined to review the matter. Upon the return of the matter to the Los Angeles County Superior Court, motions for summary judgment were scheduled. Health Net California's motion for summary judgment was heard by the Court in March 2020. In March 2020, the Court granted Health Net California's motion for summary judgment. In September 2020, the plaintiff appealed the Court's decision. The Company intends to continue its vigorous defense 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 the Company's financial position, results of operations and cash flows.

19. Earnings Per Share

The following table sets forth the calculation of basic and diluted net earnings per common share for the years ended December 31 ($ in millions, except per share data in dollars and shares in thousands):

	2020	2019	2018
Earnings attributable to Centene Corporation	$ 1,808	$ 1,321	$ 900
Shares used in computing per share amounts:			
Weighted average number of common shares outstanding	570,722	413,487	390,248
Common stock equivalents (as determined by applying the treasury stock method)	8,413	6,922	8,258
Weighted average number of common shares and potential dilutive common shares outstanding	579,135	420,409	398,506
Net earnings per common share attributable to Centene Corporation:			
Basic earnings per common share	$ 3.17	$ 3.19	$ 2.31
Diluted earnings per common share	$ 3.12	$ 3.14	$ 2.26

The calculation of diluted earnings per common share for 2020, 2019 and 2018 excludes the impact of 398 thousand shares, 1,048 thousand shares and 58 thousand shares, respectively, related to anti-dilutive stock options, restricted stock and restricted stock units.

20. 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. Subsequent to the closing of the WellCare Acquisition, the Managed Care segment also includes WellCare's legacy Medicaid Health Plans, Medicare Health Plans and Medicare Prescription Drug Plan (PDP) segments. The Specialty Services segment consists of Centene's specialty companies offering auxiliary healthcare services and products. Factors used in determining the reportable business segments include the nature of operating activities, the existence of separate senior management teams, and the type of information presented to the Company's chief operating decision-maker to evaluate all results of operations. The Company does not report total assets by segment since this is not a metric used to allocate resources or evaluate segment performance.

Segment information for the year ended December 31, 2020, follows ($ in millions):

	Managed Care	Specialty Services	Eliminations	Consolidated Total
Total revenues from external customers	$ 106,862	$ 4,253	$ —	$ 111,115
Total revenues from internal customers	434	11,902	(12,336)	—
Total revenues	$ 107,296	$ 16,155	$ (12,336)	$ 111,115
Earnings from operations	$ 3,031	$ 51	$ —	$ 3,082

Segment information for the year ended December 31, 2019, follows ($ in millions):

	Managed Care	Specialty Services	Eliminations	Consolidated Total
Total revenues from external customers	$ 71,209	$ 3,430	$ —	$ 74,639
Total revenues from internal customers	170	10,351	(10,521)	—
Total revenues	$ 71,379	$ 13,781	$ (10,521)	$ 74,639
Earnings from operations	$ 1,806	$ (25)	$ —	$ 1,781

Segment information for the year ended December 31, 2018, follows ($ in millions):

	Managed Care	Specialty Services	Eliminations	Consolidated Total
Total revenues from external customers	$ 56,999	$ 3,117	$ —	$ 60,116
Total revenues from internal customers	100	9,389	(9,489)	—
Total revenues	$ 57,099	$ 12,506	$ (9,489)	$ 60,116
Earnings from operations	$ 1,310	$ 148	$ —	$ 1,458

21. Condensed Financial Information of Registrant

Centene Corporation (Parent Company Only)
Condensed Balance Sheets
(In millions, except shares in thousands and per share data in dollars)

	December 31,	
	2020	**2019**
ASSETS		
Current assets:		
Cash and cash equivalents	$ 668	$ 6,257
Short-term investments	1	3
Other current assets	24	50
Total current assets	693	6,310
Long-term investments	129	130
Investment in subsidiaries	41,565	19,561
Other long-term assets	101	337
Total assets	$ 42,488	$ 26,338
LIABILITIES, REDEEMABLE NONCONTROLLING INTERESTS AND STOCKHOLDERS' EQUITY		
Current liabilities	$ 133	$ 198
Long-term debt	16,393	13,411
Other long-term liabilities	—	37
Total liabilities	16,526	13,646
Redeemable noncontrolling interest	77	33
Stockholders' equity:		
Preferred stock, $0.001 par value; authorized 10,000 shares; no shares issued or outstanding at December 31, 2020 and December 31, 2019	—	—
Common stock, $0.001 par value; authorized 800,000 shares; 598,249 issued and 581,479 outstanding at December 31, 2020, and 421,508 issued and 415,048 outstanding at December 31, 2019	1	—
Additional paid-in capital	19,459	7,647
Accumulated other comprehensive earnings	337	134
Retained earnings	6,792	4,984
Treasury stock, at cost (16,770 and 6,460 shares, respectively)	(816)	(214)
Total Centene stockholders' equity	25,773	12,551
Noncontrolling interest	112	108
Total stockholders' equity	25,885	12,659
Total liabilities, redeemable noncontrolling interests and stockholders' equity	$ 42,488	$ 26,338

See notes to condensed financial information of registrant.

Centene Corporation (Parent Company Only)
Condensed Statements of Operations
(In millions, except per share data in dollars)

	Year Ended December 31,		
	2020	**2019**	**2018**
Expenses:			
Selling, general and administrative expenses	$ 13	$ 11	$ 28
Contingent consideration	(1)	(24)	(4)
Other income (expense):			
Investment and other income	5	11	3
Gain on divestiture	104	—	—
Debt extinguishment costs	(61)	(30)	—
Interest expense	(723)	(394)	(334)
Loss before income taxes	(687)	(400)	(355)
Income tax benefit	(331)	(172)	(64)
Net (loss) before equity in subsidiaries	(356)	(228)	(291)
Equity in earnings from subsidiaries	2,150	1,537	1,185
Net earnings	1,794	1,309	894
Loss attributable to noncontrolling interests	14	12	6
Net earnings attributable to Centene	$ 1,808	$ 1,321	$ 900
Net earnings per share:			
Basic earnings per common share	$ 3.17	$ 3.19	$ 2.31
Diluted earnings per common share	$ 3.12	$ 3.14	$ 2.26

See notes to condensed financial information of registrant.

Centene Corporation (Parent Company Only)
Condensed Statements of Cash Flows
(In millions)

	Year Ended December 31,		
	2020	2019	2018
Cash flows from operating activities:			
Dividends from subsidiaries, return on investment	$ 739	$ 429	$ 464
Other operating activities, net	(287)	(231)	(317)
Net cash provided by operating activities	452	198	147
Cash flows from investing activities:			
Capital contributions to subsidiaries	(761)	(731)	(681)
Purchases of investments	(111)	(124)	(23)
Sales and maturities of investments	11	—	7
Dividends from subsidiaries, return of investment	87	291	11
Investments in acquisitions	(7,188)	(302)	(4,226)
Proceeds from divestitures	533	—	—
Intercompany activities	1,185	140	215
Other investing activities, net	(12)	—	—
Net cash used in investing activities	(6,256)	(726)	(4,697)
Cash flows from financing activities:			
Proceeds from the issuance of common stock	—	—	2,778
Proceeds from long-term debt	4,870	24,647	6,014
Payments of long-term debt	(3,875)	(17,778)	(4,080)
Common stock repurchases	(626)	(75)	(71)
Payments for debt extinguishment	(81)	(23)	—
Debt issuance costs	(120)	(25)	(25)
Other financing activities, net	47	33	(66)
Net cash provided by financing activities	215	6,779	4,550
Net increase (decrease) in cash and cash equivalents	(5,589)	6,251	—
Cash and cash equivalents, beginning of period	6,257	6	6
Cash and cash equivalents, end of period	$ 668	$ 6,257	$ 6

See notes to condensed financial information of registrant.

Notes to Condensed Financial Information of Registrant

Note A - Basis of Presentation and Significant Accounting Policies

The parent company only financial statements should be read in conjunction with Centene Corporation's audited consolidated financial statements and the notes to consolidated financial statements included in this Form 10-K.

The parent company's investment in subsidiaries is stated at cost plus equity in undistributed earnings of the subsidiaries. The parent company's share of net income of its unconsolidated subsidiaries is included in income using the equity method of accounting. Certain unrestricted subsidiaries receive monthly management fees from the Company's restricted subsidiaries. The management and service fees received by its unrestricted subsidiaries are associated with all of the functions required to manage the restricted subsidiaries including but not limited to salaries and wages for all personnel, rent, utilities, population health management, provider contracting, compliance, member services, claims processing, information technology, cash management, finance and accounting, and other services. The management fees are based either on a percentage of the restricted subsidiaries' revenue or a cost basis reimbursement.

Due to the Company's centralized cash management function, cash flows generated by its unrestricted subsidiaries are utilized by the parent company to the extent required, primarily to repay borrowings on the parent company's credit facilities, make acquisitions, fund capital contributions to subsidiaries and fund its operations.

Certain amounts presented in the parent company only financial statements are eliminated in the consolidated financial statements of Centene Corporation.

Item 9. ***Changes in and Disagreements With Accountants on Accounting and Financial Disclosure***

None.

Item 9A. ***Controls and Procedures***

Evaluation of Disclosure Controls and Procedures - Our management, with the participation of our Chief Executive Officer and Chief Financial Officer, evaluated the effectiveness of our disclosure controls and procedures as of December 31, 2020. The term "disclosure controls and procedures," as defined in Rules 13a-15(e) and 15d-15(e) under the Exchange Act, means controls and other procedures of a company that are designed to ensure that information required to be disclosed by a company in the reports that it files or submits under the Exchange Act is recorded, processed, summarized and reported, within the time periods specified in the SEC's rules and forms. Disclosure controls and procedures include, without limitation, controls and procedures designed to ensure that information required to be disclosed by a company in the reports that it files or submits under the Exchange Act is accumulated and communicated to the company's management, including its principal executive and principal financial officers, as appropriate to allow timely decisions regarding required disclosure. Management recognizes that any controls and procedures, no matter how well designed and operated, can provide only reasonable assurance of achieving their objectives and management necessarily applies its judgment in evaluating the cost-benefit relationship of possible controls and procedures. Based on the evaluation of our disclosure controls and procedures as of December 31, 2020, our Chief Executive Officer and Chief Financial Officer concluded that, as of such date, our disclosure controls and procedures were effective at the reasonable assurance level.

Management's Report on Internal Control Over Financial Reporting- Our management is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Exchange Act Rules 13a-15(f) and 15d-15(f). Under the supervision and with the participation of our management, including our principal executive officer and principal financial officer, we conducted an evaluation of the effectiveness of our internal control over financial reporting based on the framework in *Internal Control - Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission. Based on our evaluation under the framework in *Internal Control - Integrated Framework (2013)*, our management concluded that our internal control over financial reporting was effective at the reasonable assurance level as of December 31, 2020. Our management's assessment of the effectiveness of our internal control over financial reporting as of December 31, 2020, has been audited by KPMG LLP, an independent registered public accounting firm, as stated in their report which is included herein.

Changes in Internal Control Over Financial Reporting- On January 23, 2020, we acquired WellCare. Management has finalized our evaluation of the internal controls and has integrated WellCare's internal controls over financial reporting with our existing internal controls over financial reporting. This integration has led to changes in the internal controls over financial reporting for us and the acquired WellCare business.

We have not experienced any material impact to our internal controls over financial reporting even though our global workforce continues to primarily work-from-home due to COVID-19. We are continually monitoring and assessing the COVID-19 situation and its impact on our internal controls.

Report of Independent Registered Public Accounting Firm

To the Stockholders and Board of Directors
Centene Corporation:

Opinion on Internal Control Over Financial Reporting

We have audited Centene Corporation and subsidiaries' (the Company) internal control over financial reporting as of December 31, 2020, based on criteria established in *Internal Control - Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission. In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2020, based on criteria established in *Internal Control - Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated balance sheets of the Company as of December 31, 2020 and 2019, the related consolidated statements of operations, comprehensive earnings, stockholders' equity, and cash flows for each of the years in the three-year period ended December 31, 2020, and the related notes (collectively, the consolidated financial statements), and our report dated February 22, 2021 expressed an unqualified opinion on those consolidated financial statements.

Basis for Opinion

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Management's Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audit also included performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control Over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ KPMG LLP

St. Louis, Missouri
February 22, 2021

Item 9B. ***Other Information***

None.

PART III

Item 10. ***Directors, Executive Officers and Corporate Governance***

(a) Directors of the Registrant

Information concerning our directors will appear in our Proxy Statement for our 2021 annual meeting of stockholders under "Proposal One: Election of Directors." This portion of the Proxy Statement is incorporated herein by reference.

(b) Information about our Executive Officers

Pursuant to General Instruction G(3) to Form 10-K and the Instruction to Item 401of Regulation S-K, information regarding our executive officers is provided in Item 1 of Part I of this Annual Report on Form 10-K under the caption "Information about our Executive Officers."

Information concerning our executive officers' compliance with Section 16(a) of the Exchange Act will appear in our Proxy Statement for our 2021 annual meeting of stockholders under "Delinquent Section 16(a) Reports, if applicable."

(c) Corporate Governance

Information concerning certain corporate governance matters will appear in our Proxy Statement for our 2021 annual meeting of stockholders under "Corporate Governance and Risk Management." These portions of our Proxy Statement are incorporated herein by reference.

Information concerning our audit committee financial expert and identification of our audit committee will appear in our Proxy Statement for our 2021 annual meeting of stockholders under "Board of Directors Committees." Information concerning our code of ethics will appear in our Proxy Statement for our 2021 annual meeting of stockholders under "Corporate Governance and Risk Management." These portions of our Proxy Statement are incorporated herein by reference.

Item 11. ***Executive Compensation***

Information concerning executive compensation will appear in our Proxy Statement for our 2021 Annual Meeting of Stockholders under "Information About Executive Compensation." Information concerning Compensation Committee interlocks and insider participation will appear in the Proxy Statement for our 2021 Annual Meeting of Stockholders under "Compensation Committee Interlocks and Insider Participation." These portions of the Proxy Statement are incorporated herein by reference.

Item 12. ***Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters***

Information concerning the security ownership of certain beneficial owners and management and our equity compensation plans will appear in our Proxy Statement for our 2021 annual meeting of stockholders under "Information About Stock Ownership" and "Equity Compensation Plan Information." These portions of the Proxy Statement are incorporated herein by reference.

Item 13. ***Certain Relationships and Related Transactions, and Director Independence***

Information concerning director independence, certain relationships and related transactions will appear in our Proxy Statement for our 2021 annual meeting of stockholders under "Corporate Governance and Risk Management," "Director Independence" and "Related Party Transactions." These portions of our Proxy Statement are incorporated herein by reference.

Item 14. ***Principal Accountant Fees and Services***

Information concerning principal accountant fees and services will appear in our Proxy Statement for our 2021 annual meeting of stockholders under "Proposal Three: Ratification of Appointment of Independent Registered Public Accounting Firm." This portion of our Proxy Statement is incorporated herein by reference.

PART IV

Item 15. *Exhibits and Financial Statement Schedules*

(a) **Financial Statements and Schedules**

The following documents are filed under Item 8 of this report:

1. Financial Statements:

   Report of Independent Registered Public Accounting Firm
   Consolidated Balance Sheets as of December 31, 2020 and 2019
   Consolidated Statements of Operations for the years ended December 31, 2020, 2019 and 2018
   Consolidated Statements of Comprehensive Earnings for the years ended December 31, 2020, 2019 and 2018
   Consolidated Statements of Stockholders' Equity for the years ended December 31, 2020, 2019 and 2018
   Consolidated Statements of Cash Flows for the years ended December 31, 2020, 2019 and 2018
   Notes to Consolidated Financial Statements

2. Financial Statement Schedules:

   None.

3. The exhibits listed in the accompanying Exhibit Index are filed or incorporated by reference as part of this filing.

EXHIBIT INDEX

EXHIBIT NUMBER		DESCRIPTION	FILED WITH THIS FORM 10-K	INCORPORATED BY REFERENCE[1] FORM	FILING DATE WITH SEC	EXHIBIT NUMBER
2.1		Agreement and Plan of Merger, dated as of March 26, 2019, by and among Centene Corporation, Wellington Merger Sub I, Inc., Wellington Merger Sub II, Inc., and WellCare Health Plans, Inc.		8-K	March 27, 2019	2.1
2.2	+	Agreement and Plan of Merger, dated as of January 4, 2021, by and among Centene Corporation, Mayflower Merger Sub, Inc. and Magellan Health, Inc.		8-K	January 4, 2021	2.1
3.1		Certificate of Incorporation of Centene Corporation		S-1	October 9, 2001	3.2
3.1a		Certificate of Amendment to Certificate of Incorporation of Centene Corporation, dated November 8, 2001		S-1/A	November 13, 2001	3.2a
3.1b		Certificate of Amendment to Certificate of Incorporation of Centene Corporation as filed with the Secretary of State of the State of Delaware		10-Q	July 26, 2004	3.1b
3.1c		Certificate of Amendment to Certificate of Incorporation of Centene Corporation as filed with the Secretary of State of the State of Delaware		S-3ASR	May 16, 2014	3.1c
3.1d		Certificate of Amendment to Certificate of Incorporation of Centene Corporation as filed with the Secretary of State of the State of Delaware		8-K	October 26, 2015	3.1
3.1e		Certificate of Amendment to Certificate of Incorporation of Centene Corporation as filed with the Secretary of State of the State of Delaware		8-K	February 7, 2019	3.1
3.2		By-laws of Centene Corporation, as amended and restated effective as of October 22, 2019		8-K	October 22, 2019	3.1
4.1		Description of Securities of the Company		10-K	February 18, 2020	4.1
4.2		Indenture, dated November 9, 2016, among Centene Escrow Corporation and The Bank of New York Mellon Trust Company, N.A., relating to the Company's 4.75% Senior Notes due 2025 (including Form of Global Note as Exhibit A thereto)		8-K	November 9, 2016	4.1
4.3		Indenture, dated as of May 23, 2018, by and between Centene Escrow I Corporation, as issuer, and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to the Company's 5.375% Senior Notes due 2026 (including Form of Global Note attached thereto)		8-K	May 23, 2018	4.1
4.4		First Supplemental Indenture, dated as of July 1, 2018, by and between Centene Corporation and The Bank of New York Mellon Trust Company, N.A., as Trustee		8-K	July 2, 2018	4.2
4.5		Indenture, dated as of December 6, 2019, by and between Centene Corporation, as issuer, and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to the Company's 4.75% Senior Notes due 2025 (including the Form of Global Note attached thereto)		8-K	December 6, 2019	4.1
4.6		Indenture, dated as of December 6, 2019, by and between Centene Corporation, as issuer, and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to the Company's 4.25% Senior Notes due 2027 (including the Form of Global Note attached thereto)		8-K	December 6, 2019	4.2

4.7	Indenture, dated as of December 6, 2019, by and between Centene Corporation, as issuer, and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to the Company's 4.625% Senior Notes due 2029 (including the Form of Global Note attached thereto)		8-K	December 6, 2019	4.3
4.8	Indenture, dated as of January 23, 2020, by and between Centene Corporation, as issuer, and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to the Company's 5.375% Senior Notes due 2026 (including the Form of Global Note attached thereto)		8-K	January 23, 2020	4.2
4.9	Indenture, dated as of February 13, 2020, by and between Centene Corporation, as issuer, and The Bank of New York Mellon Trust Company, N.A., as trustee, relating to the Company's 3.375% Senior Notes due 2030 (including the Form of Global Note attached thereto)		8-K	February 13, 2020	4.1
4.10	Base Indenture, dated as of October 7, 2020, between the Company and The Bank of New York Mellon Trust Company, N.A., as trustee		8-K	October 7, 2020	4.1
4.11	First Supplemental Indenture, dated as of October 7, 2020, between the Company and The Bank of New York Mellon Trust Company, N.A., as trustee		8-K	October 7, 2020	4.2
4.12	Second Supplemental Indenture, dated as of February 17, 2021, between the Company and The Bank of New York Mellon Trust Company, N.A., as trustee		8-K	February 17, 2021	4.2
10.1 *	2002 Employee Stock Purchase Plan, As Amended and Restated		10-Q	July 23, 2019	10.1
10.2 *	Amendment No.1 to the 2002 Employee Stock Purchase Plan, As Amended and Restated		S-8	May 22, 2020	4.2
10.3 *	2012 Stock Incentive plan, as Amended		8-K	April 27, 2017	10.1
10.4 *	Amended and Restated Non-Employee Directors Deferred Stock Compensation Plan		10-Q	July 28, 2015	10.1
10.5 *	Amended and Restated Voluntary Nonqualified Deferred Compensation Plan		10-K	February 19, 2019	10.6
10.6 *	Centene Corporation 2007 Long-Term Incentive Plan, as Amended	X			
10.7 *	Centene Corporation Short-Term Executive Compensation Plan		10-K	February 22, 2011	10.12
10.8 *	Executive Employment Agreement between Centene Corporation and Michael F. Neidorff, dated November 8, 2004		8-K	November 9, 2004	10.1
10.8a *	Amendment No. 1 to Executive Employment Agreement between Centene Corporation and Michael F. Neidorff		10-Q	October 28, 2008	10.2
10.8b *	Amendment No. 2 to Executive Employment Agreement between Centene Corporation and Michael F. Neidorff		10-Q	April 28, 2009	10.2
10.8c *	Amendment No. 3 to Executive Employment Agreement between Centene Corporation and Michael F. Neidorff		10-Q	October 23, 2012	10.2
10.8d *	Amendment No. 4 to Executive Employment Agreement between Centene Corporation and Michael F. Neidorff		8-K	May 16, 2013	10.1
10.8e *	Amendment No. 5 to Executive Employment Agreement between Centene Corporation and Michael F. Neidorff		8-K	December 14, 2016	10.1
10.8f *	Amendment No. 6 to Executive Employment Agreement between Centene Corporation and Michael F. Neidorff		8-K	February 4, 2019	10.1

10.9 *	Form of Executive Severance and Change in Control Agreement		10-Q	October 28, 2008	10.3
10.9a *	Amendment No. 1 to Form of Executive Severance and Change in Control Agreement		10-Q	October 23, 2012	10.3
10.9b *	Amendment No. 2 to Form of Executive Severance and Change in Control Agreement		10-Q	April 28, 2015	10.1
10.10 *	Form of Non-statutory Stock Option Agreement (Employees)		10-Q	October 28, 2008	10.5
10.11 *	Form of Non-statutory Stock Option Agreement (Employees) #2	X			
10.12 *	Form of Non-statutory Stock Option Agreement (Directors)		10-K	February 23, 2009	10.18
10.13 *	Form of Incentive Stock Option Agreement		10-Q	October 28, 2008	10.6
10.14 *	Form of Restricted Stock Unit Agreement #1		10-K	February 21, 2017	10.20
10.15 *	Form of Restricted Stock Unit Agreement #2 (under the 2012 Stock Incentive Plan, As Amended)		8-K	December 21, 2020	10.1
10.16 *	Form of Performance Based Restricted Stock Unit Agreement #1		10-K	February 21, 2017	10.23
10.17 *	Form of Performance Based Restricted Stock Unit Agreement #2 (under the 2012 Stock Incentive Plan, As Amended)		8-K	December 21, 2020	10.2
10.18 *	Form of Long-Term Incentive Plan Agreement #1		10-K	February 21, 2017	10.25
10.19 *	Form of Long-Term Incentive Plan Agreement #2 (under the 2007 Long-Term Incentive Plan, As Amended)		8-K	December 21, 2020	10.3
10.20 *	2019 Incentive Compensation Plan of WellCare Health Plans, Inc.		DEF14A[2]	April 8, 2019	A
10.21 *	Amendment No. 1 to the 2019 Incentive Compensation Plan of WellCare Health Plans, Inc., dated as of January 23, 2020		S-8	January 23, 2020	4.4
10.22 *	Incentive Compensation Plan of WellCare Health Plans, Inc.		DEF14A[2]	April 10, 2013	A
10.23 *	WellCare Health Plans, Inc. Executive Severance Plan, as amended and restated		10-K[2]	February 12, 2019	10.3(c)
10.24 *	Executive Employment Agreement between Centene Corporation and Kenneth Burdick, dated May 30, 2019	X			
10.25 *	Transition Services Agreement between Centene Corporation and Kenneth Burdick, dated February 21, 2020	X			
10.26 *	Consulting Services Agreement between Centene Corporation and Kenneth Burdick, dated January 23, 2021	X			
10.27	Credit Agreement originally dated as of March 24, 2016, as amended and restated as of December 14, 2017, as further amended and restated as of May 7, 2019, and as further amended and restated as of September 11, 2019 among Centene Corporation, as the Company, the various financial institutions party hereto, as lenders, and Wells Fargo Bank, National Association, as administrative agent		10-Q	October 22, 2019	10.1

10.27a	Amendment No. 1, dated as of November 14, 2019, to the Credit Agreement dated as of March 24, 2016, as amended and restated as of December 14, 2017, as further amended and restated as of May 7, 2019, and as further amended and restated as of September 11, 2019, among Centene Corporation, a Delaware corporation, the lenders party thereto and Wells Fargo Bank, National Association, as administrative agent		10-K	February 18, 2020	10.25c
21	List of subsidiaries	X			
23	Consent of Independent Registered Public Accounting Firm incorporated by reference in each prospectus constituting part of the Registration Statements on Form S-8 (File Numbers 333-238597, 333-236036, 333-217634, 333-210376, 333-197737, 333-180976, 333-108467 and 333-90976) and on Form S-3 (File Numbers 333-238050 and 333-209252)	X			
31.1	Certification Pursuant to Rule 13a-14(a) and 15d-14(a) of the Exchange Act, as Adopted Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002 (Chief Executive Officer)	X			
31.2	Certification Pursuant to Rule 13a-14(a) and 15d-14(a) of the Exchange Act, as Adopted Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002 (Chief Financial Officer)	X			
32.1	Certification Pursuant to 18 U.S.C. Section 1350 (Chief Executive Officer)	X			
32.2	Certification Pursuant to 18 U.S.C. Section 1350 (Chief Financial Officer)	X			
101	The following materials from the Centene Corporation Annual Report on Form 10-K for the fiscal year ended December 31, 2020, formatted in iXBRL (Inline Extensible Business Reporting Language): (i) the Consolidated Balance Sheets, (ii) the Consolidated Statements of Operations, (iii) the Consolidated Statements of Comprehensive Earnings, (iv) the Consolidated Statements of Stockholders' Equity, (v) the Consolidated Statements of Cash Flows and (vi) related notes.	X			
104	Cover Page Interactive Data File (embedded within the Inline XBRL document)	X			

1 SEC File No. 001-31826 (for filings prior to October 14, 2003, the Registrant's SEC File No. was 000-33395).
2 SEC File No. 001-32209
+ Schedules (as similar attachments) have been omitted from this filing pursuant to Item 601(a)(5) of Regulation S-K.
* Indicates a management contract or compensatory plan or arrangement.

Item 16. ***Form 10-K Summary***

None.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) 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 February 22, 2021.

CENTENE CORPORATION

By: /s/ Michael F. Neidorff

Michael F. Neidorff
Chairman, President and Chief Executive Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities as indicated, as of February 22, 2021.

Signature	Title
/s/ Michael F. Neidorff **Michael F. Neidorff**	Chairman, President and Chief Executive Officer (principal executive officer)
/s/ Jeffrey A. Schwaneke **Jeffrey A. Schwaneke**	Executive Vice President, Chief Financial Officer (principal financial officer)
/s/ Christopher R. Isaak **Christopher R. Isaak**	Senior Vice President, Corporate Controller and Chief Accounting Officer (principal accounting officer)
/s/ Orlando Ayala **Orlando Ayala**	Director
/s/ Jessica L. Blume **Jessica L. Blume**	Director
/s/ H. James Dallas **H. James Dallas**	Director
/s/ Robert K. Ditmore **Robert K. Ditmore**	Director
/s/ Fred H. Eppinger **Fred H. Eppinger**	Director
/s/ Richard A. Gephardt **Richard A. Gephardt**	Director
/s/ John R. Roberts **John R. Roberts**	Director
/s/ Lori J. Robinson **Lori J. Robinson**	Director
/s/ David L. Steward **David L. Steward**	Director
/s/ Tommy G. Thompson **Tommy G. Thompson**	Director
/s/ William L. Trubeck **William L. Trubeck**	Director

Exhibit 10.6

Centene Corporation
2007 Long-Term Incentive Plan
Effective **April 24, 2007**

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Centene Corporation
2007 Long-Term Incentive Plan
Article 1. Establishment, Purpose, and Duration

1.1 Establishment. Centene Corporation, a Delaware corporation (hereinafter referred to as the "Company"), establishes an incentive compensation plan to be known as the Centene Corporation 2007 Long-Term Incentive Plan (hereinafter referred to as the "Plan"), as set forth in this document.
This Plan permits the grant of Cash-Based Awards.

This Plan shall become effective upon shareholder approval (the "Effective Date") and shall remain in effect as provided in Section 1.3 hereof.

1.2 Purpose of this Plan. The purpose of this Plan is to provide a means whereby Employees of the Company develop a sense of proprietorship and personal involvement in the development and financial success of the Company, and to encourage them to devote their best efforts to the business of the Company, thereby advancing the interests of the Company and its shareholders. A further purpose of this Plan is to provide a means through which the Company may attract able individuals to become Employees of the Company and to retain key Employees of the Company.

1.3 Duration of this Plan. Unless sooner terminated as provided herein, this Plan shall terminate ten (10) years from the Effective Date. After this Plan is terminated, no Awards may be granted but Awards previously granted shall remain outstanding in accordance with their applicable terms and conditions and this Plan's terms and conditions.

Article 2. Definitions

Whenever used in this Plan, the following terms shall have the meanings set forth below, and when the meaning is intended, the initial letter of the word shall be capitalized.

2.1 "Affiliate" shall mean any corporation or other entity (including, but not limited to, a partnership or a limited liability company), that is affiliated with the Company through stock or equity ownership or otherwise, and is designated as an Affiliate for purposes of this Plan by the Committee.

2.2 "Award" means, individually or collectively, a grant under this Plan of Cash-Based Awards or Covered Employee Annual Incentive Awards, subject to the terms of this Plan.

2.3 "Award Agreement" means either (i) a written agreement entered into by the Company and a Participant setting forth the terms and provisions applicable to an Award granted under this Plan, or (ii) a written or electronic statement issued by the Company to a Participant describing the terms and provisions of such Award, including any amendment or modification thereof. The Committee may provide for the use of electronic, internet or other non-paper Award Agreements, and the use of electronic, internet or other non-paper means for the acceptance thereof and actions thereunder by a Participant.

2.4 "Beneficial Owner" or "Beneficial Ownership" shall have the meaning ascribed to such term in Rule 13d-3 of the General Rules and Regulations under the Exchange Act.

2.5 "Board" or "Board of Directors" means the Board of Directors of the Company.

2.6 "Cash-Based Award" means an Award, denominated in cash, granted to a Participant as described in Article 6.

2.7 “Cause” means, unless otherwise specified in an Award Agreement or in an applicable employment agreement between the Company and a Participant, with respect to any Participant, as determined by the Committee in its sole discretion:

(a) Willful failure to substantially perform his or her duties as an Employee (for reasons other than physical or mental illness) or Director after reasonable notice to the Participant of that failure;

(b) Misconduct that materially injures the Company or any Subsidiary or Affiliate;

(c) Conviction of, or entering into a plea of nolo contendere to, a felony; or

(d) Breach of any written covenant or agreement with the Company or any Subsidiary or Affiliate.

2.8 “Change of Control” means any of the following events:

(a) The acquisition by any one person, or more than one person acting as a group (as defined in paragraph (g)(5)(v)(B) of 26 CFR §1.409A-3), acquires ownership of stock of the Company that, together with stock held by such person or group, constitutes more than fifty (50) percent of the total fair market value or total voting power of the stock of the Company. However, if any one person, or more than one person acting as a group, is considered to own more than fifty (50) percent of the total fair market value or total voting power of the stock of the Company, the acquisition of additional stock by the same person or persons is not considered to cause a Change of Control. An increase in the percentage of stock owned by any one person, or persons acting as a group, as a result of a transaction in which the Company acquires its stock in exchange for property will be treated as an acquisition of stock for purposes of this section (a);

(b) A majority of members of the Board is replaced during any 12-month period by directors whose appointment or election is not endorsed by a majority of the members of the Company's Board prior to the date of the appointment or election; or

(c) The acquisition by any one person, or more than one person acting as a group (as defined in paragraph (g)(5)(v)(B) of 26 CFR §1.409A-3), acquires (or has acquired during the 12- month period ending on the date of the most recent acquisition by such person or persons) assets from the Company that have a total gross fair market value equal to or more than forty (40) percent of the total gross fair market value of all of the assets of the Company immediately prior to such acquisition or acquisitions. For purposes of this paragraph (c), gross fair market value means the value of the assets of the Company, or the value of the assets being disposed of, determined without regard to any liabilities associated with such assets.

2.9 “Code” means the U.S. Internal Revenue Code of 1986, as amended from time to time. For purposes of this Plan, references to sections of the Code shall be deemed to include references to any applicable regulations thereunder and any successor or similar provision.

2.10 “Committee” means the Compensation Committee of the Board or a subcommittee thereof, or any other committee designated by the Board to administer this Plan. The members of the Committee shall be

appointed from time to time by and shall serve at the discretion of the Board. If the Committee does not exist or cannot function for any reason, the Board may take any action under the Plan that would otherwise be the responsibility of the Committee.

2.11 **"Company"** means Centene Corporation, a Delaware corporation, and any successor thereto as provided in Article 14 herein.

2.12 **"Consolidated Operating Earnings"** means the consolidated earnings before income taxes of the Company, computed in accordance with generally accepted accounting principles, but shall exclude the effects of Extraordinary Items.

2.13 "Covered Employee" means any Employee who is or may become a "Covered Employee," as defined in Code Section 162(m), and who is designated, either as an individual Employee or class of Employees, by the Committee within the shorter of (i) ninety (90) days after the beginning of the Performance Period, or (ii) twenty-five percent (25%) of the Performance Period has elapsed, as a "Covered Employee" under this Plan for such applicable Performance Period.

2.14 "Covered Employee Annual Incentive Award" means an Award granted to a Covered Employee as described in Article 9.

2.15 "Effective Date" has the meaning set forth in Section 1.1.

2.16 "Employee" means any individual performing services for the Company, an Affiliate, or a Subsidiary and designated as an employee of the Company, its Affiliates, and/or its Subsidiaries on the payroll records thereof. An Employee shall not include any individual during any period he or she is classified or treated by the Company, Affiliate, and/or Subsidiary as an independent contractor, a consultant, or any employee of an employment, consulting, or temporary agency or any other entity other than the Company, Affiliate, and/or Subsidiary, without regard to whether such individual is subsequently determined to have been, or is subsequently retroactively reclassified as a common-law employee of the Company, Affiliate, and/or Subsidiary during such period.

2.17 "Exchange Act" means the Securities Exchange Act of 1934, as amended from time to time, or any successor act thereto.

2.18 "Extraordinary Items" means (i) extraordinary, unusual, and/or nonrecurring items of gain or loss; (ii) gains or losses on the disposition of a business; (iii) changes in tax or accounting regulations or laws; or (iv) the effect of a merger or acquisition, all of which must be identified in the audited financial statements, including footnotes, or Management Discussion and Analysis section of the Company's annual report.

2.19 "Insider" shall mean an individual who is, on the relevant date, an officer, or Director of the Company, or a more than ten percent (10%) Beneficial Owner of any class of the Company's equity securities that is registered pursuant to Section 12 of the Exchange Act, as determined by the Board in accordance with Section 16 of the Exchange Act.

2.20 "Net Income" means the consolidated net income before taxes for the Plan Year, as reported in the Company's annual report to shareholders or as otherwise reported to shareholders.

2.21 "Operating Cash Flow" means cash flow from operating activities as defined in Statement of Financial Accounting Standard No. 95, "Statement of Cash Flows."

2.22 "Participant" means any eligible individual as set forth in Article 5 to whom an Award is granted.

2.23 "Performance-Based Compensation" means compensation under an Award that is intended to satisfy the requirements of Code Section 162(m) for certain performance-based compensation paid to Covered Employees. Notwithstanding the foregoing, nothing in this Plan shall be construed to mean that an Award which does not satisfy the requirements for performance-based compensation under Code Section 162(m) does not constitute performance-based compensation for other purposes, including Code Section 409A.

2.24 "Performance Measures" means measures as described in Article 8 on which the performance goals are based and which are approved by the Company's shareholders pursuant to this Plan in order to qualify Awards as Performance-Based Compensation.

2.25 "Performance Period" means the period of time during which the performance goals must be met in order to determine the degree of payout and/or vesting with respect to an Award.

2.26 "Plan" means the Centene Corporation 2007 Long-Term Incentive Plan.

2.27 "Plan Year" means the respective calendar year.

2.28 "Subsidiary" means any corporation or other entity, whether domestic or foreign, in which the Company has or obtains, directly or indirectly, a proprietary interest of more than fifty percent (50%) by reason of stock ownership or otherwise.

Article 3. Administration

3.1 General. The Committee shall be responsible for administering this Plan, subject to this Article 3 and the other provisions of this Plan. The Committee may employ attorneys, consultants, accountants, agents, and other individuals, any of whom may be an Employee, and the Committee, the Company, and its officers and Directors shall be entitled to rely upon the advice, opinions, or valuations of any such individuals. All actions taken and all interpretations and determinations made by the Committee shall be final and binding upon the Participants, the Company, and all other interested individuals.

3.2 Authority of the Committee. The Committee shall have full and exclusive discretionary power to interpret the terms and the intent of this Plan and any Award Agreement or other agreement or document ancillary to or in connection with this Plan, to determine eligibility for Awards and to adopt such rules, regulations, forms, instruments, and guidelines for administering this Plan as the Committee may deem necessary or proper. Such authority shall include, but not be limited to, selecting Award recipients, establishing all Award terms and conditions, including the terms and conditions set forth in Award Agreements, granting Awards as an alternative to or as the form of payment for grants or rights earned or due under compensation plans or arrangements of the Company, construing any ambiguous provision of the Plan or any Award Agreement, and, subject to Article 12 adopting modifications and amendments to this Plan or any Award Agreement, including without limitation, any that are necessary to comply with the laws of the countries and other jurisdictions in which the Company, its Affiliates, and/or its Subsidiaries operate.

3.3 Delegation. The Committee may delegate to one or more of its members or to one or more officers of the Company, and/or its Subsidiaries and Affiliates or to one or more agents or advisors such administrative duties or powers as it may deem advisable, and the Committee or any individuals to whom it has delegated duties or powers as aforesaid may employ one or more individuals to render advice with respect to any responsibility the Committee or such individuals may have under this Plan. The Committee may, by resolution, authorize one or more officers of the Company to do one or both of the following on the same basis as can the Committee: (a) designate Employees to be recipients of Awards; determine the size of any such Awards; provided, however, (i) the Committee shall not delegate such responsibilities to any such officer for Awards granted to an Employee who is considered an Insider; (ii) the resolution providing such authorization sets forth the total number of Awards such officer(s) may grant; and (iii) the officer(s) shall report periodically to the Committee regarding the nature and scope of the Awards granted pursuant to the authority delegated.

Article 4. Adjustments in Awards

In the event of any corporate event or transaction (including, but not limited to, a change in the Shares of the Company or the capitalization of the Company) such as a merger, consolidation, reorganization, recapitalization, separation, partial or complete liquidation, stock dividend, stock split, reverse stock split, split up, spin-off, or

other distribution of stock or property of the Company, combination of Shares, exchange of Shares, dividend in-kind, or other like change in capital structure, the Committee shall make appropriate adjustments in the terms of any Awards under this Plan to reflect or relate to such changes or distributions and to modify any other terms of outstanding Awards, including modifications of performance goals and changes in the length of Performance Periods. Notwithstanding anything herein to the contrary, following a Change in Control the Committee may not take any such action as described in this Article 4 if such action would result in a violation of the requirements of Code Section 409A. The determination of the Committee as to the foregoing adjustments, if any, shall be conclusive and binding on Participants under this Plan.

Subject to the provisions of Article 12 and notwithstanding anything else herein to the contrary, the Committee may authorize the issuance or assumption of benefits under this Plan in connection with any merger, consolidation, acquisition of property or stock, or reorganization upon such terms and conditions as it may deem appropriate, subject to compliance with the rules under Code Section 409A, where applicable.

Article 5. Eligibility and Participation

5.1 Eligibility. Individuals eligible to participate in this Plan include all Employees.

5.2 Actual Participation. Subject to the provisions of this Plan, the Committee may, from time to time, select from all eligible individuals, those individuals to whom Awards shall be granted and shall determine, in its sole discretion, the nature of, any and all terms permissible by law, and the amount of each Award.

Article 6. Cash-Based Awards

6.1 Grant of Cash-Based Awards. Subject to the terms and provisions of the Plan, the Committee, at any time and from time to time, may grant Cash-Based Awards to Participants in such amounts and upon such terms as the Committee may determine.

6.2 Value of Cash-Based Awards. Each Cash-Based Award shall specify a payment amount or payment range as determined by the Committee. The Committee may establish performance goals in its discretion. If the Committee exercises its discretion to establish performance goals, the number and/or value of Cash-Based Awards that will be paid out to the Participant will depend on the extent to which the performance goals are met.

6.3 Payment of Cash-Based Awards. Payment, if any, with respect to a Cash-Based Award shall be made in accordance with the terms of the Award, in cash or Shares as the Committee determines.

6.4 Termination of Employment. The Committee shall determine the extent to which the Participant shall have the right to receive Cash-Based Awards following termination of the Participant’s employment with or provision of services to the Company, its Affiliates, and/or its Subsidiaries, as the case may be. Such provisions shall be determined in the sole discretion of the Committee, such provisions may be included in an agreement entered into with each Participant, but need not be uniform among all Awards of Cash-Based Awards issued pursuant to the Plan, and may reflect distinctions based on the reasons for termination.

6.5 Change of Control. The Committee shall determine the extent to which the Participant shall have the right to receive Cash-Based Awards following a Change of Control. Such provisions shall be determined in the sole discretion of the Committee, such provisions may be included in an agreement entered into with each Participant, but need not be uniform among all Awards of Cash-Based Awards issued pursuant to the Plan.

Article 7. Transferability of Awards

Except as otherwise provided in a Participant's Award Agreement or otherwise determined at any time by the Committee, no Award granted under this Plan may be sold, transferred, pledged, assigned, or otherwise alienated or hypothecated, other than by will or by the laws of descent and distribution; provided that the Board or Committee may permit further transferability, on a general or a specific basis, and may impose conditions and limitations on any permitted transferability.

Article 8. Performance Measures

8.1 Performance Measures. The performance goals upon which the payment or vesting of an Award to a Covered Employee (other than a Covered Employee Annual Incentive Award awarded or credited pursuant to Article 9) that is intended to qualify as Performance-Based Compensation shall be limited to the following Performance Measures:

(a) Net earnings or net income (before or after taxes);

(b) Earnings per share;

(c) Net sales or revenue growth;

(d) Net operating profit;

(e) Return measures (including, but not limited to, return on assets, capital, invested capital, equity, sales, or revenue);

(f) Cash flow (including, but not limited to, operating cash flow, free cash flow, cash flow return on equity, and cash flow return on investment);

(g) Earnings before or after taxes, interest, depreciation, and/or amortization;

(h) Gross or operating margins;

(i) Productivity ratios;

(j) Share price (including, but not limited to, growth measures and total shareholder return);

(k) Expense targets;

(l) Margins;

(m) Operating efficiency;

(n) Market share;

(o) Customer satisfaction;

(p) Working capital targets; and

(q) Economic value added or EVA® (net operating profit after tax minus the sum of capital multiplied by the cost of capital).

Any Performance Measure(s) may be used to measure the performance of the Company, Subsidiary, and/or Affiliate as a whole or any business unit of the Company, Subsidiary, and/or Affiliate or any combination

thereof, as the Committee may deem appropriate, or any of the above Performance Measures as compared to the performance of a group of comparator companies, or published or special index that the Committee, in its sole discretion, deems appropriate, or the Company may select Performance Measure (j) above as compared to various stock market indices. The Committee also has the authority to provide for accelerated vesting of any Award based on the achievement of performance goals pursuant to the Performance Measures specified in this Article 8.

8.2 Evaluation of Performance. The Committee may provide in any such Award that any evaluation of performance may include or exclude any of the following events that occurs during a Performance Period: (a) asset write-downs, (b) litigation or claim judgments or settlements, (c) the effect of changes in tax laws, accounting principles, or other laws or provisions affecting reported results, (d) any reorganization and restructuring programs, (e) extraordinary nonrecurring items as described in Accounting Principles Board Opinion No. 30 and/or in management's discussion and analysis of financial condition and results of operations appearing in the Company's annual report to shareholders for the applicable year, (f) acquisitions or divestitures, and (g) foreign exchange gains

and losses. To the extent such inclusions or exclusions affect Awards to Covered Employees, they shall be prescribed in a form that meets the requirements of Code Section 162(m) for deductibility.

8.3 Adjustment of Performance-Based Compensation. Awards that are intended to qualify as Performance-Based Compensation may not be adjusted upward. The Committee shall retain the discretion to adjust such Awards downward, either on a formula or discretionary basis or any combination, as the Committee determines.

8.4 Committee Discretion. In the event that applicable tax and/or securities laws change to permit Committee discretion to alter the governing Performance Measures without obtaining shareholder approval of such changes, the Committee shall have sole discretion to make such changes without obtaining shareholder approval, provided the exercise of such discretion does not violate Code Section 409A. In addition, in the event that the Committee determines that it is advisable to grant Awards that shall not qualify as Performance-Based Compensation, the Committee may make such grants without satisfying the requirements of Code Section 162(m) and base vesting on Performance Measures other than those set forth in Section 8.1.

Article 9. Covered Employee Incentive Award

9.1 Establishment of Incentive Pool. The Committee may designate Covered Employees who are eligible to receive a monetary payment in any Plan Year based on a percentage of an incentive pool equal to the greater of: (i) five percent (5%) of the Company’s Consolidated Net Earnings before income taxes for this Plan Year, (ii) three percent (3%) of the Company’s Operating Cash Flow for this Plan Year, or (iii) eight percent (8%) of the Company’s Net Income for this Plan Year. The Committee shall allocate an incentive pool percentage to each designated Covered Employee for each Plan Year. In no event may (1) the incentive pool percentage for any one Covered Employee exceed fifty percent (50%) of the total pool and (2) the sum of the incentive pool percentages for all Covered Employees cannot exceed one hundred percent (100%) of the total pool.

9.2 Determination of Covered Employees’ Portions. As soon as possible after the determination of the incentive pool for a Plan Year, the Committee shall calculate each Covered Employee’s allocated portion of the incentive pool based upon the percentage established at the beginning of this Plan Year. Each Covered Employee’s incentive Award then shall be determined by the Committee based on the Covered Employee’s allocated portion of the incentive pool subject to adjustment in the sole discretion of the Committee. In no event may the portion of the incentive pool allocated to a Covered Employee be increased in any way, including as a result of the reduction of any other Covered Employee’s allocated portion. The Committee shall retain the discretion to adjust such Awards downward.

9.3 Change of Control. The Committee shall determine the extent to which the Participant shall have the right to receive Covered Employee Annual Incentive Award following a Change of Control. Such provisions shall be determined in the sole discretion of the Committee, such provisions may be included in an agreement entered into with each Participant, but need not be uniform among all Covered Employee Annual Incentive Awards issued pursuant to the Plan.

Article 10. Beneficiary Designation

Each Participant under this Plan may, from time to time, name any beneficiary or beneficiaries (who may be named contingently or successively) to whom any benefit under this Plan is to be paid in case of his death before he receives any or all of such benefit. Each such designation shall revoke all prior designations by the same Participant, shall be in a form prescribed by the Committee, and will be effective only when filed by the Participant in writing with the Company during the Participant’s lifetime. In the absence of any such beneficiary designation, benefits remaining unpaid at the Participant’s death shall be paid to the Participant’s executor, administrator, or legal representative.

Article 11. Rights of Participants

11.1 Employment. Nothing in this Plan or an Award Agreement shall interfere with or limit in any way the right of the Company, its Affiliates, and/or its Subsidiaries, to terminate any Participant's employment at any time or for any reason not prohibited by law, nor confer upon any Participant any right to continue his employment for any specified period of time.

Neither an Award nor any benefits arising under this Plan shall constitute an employment contract with the Company, its Affiliates, and/or its Subsidiaries and, accordingly, subject to Articles 3 and 12 this Plan and the benefits hereunder may be terminated at any time in the sole and exclusive discretion of the Committee without giving rise to any liability on the part of the Company, its Affiliates, and/or its Subsidiaries.

11.2 Participation. No individual shall have the right to be selected to receive an Award under this Plan, or, having been so selected, to be selected to receive a future Award.

Article 12. Amendment, Modification, Suspension, and Termination

12.1 Amendment, Modification, Suspension, and Termination. Subject to Section 12.3, the Committee may, at any time and from time to time, alter, amend, modify, suspend, or terminate this Plan and any Award Agreement in whole or in part; provided, however, that, no amendment of this Plan shall be made without shareholder approval if shareholder approval is required by law, regulation, or stock exchange rule, including, but not limited to, the Securities Exchange Act of 1934, as amended, the Internal Revenue Code of 1986, as amended, and, if applicable, the New York Stock Exchange Listed Company Manual/the Nasdaq issuer rules.

12.2 Adjustment of Awards Upon the Occurrence of Certain Unusual or Nonrecurring Events. The Committee may make adjustments in the terms and conditions of, and the criteria included in, Awards in recognition of unusual or nonrecurring events affecting the Company or the financial statements of the Company or of changes in applicable laws, regulations, or accounting principles, whenever the Committee determines that such adjustments are appropriate in order to prevent unintended dilution or enlargement of the benefits or potential benefits intended to be made available under this Plan. The determination of the Committee as to the foregoing adjustments, if any, shall be conclusive and binding on Participants under this Plan.

12.3 Awards Previously Granted. Notwithstanding any other provision of this Plan to the contrary (other than Section 12.4), no termination, amendment, suspension, or modification of this Plan or an Award Agreement shall adversely affect in any material way any Award previously granted under this Plan, without the written consent of the Participant holding such Award.

12.4 Amendment to Conform to Law. Notwithstanding any other provision of this Plan to the contrary, the Board of Directors may amend the Plan or an Award Agreement, to take effect retroactively or otherwise, as deemed necessary or advisable for the purpose of conforming the Plan or an Award Agreement to any present or future law relating to plans of this or similar nature (including, but not limited to, Code Section 409A), and to the administrative regulations and rulings promulgated thereunder. By accepting an Award under this Plan, a Participant agrees to any amendment made pursuant to this Section 12.4 to any Award granted under the Plan without further consideration or action.

Article 13. Tax Withholding

The Company shall have the power and the right to deduct or withhold, or require a Participant to remit to the Company, the minimum statutory amount to satisfy federal, state, and local taxes, domestic or foreign, required by law or regulation to be withheld with respect to any taxable event arising as a result of this Plan.

Article 14. Successors

All obligations of the Company under this Plan with respect to Awards granted hereunder shall be binding on any successor to the Company, whether the existence of such successor is the result of a direct or indirect purchase, merger, consolidation, or otherwise, of all or substantially all of the business and/or assets of the Company.

Article 15. General Provisions

15.1 Forfeiture Events.

(a) The Committee may specify in an Award Agreement that the Participant's rights, payments, and benefits with respect to an Award shall be subject to reduction, cancellation, forfeiture, or recoupment upon the occurrence of certain specified events, in addition to any otherwise applicable vesting or performance conditions of an Award. Such events may include, but shall not be limited to, termination of employment for cause, termination of the Participant's provision of services to the Company, Affiliate, and/or Subsidiary, violation of material Company, Affiliate, and/or Subsidiary policies, breach of noncompetition, confidentiality, or other restrictive covenants that may apply to the Participant, or other conduct by the Participant that is detrimental to the business or reputation of the Company, its Affiliates, and/or its Subsidiaries.

(b) If the Company is required to prepare an accounting restatement due to the material noncompliance of the Company, as a result of misconduct, with any financial reporting requirement under the securities laws, if the Participant is one of the individuals subject to automatic forfeiture under Section 304 of the Sarbanes-Oxley Act of 2002, the Board may require the Participant to reimburse the Company the amount of any payment in settlement of an Award earned or accrued during the twelve- (12-) month period following the first public issuance or filing with the United States Securities and Exchange Commission (whichever just occurred) of the financial document embodying such financial reporting requirement.

15.2 Gender and Number. Except where otherwise indicated by the context, any masculine term used herein also shall include the feminine, the plural shall include the singular, and the singular shall include the plural.

15.3 Severability. In the event any provision of this Plan shall be held illegal or invalid for any reason, the illegality or invalidity shall not affect the remaining parts of this Plan, and this Plan shall be construed and enforced as if the illegal or invalid provision had not been included.

15.4 Requirements of Law. The granting of Awards under this Plan shall be subject to all applicable laws, rules, and regulations, and to such approvals by any governmental agencies or national securities exchanges as may be required.

15.5 Employees Based Outside of the United States. Notwithstanding any provision of this Plan to the contrary, in order to comply with the laws in other countries in which the Company, its Affiliates, and/or its Subsidiaries operate or have Employees, the Committee, in its sole discretion, shall have the power and authority to:

(a) Determine which Affiliates and Subsidiaries shall be covered by this Plan;

(b) Determine which Employees outside the United States are eligible to participate in this Plan;

(c) Modify the terms and conditions of any Award granted to Employees outside the United States to comply with applicable foreign laws;

(d) Establish subplans and modify exercise procedures and other terms and procedures, to the extent such actions may be necessary or advisable. Any subplans and modifications to Plan terms and procedures established under this Section 15.5 by the Committee shall be attached to this Plan document as appendices; and

(e) Take any action, before or after an Award is made, that it deems advisable to obtain approval or comply with any necessary local government regulatory exemptions or approvals.

Notwithstanding the above, the Committee may not take any actions hereunder, and no Awards shall be granted, that would violate applicable law.

15.6 Unfunded Plan. Participants shall have no right, title, or interest whatsoever in or to any investments that the Company, and/or its Subsidiaries, and/or its Affiliates may make to aid it in meeting its obligations under this Plan. Nothing contained in this Plan, and no action taken pursuant to its provisions, shall create or be construed to create a trust of any kind, or a fiduciary relationship between the Company and any Participant, beneficiary, legal representative, or any other individual. To the extent that any individual acquires a right to receive payments from the Company, its Subsidiaries, and/or its Affiliates under this Plan, such right shall be no greater than the right of an unsecured general creditor of the Company, a Subsidiary, or an Affiliate, as the case may be. All payments to be made hereunder shall be paid from the general funds of the Company, a Subsidiary, or an Affiliate, as the case may be and no special or separate fund shall be established and no segregation of assets shall be made to assure payment of such amounts except as expressly set forth in this Plan.

15.7 Retirement and Welfare Plans. Neither Awards made under this Plan nor cash paid pursuant to such Awards except pursuant to Covered Employee Annual Incentive Awards, may be included as “compensation” for purposes of computing the benefits payable to any Participant under the Company’s or any Subsidiary’s or Affiliate’s retirement plans (both qualified and non-qualified) or welfare benefit plans unless such other plan expressly provides that such compensation shall be taken into account in computing a Participant’s benefit.

15.8 Deferred Compensation. It is intended that any Award made under this Plan that results in the deferral of compensation (as defined under Code Section 409A) complies with the requirements of Code Section 409A.

15.9 Nonexclusivity of this Plan. The adoption of this Plan shall not be construed as creating any limitations on the power of the Board or Committee to adopt such other compensation arrangements as it may deem desirable for any Participant.

15.10 No Constraint on Corporate Action. Nothing in this Plan shall be construed to: (i) limit, impair, or otherwise affect the Company’s or a Subsidiary’s or an Affiliate’s right or power to make adjustments, reclassifications, reorganizations, or changes of its capital or business structure, or to merge or consolidate, or dissolve, liquidate, sell, or transfer all or any part of its business or assets; or, (ii) limit the right or power of the Company or a Subsidiary or an Affiliate to take any action which such entity deems to be necessary or appropriate.

15.11 Governing Law. The Plan and each Award Agreement shall be governed by the laws of the State of Delaware, excluding any conflicts or choice of law rule or principle that might otherwise refer construction or interpretation of this Plan to the substantive law of another jurisdiction. Unless otherwise provided in the Award Agreement, recipients of an Award under this Plan are deemed to submit to the exclusive jurisdiction and venue of the federal or state courts of Delaware, to resolve any and all issues that may arise out of or relate to this Plan or any related Award Agreement.

15.12 Indemnification. Subject to requirements of Delaware law, each individual who is or shall have been a member of the Board, or a Committee appointed by the Board, or an officer of the Company to whom authority was delegated in accordance with Article 3, shall be indemnified and held harmless by the Company against and from any loss, cost, liability, or expense that may be imposed upon or reasonably incurred by him or her in connection with or resulting from any claim, action, suit, or proceeding to which he or she may be a party or in which he or she may be involved by reason of any action taken or failure to act under this Plan and against and from any and all amounts paid by him or her in settlement thereof, with the Company's approval, or paid by him or her in satisfaction of any judgment in any such action, suit, or proceeding against him or her, provided he or she shall give the Company an opportunity, at its own expense, to handle and defend the same before he or she undertakes to handle and defend it on his/her own behalf, unless such loss, cost, liability, or expense is a result of his/her own willful misconduct or except as expressly provided by statute.

The foregoing right of indemnification shall not be exclusive of any other rights of indemnification to which such individuals may be entitled under the Company's Certificate of Incorporation or Bylaws, as a matter of law, or otherwise, or any power that the Company may have to indemnify them or hold them harmless.

AMENDMENT
TO THE
CENTENE CORPORATION
2007 LONG-TERM INCENTIVE PLAN

WHEREAS, Centene Corporation (the "Corporation") sponsors the Centene Corporation 2007 Long-Term Incentive Plan (the "Plan"); and

WHEREAS, in accordance with Section 12.1 of the Plan, the Compensation Committee of the Board (the "Committee") has authority to amend the Plan at any time; and

WHEREAS, the Committee desires to clarify the language governing benefit payment upon the death of a participant.

NOW, THEREFORE, BE IT RESOLVED, effective April 1, 2017, the Plan is amended to read as follows:

1. Section 1.3 is deleted in its entirety.

2. Article 10 is deleted in its entirety and substituted in lieu thereof is the following:

Article 10. Beneficiary Designation

Each Participant under this Plan may, from time to time, name any beneficiary or beneficiaries (who may be named contingently or successively) to whom any benefit under this Plan is to be paid in case of his death before he receives any or all of such benefit. Each such designation shall revoke all prior designations by the same Participant, shall be in a form prescribed by the Committee, and will be effective only when filed by the Participant in writing with the Company during the Participant's lifetime. If a Participant dies without designating a beneficiary, then the benefit under this Plan will be paid consistent with the Participant's beneficiary designation election under the Centene Management Corporation Retirement Plan. In the absence of any such beneficiary designation, benefits remaining unpaid at the Participant's death shall be paid to the Participant's executor, administrator, or legal representative.

IN WITNESS WHEREOF, the undersigned has caused this Amendment to the Plan, to be adopted this 3rd day of February, 2019.

CENTENE CORPORATION

By: /s/ Robert K. Ditmore
Title: Chairman, Compensation Committee

Exhibit 10.11

CENTENE CORPORATION

Nonstatutory Stock Option Agreement Granted Under

2012 Stock Incentive Plan

THIS AGREEMENT is entered into by and between CENTENE CORPORATION, a Delaware corporation (hereinafter the "Company"), and the undersigned employee of the Company (hereinafter the "Participant").

WHEREAS, the Participant renders important services to the Company and acquires access to Confidential Information (as defined below) of the Company in connection with Participant's relationship with the Company; and

WHEREAS, the Company desires to align the long-term interests of its valued employees with those of the Company by providing the ownership interest granted herein and to prevent former employees whose interest may become adverse to the Company from maintaining an ownership interest in the Company;

NOW, THEREFORE, in consideration of the foregoing and the mutual agreements herein contained, the parties hereto hereby agree as follows:

1. Grant of Option

This agreement evidences the grant by the Company on [GRANT DATE] (the "Grant Date") to [PARTICIPANT NAME] (the "Participant"), of an option to purchase, in whole or in part, on the terms provided herein and in the Company's 2012 Stock Incentive Plan (the "Plan"), a total of [NUMBER OF AWARD GRANTED] shares (the "Shares") of common stock, $0.001 par value per share, of the Company ("Common Stock") at [PRICE] per Share Unless earlier terminated, this option shall expire at 3:00 p.m., Central time, on [FINAL EXERCISE DATE] (the "Final Exercise Date"). If the Final Exercise Date is not an open trading date then this option shall expire at 3:00 p.m., Central Standard Time, on the last open trading date prior to the Final Exercise Date.

It is intended that the option evidenced by this agreement shall not be an incentive stock option as defined in Section 422 of the Internal Revenue Code of 1986, as amended, and any regulations promulgated thereunder (the "Code"). Except as otherwise indicated by the context, the term "Participant," as used in this option, shall be deemed to include any person who acquires the right to exercise this option validly under its terms.

2. Vesting Schedule

This option will become exercisable ("vest") as to one-third of the original number of Shares on the first anniversary of the Grant Date and as to an additional one-third of the original number of Shares at the end of each successive annual period following the first anniversary of

the Grant Date until the third anniversary of the Grant Date (each such vesting date, a "Vesting Date").

The right of exercise shall be cumulative so that to the extent the option is not exercised in any period to the maximum extent permissible it shall continue to be exercisable, in whole or in part, with respect to all Shares for which it is vested until the earlier of the Final Exercise Date or the termination of this option under Section 3 hereof or the Plan.

The foregoing vesting schedule notwithstanding, if a Change in Control (as defined below) occurs and the Participant's employment with the Company (and any parent or subsidiary thereof) is terminated by the Company (or a parent or subsidiary thereof) without Cause (as defined below) or by the Participant for Good Reason (as defined below), and the Participant's date of termination occurs (or in the case of the Participant's termination of employment for Good Reason, the event giving rise to Good Reason occurs) within 24 months following the Change in Control, all unvested shares shall automatically become 100% vested and shall be paid on the Participant's date of termination ("CIC Termination Payment"). A "Change in Control" shall be deemed to have occurred if any of the events set forth in any one of the following clauses shall occur: (i) any Person (as defined in section 3(a)(9) of the Securities Exchange Act of 1934, as amended (the "Exchange Act"), and as such term is modified in sections 13(d) and 14(d) of the Exchange Act), excluding a group of persons including the Participant, is or becomes the "beneficial owner" (as defined in Rule 13(d)(3) under the Exchange Act), directly or indirectly, of securities representing forty percent or more of the combined voting power of the Company's then outstanding securities; (ii) individuals who, as of the Grant Date, constitute the Board of Directors of the Company (the "Incumbent Board"), cease for any reason to constitute a majority thereof (provided, however, that an individual becoming a director subsequent to the Grant Date whose election, or nomination for election by the Company's stockholders, was approved by at least a majority of the directors then comprising the Incumbent Board shall be included within the definition of Incumbent Board, but excluding, for this purpose, any such individual whose initial assumption of office occurs as a result of either an actual election contest (or such terms used in Rule 14a-11 of Regulation 14A promulgated under the Exchange Act) or other actual or threatened solicitation of proxies or consents by or on behalf of a person other than the Board of Directors of the Company); or (iii) the stockholders of the Company consummate a merger or consolidation of the Company with any other corporation, other than a merger or consolidation which would result in the voting securities of the Company outstanding immediately prior thereto continuing to represent (either by remaining outstanding or by being converted into voting securities of the surviving entity) at least fifty percent of the combined voting power of the voting securities of the Company or such surviving entity outstanding immediately after such merger or consolidation. "Cause" shall include acts or omissions that the Company determines, after affording the Participant an opportunity to be heard, (i) are criminal, dishonest, fraudulent, constitute misconduct, or reflect negatively on the reputation of the Company (including any parent, subsidiary, affiliate or division of the Company); (ii) could expose the Company or any parent, subsidiary, affiliate or division of the Company to claims of illegal harassment or discrimination in employment; (iii) are material breaches of this Agreement or other agreement with the Company; or (iv) reflect continued and repeated failure to perform substantially the duties of his/her employment. "Good Reason" means: (a) if the Participant is a party to an employment or service agreement with the Company or its affiliates and such agreement provides for a definition of Good Reason, the

definition contained therein; or (b) if no such agreement exists or if such agreement does not define Good Reason, the occurrence of one or more of the following without the Participant's express written consent, which circumstances are not remedied by the Company within thirty (30) days of its receipt of a written notice from the Participant describing the applicable circumstances (which notice must be provided by the Participant within ninety (90) days of the Participant's knowledge of the applicable circumstances): (i) any material, adverse change in the Participant's responsibilities, authority, title, status or reporting structure; (ii) a material reduction in the Participant's base salary or short-term cash incentive opportunity; or (iii) a geographical relocation of the Participant's principal office location by more than fifty (50) miles; provided that, the Participant in fact terminates employment for Good Reason within one hundred fifty (150) days following the initial existence of the circumstances giving rise to such Good Reason.

3. Exercise of Option

(a) Form of Exercise. Each election to exercise this option shall be in writing, signed by the Participant, and received by the Company at its principal office, accompanied by this agreement, and payment in full in the manner provided in the Plan. Common Stock purchased upon the exercise of this option shall be paid for as follows

(1) in cash or by check, payable to the order of the Company;

(2) by (i) delivery of an irrevocable and unconditional undertaking by a creditworthy broker to deliver promptly to the Company sufficient funds to pay the exercise price and any required tax withholding or (ii) delivery by the Participant to the Company of a copy of irrevocable and unconditional instructions to a creditworthy broker to deliver promptly to the Company cash or a check sufficient to pay the exercise price and any required tax withholding;

(3) when the Common Stock is registered under the Securities and Exchange Act of 1934, as amended, by delivery of shares of Common Stock owned by the Participant valued at their fair market value as determined by (or in a manner approved by) the board of directors of the Company (the "Board") in good faith ("Fair Market Value"), *provided* (i) such method of payment is then permitted under applicable law and (ii) such Common Stock, if acquired directly from the Company was owned by the Participant at least six months prior to such delivery;

(4) to the extent permitted under applicable law and permitted by the Board, in its sole discretion, *provided* that at least an amount equal to the par value of the Common Stock being purchased shall be paid in cash; or

(5) by any combination of the above permitted forms of payment.

The Participant may purchase less than the number of shares covered hereby, provided that no partial exercise of this option may be for any fractional share or for fewer than ten whole shares.

(b) Continuous Relationship with the Company Required. Except as otherwise provided in this Section 3, this option may not be exercised unless the Participant, at the time he or she exercises this option, is, and has been at all times since the Grant Date, an employee, officer or director of, or consultant or advisor to, the Company or any other entity the employees, officers,

directors, consultants or advisors of which are eligible to receive option grants under the Plan (an “Eligible Participant”).

(c) Termination of Relationship with the Company. If the Participant ceases to be an Eligible Participant for any reason, then, except as provided in paragraphs (d) and (e) below, the right to exercise this option shall terminate 30 days after such cessation (but in no event after the Final Exercise Date), *provided* that this option shall be exercisable only to the extent that the Participant was entitled to exercise this option on the date of such cessation. Notwithstanding the foregoing, if the Participant, prior to the Final Exercise Date, violates the non-competition or confidentiality provisions of any employment, consulting, advisory, nondisclosure, non-competition or other agreement between the Participant and the Company, the right to exercise this option shall terminate immediately upon such violation.

(d) Exercise Period Upon Death or Disability. If the Participant dies or becomes disabled (within the meaning of Section 22(e)(3) of the Code) prior to the Final Exercise Date while he or she is an Eligible Participant and the Company has not terminated such relationship for “cause” as specified in paragraph (e) below, this option shall be exercisable, within the period of 90 days following the date of death or disability of the Participant, by the Participant (or in the case of death by an authorized transferee), *provided* that this option shall be exercisable only to the extent that this option was exercisable by the Participant on the date of his or her death or disability, and *further provided* that this option shall not be exercisable after the Final Exercise Date.

(e) Discharge for Cause. If the Participant, prior to the Final Exercise Date, is discharged by the Company for “cause” (as defined below), the right to exercise this option shall terminate immediately upon the effective date of such discharge. “Cause” shall include acts or omissions that the Company determines, after affording the Participant an opportunity to be heard, (i) are criminal, dishonest, fraudulent, constitute misconduct, or reflect negatively on the reputation of the Company (including any parent, subsidiary, affiliate or division of the Company); (ii) could expose the Company or any parent, subsidiary, affiliate or division of the Company to claims of illegal harassment or discrimination in employment; (iii) are material breaches of this Agreement or other agreement with the Company; or (iv) reflect continued and repeated failure to perform substantially the duties of his/her employment.

(f) Right to Exercise. The Participant’s right to exercise this option and to retain any gains upon a sale or other disposition of the Shares therefrom is subject to the Participant’s compliance with the covenants set forth in Section 4 hereof.

4. Optionee’s Covenants. For and in consideration of the option hereunder, the Participant agrees to the provisions of this Section 4.

(a) Confidential Information. As used in this Section 4, “Confidential Information” shall mean the Company’s trade secrets and other non-public proprietary information relating to the Company or the business of the Company, including information relating to financial statements, existing or proposed target markets, employee skills and compensation, employee data, acquisition targets, servicing methods, programs, strategies and information, analyses, expansion plans and strategies, profit margins, financial, promotional, training or operational information,

and other information developed or used by the Company that is not known generally to the public or the industry. Confidential Information shall not include any information that is in the public domain or becomes known in the public domain through no wrongful act on the part of the Participant.

(b) Non-Disclosure. The Participant agrees that the Confidential Information is a valuable, special and unique asset of the Company's business, that such Confidential Information is important to the Company and the effective operation of the Company's business, and that during employment with the Company and at all times thereafter, the Participant shall not, directly or indirectly, disclose to any competitor or other person or entity (other than current employees of the Company) any Confidential Information that the Participant obtains while performing services for the Company, except as may be required in the Participant's reasonable judgment to fulfill the Participant's duties hereunder or to comply with any applicable legal obligation.

(c) Non-Competition; Non-Solicitation.

(1) During Participant's employment with the Company and for the period of six (6) months immediately after the termination of Participant's employment with the Company (including any parent, subsidiary, affiliate or division of the Company) for any reason whatsoever, and whether voluntary or involuntary, Participant shall not invest in (other than in a publicly traded company with a maximum investment of no more than 1% of outstanding shares), counsel, advise, consult, be employed or otherwise engaged by or with any entity or enterprise ("Competitor") that competes with (A) the Company's business of providing Medicaid managed care services, Medicaid-related services, behavioral health, nurse triage or pharmacy compliance specialty services or (B) any other business in which, after the date of this Agreement, the Company (or any parent, subsidiary, affiliate or division of the Company) becomes engaged (or has taken substantial steps in which to become engaged) on or prior to the date of termination of Participant's employment. For purposes of paragraph 4, Participant agrees that this agreement not to compete applies to any Competitor that does business within the state of Missouri or and/or any other state or other jurisdiction in the world in which Centene does business, and that such geographical limitation is reasonable.

(2) During the Participant's employment with the Company (or any parent, subsidiary, affiliate or division of the Company) and for the period of twelve months immediately after the termination of the Participant's employment with the Company (or any parent, subsidiary, affiliate or division of the Company) for any cause whatsoever, and whether voluntary or involuntary ("Restricted Period"), the Participant will not, either directly or indirectly, either for himself or for any other person, firm, company or corporation, call upon, solicit, divert, or take away, or attempt to solicit, divert or take away any of the customers, prospective customers, business, vendors or suppliers of the Company that the Participant had dealings with, or responsibility for, or the Participant had access to, confidential information of such customers', vendors' or suppliers' confidential information.

(3) The Participant shall not, at any time during the Restricted Period, without the prior written consent of the Company, (i) directly or indirectly, solicit, recruit or employ (whether as an employee, officer, director, agent, consultant or independent contractor) any person who was or is at any time during the previous six months an employee, representative, officer or director of the Company (or any parent, subsidiary, affiliate or division of the Company); or (ii) take any action to encourage or induce any employee, representative, officer or director of the Company (or any parent, subsidiary, affiliate or division of the Company) to cease their relationship with the Company (or any parent, subsidiary, affiliate or division of the Company) for any reason.

(4) This Section 4(c) shall not apply if a "Change in Control" (as defined in Section 2) occurs under Section 2(ii) thereof, or if such Change in Control occurs under Section 2(i) or 2(iii) thereof without the prior approval, recommendation or consent of the Board of Directors of the Corporation

(d) Enforcement. If any of the provisions of this Section 4 shall be held to be invalid or unenforceable by a court of competent jurisdiction, the remaining provisions or subparts thereof shall nevertheless continue to be valid and enforceable according to their terms. Further, if any restriction contained in the provisions or subparts of this Section 4 is held to be overbroad or unreasonable as written, the parties agree that the applicable provision should be considered to be amended to reflect the maximum period, scope or geographical area deemed reasonable and enforceable by the court and enforced as amended.

(e) Remedy for Breach.

(1) Because the Participant's services are unique and because the Participant has access to the Company's Confidential Information, the parties agree that any breach or threatened breach of this Section 4 will cause irreparable harm to the Company and that money damages alone would be an inadequate remedy. The parties therefore agree that, in the event of any breach or threatened breach of this Section 4, and in addition to all other rights and remedies available to it, the Company may apply to any court of competent jurisdiction for specific performance and/or injunctive or other relief, without a bond, in order to enforce or prevent any violations of the provisions of this Section 4.

(2) The Participant shall immediately repay to the Company a cash sum in the principal amount equal to all gross proceeds (before-tax) realized by the Participant upon the sale or other disposition of shares occurring at any time during the period commencing on the date that is three years before the date of the termination of the Participant's employment with the Company and ending on the date of the breach or threatened breach of this Section 4 (the "Refund Period"), together with interest accrued thereon from the date of such breach or threatened breach, at the prime rate (compounded calendar monthly) as published from time to time in The Wall Street Journal, electronic edition ("Interest"); and

(3) The Participant shall repay to the Company a cash sum equal to the fair market value of all Shares and all or any portion of the option transferred by the Participant as a gift or gifts at any time during the Refund Period, together with Interest, and for which purpose, "fair

market value" per Share shall be the Fair Market Value of one Share on the date such gift occurs and per option Share shall be the positive difference, if any, between the Fair Market Value of a Share and the exercise price of such option.

(4) The Participant acknowledges and agrees that nothing contained herein shall be construed to be an excessive remedy to prohibit the Company from pursuing any other remedies available to it for such actual or threatened breach, including but not limited to the recovery of money damages, proximately caused by the Participant's breach of this Section 4.

(f) Survival. The provisions of this Section 4 shall survive and continue in full force in accordance with their terms notwithstanding any forfeiture, termination or expiration of this option in accordance with its terms or any termination of the Participant's employment for any reason (whether voluntary or involuntary).

5. Withholding

No Shares will be issued pursuant to the exercise of this option unless and until the Participant pays to the Company, or makes provision satisfactory to the Company for payment of, any federal, state or local withholding taxes required by law to be withheld in respect of this option.

6. Nontransferability of Option

This option may not be sold, assigned, transferred, pledged or otherwise encumbered by the Participant, either voluntarily or by operation of law, except by will or the laws of descent and distribution, and, during the lifetime of the Participant, this option shall be exercisable only by the Participant.

7. Provisions of the Plan

This option is subject to the provisions of the Plan, a copy of which is furnished to the Participant with this option.

In Witness Whereof, the Company has caused this option to be executed under its corporate seal by its duly authorized officer. This option shall take effect as a sealed instrument.

Centene Corporation

Robert K. Ditmore
Chairman, Compensation Committee

Exhibit 10.24

May 30, 2019

Kenneth Burdick

Dear Kenneth:

Upon, and subject to, the closing of the transactions contemplated by that certain Agreement and Plan of Merger, dated as of March 26, 2019 (the "Merger Agreement") made and entered into by Centene Corporation, WellCare Health Plans, Inc., d/b/a WellCare ("WellCare"), and certain other parties thereto, Centene Management Corporation ("Centene") shall employ you on the following terms set forth in this letter agreement (the "Agreement"):

1. Title: Executive Vice President reporting directly and solely to the Chairman, President & CEO of Centene Corporation.

2. Term: Two (2) year term (the "Employment Term") commencing on the closing date of the WellCare acquisition (the "Closing Date"), which may be terminated by either Centene or you any time on ninety (90) days' advance written notice. For the avoidance of doubt, during the Employment Term, you shall be permitted to continue to serve on the board of directors of First Horizon Bank and on any not for-profit boards of directors on which you currently serve.

3. Base Salary and Annual Bonus Opportunity: Your compensation will consist of a base salary of $1,400,000 per annum. Your base salary may be increased from time to time at Centene's discretion, but may not be decreased without your written authorization. In addition, you will be eligible for an annual bonus target of 150% of your base salary (with performance targets (other than individual targets and business-segment specific targets) consistent with those applicable to other similar level Centene executives). You will begin to participate in the annual bonus plan immediately following the Closing Date. You will have the potential to exceed that target based on Centene Corporation financial performance, business unit performance and your individual performance. If your employment is terminated by Centene without Cause (as defined in Section 3 below), due to your death or disability or by you for an Acceptable Reason (as defined below), Centene shall pay you an amount equal to (i) $4.2 million (representing your annual target bonus opportunity for the entire Employment Term), less (ii) any annual bonuses paid to you by Centene pursuant to this Section 3 for services following the Closing Date (but for the avoidance of doubt, not below $0), as soon as practicable (but in no event later than 30 days following) following your termination date. If you terminate your employment other than for an Acceptable Reason (as defined below) and by virtue of your Retirement (as defined below) during, after or at the expiration of the Employment Term where such termination of employment occurs on or after July 1 of the applicable annual performance period, then you shall receive an annual bonus in an amount equal to (i) the product of (x) the annual bonus that you would have received based on continued service through the remainder of the applicable performance period based on the actual level of achievement of the applicable performance metrics and (y) a fraction, the numerator of which is the number of whole and partial months in which you were employed during the applicable performance period and the denominator of which is twelve (12) (the "Prorata Retirement Bonus") minus (ii) the Closing Date Prorata Bonus (as defined below) if paid to you in respect of the year of your Retirement. The Prorata Retirement Bonus, if any, shall be paid to you at the same time as annual bonuses are paid to similar level Centene executives who do not experience a termination of employment during the applicable performance period.

4. Initial Equity Compensation: On the Closing Date, you will be granted a number of time-based Centene Corporation restricted stock units with a grant date fair market value equal to $4,400,000 (calculated on the same basis as other restricted stock units granted generally by Centene to its senior executives) (the "Initial RSU Award"). The Initial RSU Award will vest on the second year anniversary of the Closing Date (i.e., the last day of Employment Term), subject to your continued employment through such vesting date provided that, (i) if your employment is terminated by Centene without Cause (as defined below), due to

your death or disability or by you for an Acceptable Reason (as defined below) prior to such vesting date, the Initial RSU Award shall vest in full and be settled in Centene shares as soon as practicable (but in no event later than 30 days following) following your termination date and (ii) if you terminate your employment other than for an Acceptable Reason (as defined below) and by virtue of your Retirement (as defined below) prior to such vesting date, you shall vest in a number of restricted stock units subject to the Initial RSU Award that would have vested based on your continued employment through the first anniversary of your termination date and such restricted stock units shall be settled in Centene shares as soon as practicable (but in no event later than 30 days following) your termination date. Except as provided in this Section 4, the Initial RSU Award agreement shall provide for terms and conditions no less favorable than those provided to similar level Centene executives. The holding period set forth in any equity awards granted by Centene shall not apply to you, provided, that you are otherwise in compliance with the applicable share ownership guidelines of Centene Corporation.

For purposes of this Agreement, "Acceptable Reason" means the occurrence of any of the following conditions without your express written consent: (A) a diminution in your Base Salary, Annual Bonus Opportunity or Ongoing Long-Term Compensation opportunity, except as applicable generally to other similarly situated senior executives of the Centene; (B) Centene requiring you to be based at any office or location outside of fifty miles from your current employment location (Tampa, Florida) or Centene's headquarters (St. Louis, Missouri), except for travel reasonably required in the performance of your responsibilities; (C) Centene fails to timely pay or provide you with the amounts and benefits under this Agreement; or (D) you are no longer an Executive Vice President reporting directly and solely to the CEO of Centene Corporation. You must provide written notice to Centene of the existence of Acceptable Reason no later than ninety (90) days after its initial existence, and Centene shall have a period of thirty (30) days following its receipt of such written notice during which it may remedy the Acceptable Reason condition identified in such written notice. If Centene fails to remedy such Acceptable Reason condition, you may terminate your employment for Acceptable Reason within the sixty (60) day period following the end of Centene's thirty (30)-day remedy period.

For purposes of this Agreement, "Cause" shall have the meaning set forth in the Amended an Restated WellCare Health Plans, Inc. Executive Severance Plan (the "WellCare Severance Plan").

5. Ongoing Long-Term Compensation: Centene shall grant you annual grants of equity under the terms of the Centene Corporation Stock Incentive Plan with a target amount of annual grant equal to $7,000,000 and with terms and conditions no less favorable than those provided to similar level Centene executives. You shall also participate in Centene Corporation's Cash Long-Term Incentive Plan (the "Cash LTIP"), beginning with the 2020-2022 performance cycle, with a Cash LTIP target of 100% of your annual base salary (the "Annual Cash LTIP Awards"). You will have the potential to earn up to 200% of your Cash LTIP target based on predefined company performance measures. Forty percent (40%) of each annual equity grant shall be in the form of time-based restricted stock units that vest in three (3) equal installments on each of the first three anniversaries of the date of grant, subject to your continued employment through the applicable vesting date (the "Annual RSUs"). Sixty percent (60%) of each annual equity grant shall be in the form of performance stock units that vest on the third anniversary of the date of grant, subject to your continued employment through such vesting date and the achievement of applicable performance metrics (the "Annual PSUs"). Centene's normal annual grant cycle is generally in December of each year. Notwithstanding the foregoing, if the Closing Date occurs after the 2019 long-term equity grant has been made by Centene in December 2019 and prior to the date that WellCare would otherwise have made a 2020 long-term compensation grant had the Closing not occurred, Centene shall provide you with the annual equity grant and Cash LTIP as soon as practicable following the Closing Date. If the Closing Date occurs prior to the date that Centene makes its annual long-term equity grant in December 2019, Centene shall provide you with the annual equity grant and Cash LTIP at the same time when granted to other Centene executives. In either event, you shall be eligible to receive a normal cycle grant in December 2020 and each December (or other time when similar level Centene executives receive grants) thereafter. If your employment is terminated by Centene without Cause or due to your death or disability or you terminate your employment by virtue of your Retirement (as defined below), then (i) your Annual RSUs shall vest in full immediately and (ii) your Annual Cash LTIP Awards and PSUs shall remain outstanding and shall vest or be forfeited at the end of the applicable performance period based on actual levels of achievement (without regard to additional service-based vesting requirements). Attached as Exhibit A is an illustrative example of the vesting and settlement of the Annual Cash LTIP Awards, Annual RSUs and Annual PSUs.

   For purposes of this Agreement, "Retirement" shall mean your termination of employment other than by reason of death, disability or Cause, provided that you are age sixty (60) or older with at least five (5) years of employment with Centene or a subsidiary thereof (including, for the avoidance of doubt, WellCare or the surviving corporation) at the time of such termination; provided, that, for the avoidance of doubt, Retirement shall not override any payments or benefits due upon a termination by you for Acceptable Reason or by Centene without Cause. Centene acknowledges and agrees that you have met the service requirements for "Retirement" as of the date of this agreement.

6. Employee Benefits: You will be entitled to participate in all employee benefit plans, practices and programs maintained by Centene Corporation and its affiliates on the same basis and terms as are applicable to Executive Vice Presidents of Centene Corporation. Centene Corporation and its affiliates reserve the right to review, amend and/or terminate their benefit plans and compensation practices from time to time in accordance with their terms. In addition, during the Employment

Term, Centene Corporation will provide you with (i) temporary executive housing in the St. Louis, Missouri metropolitan area (plus reimbursement of any income taxes incurred by you in connection with the provision of the executive housing) and (ii) use of corporate aircraft on an as-available basis and in accordance with the policies of Centene Corporation. You shall be provided with credited service with respect to Centene's benefit plans, policies, programs, contracts agreements or arrangements to the extent set forth in the Merger Agreement, and which shall include service credit for "Retirement" treatment (other than (i) to the extent that such service credit would result in a duplication of benefits with respect to the same period of service, (ii) for purposes of eligibility, vesting or benefit accruals under any defined benefit pension plan and (iii) for purposes of eligibility, vesting or benefit accruals under any retiree medical or welfare arrangement).

7. Legacy WellCare Compensation: Notwithstanding the terms of the Merger Agreement, you and Centene agree that your annual bonus payment with respect to 2019 performance will, except as contemplated by Section 9 below, be paid to you as soon as practicable following January 1, 2020 based on actual performance for 2019. Centene hereby acknowledges and agrees that the occurrence of the closing of the acquisition contemplated by the Merger Agreement (and the related changes to your compensation, benefits, duties, responsibilities or reporting obligations set forth this letter) constitute "good reason" under the WellCare equity plans and agreements applicable to your outstanding WellCare equity awards and the WellCare Severance Plan. Therefore, upon termination of your employment for any reason during, after, or at the expiration of, the Employment Term, and whether by you or by Centene, (i) you shall be entitled to severance benefits under, and in accordance with, the terms of the WellCare Severance Plan, as in effect on the date hereof (as a Tier 1 Participant) and calculated as if your employment terminated on the Closing Date including, for the avoidance of doubt, the "Cash Severance" and "Health Benefit Continuation" pursuant to Section 5(c) of the WellCare Severance Plan (for the avoidance of doubt your 2018 and 2019 annual short-term incentive bonuses from WellCare shall be used to determine "Bonus" for purposes of Section 5(c) of the WellCare Severance Plan), and (ii) the vesting of any WellCare equity award converted to a Centene Corporation equity award on the Closing Date will, to the extent then unvested, be accelerated and settled in accordance with the terms of such award; except that, as provided in the Merger Agreement, WellCare equity awards, if any, granted to you following the date on which the Merger Agreement was executed and converted into Centene Corporation equity awards on the Closing Date shall vest in a number of units that would have vested prior to your date of termination of employment assuming such 2020 Awards vested ratably on a daily basis from the Closing Date through the last day of the original vesting period applicable to each such award. Notwithstanding clause (i) above, no later than five (5) business days following the Closing Date, Centene shall pay you an amount equal to your Prorated Bonus (within the meaning of the WellCare Severance Plan and, for the avoidance of doubt, your 2018 and 2019 annual short-term incentive bonuses from WellCare shall be used to determine "Average Bonus" for purposes of Section 5(c) of the WellCare Severance Plan) as if you terminated employment with "good reason" as of the Closing Date (the "Closing Date Prorata Bonus"). As consideration for the Closing Date Prorata Bonus, you acknowledge and agree that you will not be eligible to receive a Prorated Bonus under the WellCare Severance Plan upon your termination of employment on or following the Closing Date.

8. Notwithstanding anything to the contrary in any other documents or agreements that you have or will sign during your employment with Centene in the event of a legal dispute between you and

Centene related in any way to your employment with or termination from Centene, such dispute may be heard by any court of competent jurisdiction.

9. As a condition to your acceptance of this position, you hereby acknowledge and agree that except as provided herein, the terms of this letter will supersede your current employment or offer letter agreement with WellCare upon execution of this letter and closing of the acquisition. As a condition to the willingness of Centene to enter into this agreement, you hereby agree to the restrictive covenants set forth on Exhibit B, which shall supersede in all respects any restrictive covenants to which you were previously subject prior to your entry into this agreement. In addition, notwithstanding the terms of the Merger Agreement, you and Centene will cooperate in good faith to modify the treatment of your outstanding WellCare equity awards to provide for treatment that minimizes or eliminates the imposition of a Section 280G golden parachute excise tax on you while maintaining as closely as possible the intended treatment of such equity awards as set forth in the Merger Agreement. Notwithstanding the foregoing, you acknowledge that you will be solely responsible for any taxes you incur under Sections 280G or 4999 of the Internal Revenue Code of 1986, as amended (the "Golden Parachute Provisions"). The Section 280G provision of the WellCare Severance Plan shall continue to apply in the event of any taxes incurred under the Golden Parachute Provisions by reason of the Closing Date (and related equity award vesting and severance), and the parties agree that all determinations under the WellCare Severance Plan in respect of the Golden Parachute Provisions and the assumptions to be utilized in arriving at such determination shall be made by Golden Parachute Tax Solutions LLC following consultation with the parties.

10. Centene will be entitled to withhold (or to cause the withholding of) the amount, if any, of all taxes of any applicable jurisdiction required to be withheld by an employer with respect to any amount paid to you hereunder. Centene, in its sole and absolute discretion, will make all determinations as to whether it is obligated to withhold any taxes hereunder and the amount thereof.

11. The intent of the parties is that payments and benefits under this letter comply with Section 409A of the Internal Revenue Code of 1986, as amended ("Section 409A"), to the extent subject thereto, and accordingly, to the maximum extent permitted, this letter will be interpreted and administered to be in compliance therewith. In the event that the parties reasonably determine that this letter is not in compliance with Section 409A, the parties shall cooperate reasonably to modify this letter (if such modification is permitted under Section 409A) to comply while endeavoring to maintain to the maximum extent possible the intended economic benefits of its terms. Notwithstanding anything contained herein to the contrary, you will not be considered to have terminated employment with the Centene for purposes of any payments under this letter or any other arrangements to which you and Centene are a party that are subject to Section 409A until you have incurred a "separation from service" from Centene within the meaning of Section 409A. Each amount to be paid or benefit to be provided under this letter will be construed as a separate identified payment for purposes of Section 409A. Without limiting the foregoing and notwithstanding anything contained herein to the contrary, to the extent required in order to avoid an accelerated or additional tax under Section 409A, amounts that would otherwise be payable and benefits that would otherwise be provided pursuant to this letter or any other arrangements to which you and Centene are a party during the six-month period immediately following your separation from service will instead be paid on the first business day after the date that is six months following your separation from service (or, if earlier, your date of death). To the extent required to avoid an accelerated or additional tax under Section 409A, the amounts reimbursable to you will be paid to you on or before the last day of the

year following the year in which the expense was incurred and the amount of expenses eligible for reimbursement (and in kind benefits provided to you) during one year may not affect amounts reimbursable or provided in any subsequent year. Notwithstanding anything set forth herein to the contrary, to the extent that any severance amount payable under a plan or agreement that you may have a right or entitlement to as of the date of this Agreement constitutes deferred compensation under Section 409A, then to the extent required to avoid accelerated taxation and/or tax penalties under Section 409A, the portion of the benefits payable hereunder equal to such other amount will instead be provided in the form set forth in such other plan or agreement. Without limiting the generality of the foregoing, you acknowledge that you will be solely responsible for any taxes, penalties or interest you incur under Section 409A.

12. Centene shall indemnify you and advance expenses to the fullest extent permitted by applicable state law and you shall be covered under Centene's directors' and officers' liability insurance policies on a basis no less favorable than provided to similar level Centene executives.

[SIGNATURE PAGE FOLLOWS]

We are excited about the future of Centene and having you as a part of our successful team. Please do not hesitate to contact me should you wish to discuss the terms of employment further.

Sincerely,

/s/ Michael F. Neidorff

Michael F. Neidorff
Chairman, President & CEO

Acknowledged and Agreed:

/s/ Kenneth Burdick May 30, 2019

Kenneth Burdick Date

EXHIBIT A
ILLUSTRATIVE EXAMPLE - ONGOING LONG-TERM COMPENSATION

Assumed Closing Date: 3/1/2020
Illustrative Stock Price at Closing Date: $55.00
Illustrative Stock Price at Settlement Date: $55.00

Annual RSUs

Grant Date	Value of RSU's Granted ($)	Units (#)	Settle in 2021 (Assuming Continued Employment) (#)	Settle in 2021 (Assuming Continued Employment) ($)	Settle in 2022 (Assuming Continued Employment) (#)	Settle in 2022 (Assuming Continued Employment) ($)	Settle in 2023 (Assuming Continued Employment) (#)	Settle in 2023 (Assuming Continued Employment) ($)	Qualifying Termination (including Retirement) (#)	Qualifying Termination (including Retirement) ($)
3/31/20	2,800,000	50,909	16,970	933,333	16,970	933,333	16,970	933,333	50,909	2,800,000
12/31/20	2,800,000	50,909	16,970	933,333	16,970	933,333	16,970	933,333	50,909	2,800,000
12/31/21	2,800,000	50,909	0	0	16,970	933,333	16,970	933,333	50,909	2,800,000
Total		152,727	33,939	1,866,667	50,909	2,800,000	50,909	2,800,000	152,727	8,400,000

Annual PSUs (Target Grant Date Value and Assumed Performance at Target)

Performance Period	Value of PSU's Granted ($)	Units (#)	End of Performance Period	Settlement Date (Assuming Continued Performance Through Performance Period or Qualifying Termination (Including Retirement) and Achievement of Applicable Performance Metrics)
2020-2022	4,200,000	76,364	12/31/2022	2/2023
2021-2023	4,200,000	76,364	12/31/2023	2/2024
2022-2024	4,200,000	76,364	12/31/2024	2/2025
Total	12,600,000	229,091		

Annual Cash LTIP (Target Grant Date Value and Assumed Performance at Target)

Performance Period	Cash LTIP Granted ($)	Total Vested ($)	End of Performance Period	Payment Date (Assuming Continued Performance Through Performance Period or Qualifying Termination (Including Retirement) and Achievement of Applicable Performance Metrics)
2020-2022	1,400,000	1,400,000	12/31/2022	2/2023
2021-2023	1,400,000	1,400,000	12/31/2023	2/2024
2022-2024	1,400,000	1,400,000	12/31/2024	2/2025
	Total	4,200,000		

EXHIBIT B

RESTRICTIVE COVENANTS

Kenneth Burdick (the "Executive") acknowledges and agrees that, as a condition to the willingness of Centene Corporation (together with its affiliates and subsidiaries, the "Centene Group") to enter into the Offer Letter Agreement dated May 30, 2019 (the "Offer Letter Agreement") and provide the compensation and benefits described therein, the following shall continue to apply in the event Executive's employment is terminated by either party for any reason:

1. Confidential Information: As used in this Exhibit B, "Confidential Information" shall mean Centene Group's trade secrets and other non-public proprietary information relating to Centene Group or the business of Centene Group, including information relating to financial statements, customer lists and identities, potential customers, customer contacts, employee skills and compensation, employee data, suppliers, acquisition targets, servicing methods, equipment, programs, strategies and information, analyses, marketing plans and strategies, pricing, profit margins, financial, promotional, marketing, training or operational information, and other information developed or used by Centene Group that is not known generally to the public or the industry. Confidential Information shall not include any information that is in the public domain or becomes known in the public domain through no wrongful act on the part of Executive.

2. Non-Disclosure: Executive agrees that the Confidential Information is a valuable, special and unique asset of the Centene Group's business, that such Confidential Information is important to Centene Group and the effective operation of Centene Group's business, and that during employment with Centene Group and at all times thereafter, Executive shall not, directly or indirectly, disclose to any competitor or other person or entity (other than current employees of Centene Group) any Confidential Information that Executive obtains while performing services for Centene Group, except as may be required in Executive's reasonable judgment to fulfill Executive's duties hereunder or to comply with any applicable legal obligation. Executive may also disclose Confidential Information if necessary in connection with any litigation between Executive and any member of the Centene Group, but subject to the terms of any agreement, stipulation or order governing the use of Confidential Information in any such action

3. Non-Competition; Non-Solicitation:

   a) During Executive's employment with Centene Group and for the period of twelve (12) months immediately after the termination of Executive's employment with Centene Group for any reason whatsoever, and whether voluntary or involuntary ("Restricted Period"), Executive shall not, without the prior written consent of Centene Group (which may be withheld in the sole discretion of Centene Group), invest in (other than in a publicly traded company with a maximum investment of no more than 1% of outstanding shares or passive investments in a non-publicly traded company of no more than 1% of outstanding equity through hedge funds, mutual funds, private equity funds or similar type investment vehicles), counsel, advise, consult, be employed or otherwise engaged by or with any entity or enterprise that (A) provides Medicaid managed care services, Medicaid-related services, behavioral health, nurse triage or pharmacy compliance specialty services or (B) engages in any other business in which Centene Group becomes engaged (or has taken substantial steps in which to become engaged) on or after the date of the Offer Letter Agreement and on or prior to the

date of termination of Executive's employment, in the case each of (A) and (B), within the state of Missouri or any other state in the United States in which Centene Group conducts or has taken substantial steps to conduct business on or after the date of the Offer Letter Agreement and on or prior to the date of termination of Executive's employment (in either case, a "Competitor"); provided, however, that, Executive may provide services to a non-competitive unit, division, subsidiary or affiliate of any Competitor so long as executive does not provide services or Confidential Information to, or attend meetings relating to the unit, division, subsidiary or affiliate of the Competitor which engages in activities competitive with the Centene Group and such competitive unit, division, subsidiary or affiliate did not constitute more than 10% of its ultimate parent's total revenue in either of the then preceding two fiscal years.

b) During Executive's employment with Centene Group and for the Restricted Period, without the prior written consent of Centene Group (which may be withheld in the sole discretion of Centene Group), Executive will not, either directly or indirectly, either for himself or for any other person, firm, company or corporation, call upon, solicit for competitive activities, divert, or take away, or attempt to solicit for competitive activities, divert or take away any of the customers, prospective customers, business, vendors or suppliers of Centene Group that Executive had dealings with, or responsibility for, or about which Executive had access to Centene Group's Confidential Information or such customers', vendors' or suppliers' confidential information.

c) Executive shall not, at any time during the Restricted Period, without the prior written consent of Centene Group (which may be withheld in the sole discretion of Centene Group), (1) directly or indirectly, solicit, recruit, hire, or employ (whether as an employee, officer, director, agent, consultant or independent contractor) any person who was or is at any time during the previous six (6) months an employee, officer or director of Centene Group; or (2) take any action to encourage or induce any employee, representative, officer or director of Centene Group to cease their relationship with Centene Group for any reason.

d) Notwithstanding anything in the foregoing to the contrary, this Section 3, and the non-competition and non-solicitation provisions of any of the Executive's equity awards, shall not apply if a "Change in Control" (as defined in the Centene Corporation Stock Incentive Plan) occurs.

e) Executive's obligations under any equity award shall be no more onerous to Executive than the terms of this Section 3.

4. Enforcement: If any of the provisions or subparts of this Exhibit B shall be held to be invalid or unenforceable by a court of competent jurisdiction, the remaining provisions or subparts thereof shall nevertheless continue to be valid and enforceable according to their terms. Further, if any restriction contained in the provisions or subparts of this Exhibit B is held to be overbroad or unreasonable as written, the parties agree that the applicable provision should be considered to be amended to reflect the maximum period, scope or geographical area deemed reasonable and enforceable by the court and enforced as amended.

5. Remedies for Breach:

a) Because Executive's services are unique and because Executive has access to Centene Group's Confidential Information, the parties agree that any breach or threatened breach of this Exhibit B

will cause irreparable harm to Centene Group and that money damages alone would be an inadequate remedy. The parties therefore agree that, in the event of any breach or threatened breach of this Exhibit B, and in addition to all other rights and remedies available to it under the Offer Letter Agreement or otherwise, and whether in equity or at law, Centene Group may apply to any court of competent jurisdiction for specific performance and/or injunctive or other relief, without a bond, in order to enforce or prevent any violations of the provisions of this Exhibit B.

b) Executive acknowledges and understands that, but for agreeing to be bound to the provisions of this Exhibit B, Executive would not be entitled to receive the benefits and payments promised by Centene Group contemplated by Paragraphs 4 (Initial Equity Compensation) and 5 (Ongoing Long-Term Compensation) of the Offer Letter Agreement, including all subparts thereto. Executive agrees that any material breach of this Exhibit B would constitute a material breach of the Offer Letter Agreement and subjects Executive to the forfeiture of all such payments. Employer expressly reserves the right to pursue all other legal and equitable remedies available to it by virtue of any breach of this Exhibit B, including without limitation injunctive relief as provided in Section 5(a) above. Executive shall not be in material breach of this Exhibit B unless and until he fails to cure (to the extent capable of being cured) any alleged material breach within twenty (20) days after the Centene Group provides Executive with written notice of such alleged material breach. During the Restricted Period, prior to becoming employed by, or providing services to, any person other than the Centene Group, Executive will provide advance written notice to Centene of his intention to provide such services.

c) Executive acknowledges and agrees that the remedies provided for in this Section 5 are cumulative and not exclusive of any and other remedies available under the Offer Letter Agreement or otherwise, and whether in equity or at law. In that regard, Executive acknowledges and agrees that, while the forfeiture of payments and benefits referenced in Section 5(b) is appropriate in the event of a breach of Exhibit B, injunctive relief to prevent a continuing breach would still be necessary to give Centene Group an adequate remedy.

d) Defense of Trade Secrets Act Notice to Executive. Notwithstanding the foregoing, Executive will not be held criminally or civilly liable under any Federal or State trade secret law for the disclosure of a trade secret that: (A) is made (i) in confidence to a Federal, State, or local government official, either directly or indirectly, or to an attorney, and (ii) solely for the purpose of reporting or investigating a suspected violation of law; or (B) is made in a complaint or other document filed in a lawsuit or other proceeding, if such filing is made under seal. In addition, if Executive files a lawsuit for retaliation by Centene Group for reporting a suspected violation of law, Executive may disclose the trade secret to Executive's attorney and use the trade secret information in the court proceeding if Executive files any document containing the trade secret under seal and does not disclose the trade secret except pursuant to court order.

6. Survival: The provisions of this Exhibit B shall survive and continue in full force in accordance with their terms notwithstanding any termination of the Offer Letter Agreement or any termination of Executive's employment for any reason (whether voluntary or involuntary).

7. Acknowledgements. Executive acknowledges and agrees that (a) this Exhibit B is being executed in connection with the transaction contemplated by the Merger Agreement, (b) the time, geographic coverage and scope of the restrictions set forth in this Exhibit B are reasonable and necessary to

protect the legitimate interests of the Centene Group, including its goodwill and Confidential Information, (c) by virtue of Executive's employment with the Centene Group, Executive will have significant access to Confidential Information, including trade secrets and customer contacts, and that this Confidential Information is of critical competitive importance and commercial value to the Centene Group and the improper use of disclosure of such Confidential Information by Executive would likely result in unfair or unlawful activity, and (d) the execution of this Exhibit B is a material inducement to Centene's consummation of the transaction contemplated by the Merger Agreement and that, absent Executive's execution of this Exhibit B, the Centene Group would not receive the bargained-for-benefits of the Merger Agreement.

8. Governing Law; Venue. This Exhibit B will be governed under the internal laws of the State of Missouri, without regard to its conflict of law principles. Executive agrees that the State and Federal courts located in the State of Missouri shall have exclusive jurisdiction in any action, suit or proceeding based on or arising out of this Exhibit B, and Executive hereby: (a) submits to the personal jurisdiction of such courts; (b) consents to the service of process in connection with any action, suit, or proceeding against Executive; and (c) waives any other requirement (whether imposed by statute, rule of court, or otherwise) with respect to personal jurisdiction, venue or service of process.

Exhibit 10.25

TRANSITION SERVICES AGREEMENT

THIS TRANSITION SERVICES AGREEMENT (the "Agreement") is made effective as of February 21, 2020, (the "Effective Date"), by and between Centene Corporation, a Delaware corporation (the "Company" and together with its affiliates within the meaning of Rule 12b-2 promulgated under Section 12 of the Securities Exchange Act of 1934, as amended, the "Company Group"), and Kenneth Burdick ("Executive" and, together with the Company, the "Parties"). Capitalized terms used but not defined herein shall have the meaning ascribed to them in the Offer Letter Agreement, dated as of May 30, 2019, by and between the Company and Executive (the "Offer Letter Agreement").

RECITALS

WHEREAS, Executive currently serves as an Executive Vice President of the Company pursuant to the Offer Letter Agreement; and

WHEREAS, the Parties each desire to enter into this Agreement to set forth the Parties' agreement as to the Retirement of Executive from the Company Group and the Parties' agreement as to advisory services to be provided by Executive following the retirement of Executive from the Company Group.

NOW, THEREFORE, in consideration of the premises and mutual covenants herein contained, the Parties agree as follows:

1. Qualifying Termination Date: Departure Date. The Parties hereby acknowledge and agree that Executive's employment with the Company Group shall cease by reason of Retirement effective as of the first anniversary of the Effective Date (the "Transition Date") or, if earlier, upon (x) Executive's termination of employment by the Company Group without Cause, (y) Executive's termination of employment for Good Reason (as defined in the WellCare Severance Plan) or for an Acceptable Reason, or (z) Executive's termination of employment as a result of Executive's Retirement, death or disability (as determined under the Company's Long-Term Disability Plan) (such date, the "Qualifying Termination Date"). Notwithstanding the foregoing, nothing contained in this Agreement shall prohibit either Party from terminating the employment of Executive for any reason prior to the Transition Date (the date of termination of employment, whether on or before the Transition Date, the "Departure Date"). Effective as of the Departure Date, Executive shall be deemed to have resigned from all positions Executive holds as an officer or employee with respect to the Company Group and agrees to execute all further documents reasonably necessary or appropriate to further memorialize any or all such resignations.

2. Transition Period: Transition Period Compensation; Transition Date Compensation.

(a) During the period commencing on the Effective Date and through and including the Departure Date (such period, the "Transition Period"), Executive agrees to continue in the employment of the Company Group as, and perform the duties of, Executive Vice President of the Company subject to and in accordance with the terms of the Offer Letter Agreement.

(b) During the Transition Period, Executive shall continue to be entitled to receive the compensation and benefits provided under, and in accordance with the terms of, the Offer Letter Agreement; provided, that Executive hereby acknowledges and agrees that (i) notwithstanding Section 5 of the Offer Letter, Executive shall not be

entitled to receive a grant of Annual Cash LTIP Awards, Annual RSUs, Annual PSUs or any other equity- or equity-based award of the Company following the date that the Company makes its annual equity grants to similarly situated executives in respect of 2021 grant cycle, which is anticipated to occur in December 2020 (the "2022 Award Waiver") and (ii) Executive shall not be entitled to terminate employment for either Good Reason or Acceptable Reason as a result of the Award Waiver.

(c) As consideration for the 2022 Award Waiver, the Company hereby releases Executive from, and deems null and void, the Restrictive Covenant Agreement attached to the Offer Letter Agreement as Exhibit B. As consideration for the Company's release of Executive from the Restrictive Covenant Agreement attached to the Offer Letter Agreement as Exhibit B, and in accordance with the terms of Sections 4(a) and 6(b) of the WellCare Severance Plan, Executive hereby agrees to the restrictive covenants set forth on Exhibit A hereto.

(d) The Parties hereby acknowledge and agree that in connection with Executive's Retirement on the Transition Date, Executive shall be entitled to receive (or be eligible for, as the case may be) the following, in each case of the Transition Date:

(i) the shares of Company common stock subject to the Initial RSU Award shall vest and be delivered to Executive in accordance with the second sentence of Section 4 of the Offer Letter Agreement;

(ii) the Annual RSUs granted to Executive by the Company shall vest in full, and the Annual Cash LTIP Award and Annual PSUs granted to Executive by the Company shall remain outstanding and shall vest or be forfeited at the end of the applicable performance period based on the actual levels of achievement of the applicable performance metrics, in each case, in accordance with Section 5 of the Offer Letter Agreement;

(iii) the severance amounts and benefits under, and in accordance with, the terms of the WellCare Severance Plan (including with respect to the execution and nonrevocation of the release of claims provided by Section 6(a) of the WellCare Severance Plan), calculated as if Executive terminated employment on January 23, 2020 and in accordance with, and as amended by, Section 7 of the Offer Letter Agreement (excluding, in accordance with Section 7 of the Offer Letter Agreement, any Prorated Bonus);

(iv) accelerated settlement of any outstanding equity awards originally granted by WellCare that were converted into equity awards of the Company on the Closing Date in accordance with the terms applicable to such converted awards and Section 7 of the Offer Letter Agreement; and

(v) an annual cash incentive bonus in respect of 2020 based on the actual level of achievement of the applicable performance metrics, which amount shall be paid to Executive at the same time that annual bonuses are paid to employees who have not experienced a termination of employment from the Company Group and, in any event, no later than March 15, 2021.

3. Consulting Services.

(a) Effective as of the day immediately following the Transition Date, and through January 23, 2022 (such period, the "Consulting Period"), Executive shall provide advisory services to the Company Group as reasonably requested by [the Chairman, President & Chief Executive Officer of the Company] or his designee, subject to reasonable and mutual agreement concerning time and place (the

"Consulting Services"). Any travel required for the Consulting Services shall be subject to mutual agreement by the Parties.

(b) Executive represents and warrants that Executive shall act honestly and in good faith and in the best interests of the Company Group at all times while providing the Consulting Services, and that Executive shall use professional care, diligence and skill to ensure that the Consulting Services are provided and completed to the reasonable satisfaction of the Company. Executive represents and warrants that Executive shall comply with all applicable laws, regulations, rules, codes, orders and standards imposed by applicable federal, state, provincial, or local government authorities with respect to the provision of any Consulting Services, and Executive shall not subcontract the provision of any Consulting Services to any third party without receiving prior written consent from the Company.

4. Consulting Fee.

(a) At the end of each calendar quarter during the Consulting Period, the Company Group shall pay Executive a quarterly fee of $350,000 (the"Consulting Fee"). Consulting Fees for Consulting Services rendered to the Company Group shall be paid to Executive as soon as reasonably practicable (and in any event within twenty (20) days) following the final business day of the quarter for which the Consulting Services were performed. Such Consulting Fees shall be the only compensation due to Executive for the performance of the Consulting Services hereunder.

(b) The Company Group shall not withhold from the Consulting Fees any income, social security, or other taxes. Executive hereby acknowledges and agrees that Executive is solely responsible for the payment of all taxes that may result from performance of the Consulting Services and with respect to the payment of the Consulting Fees. Executive hereby acknowledges and agrees that the Company Group shall have no responsibility whatsoever regarding any tax consequences arising from the payment of Consulting Fees under this Agreement.

(c) In addition to the Consulting Fees set forth in Section 4(a), the Company Group shall reimburse Executive for Executive's reasonable out-of-pocket expenses incurred in connection with the Consulting Services in accordance with the Company Group's existing expense reimbursement procedures.

5. Status as Independent Contractor.

(a) The Parties acknowledge and agree that, as of date immediately following the Transition Date, Executive's relationship with the Company Group shall be that of an independent contractor and nothing in this Agreement creates a partnership, joint venture or any employer-employee relationship between Executive on the one hand and any member of the Company Group on the other hand. No member of the Company Group shall have the authority to, nor shall it, supervise, direct or control the manner, means, details or methods utilized by Executive to perform the Consulting Services under this Agreement.

(b) Executive hereby acknowledges and agrees that, following the Transition Date, (i) Executive is not eligible to participate in and waives any claims he may have to any type of benefits offered to employees of the Company Group (other than those to which Executive might be entitled as a former employee of the Company Group pursuant to the Offer Letter Agreement or the terms of any Company Group benefit plan in which Executive participated as of the Transition Date) and (ii) neither Executive nor any individual employed by Executive or acting on Executive's behalf shall be treated or regarded as employee of the Company Group under the laws or regulations of any government or governmental agency.

(c) Following the Transition Date, Executive shall not be an agent of the Company Group and shall have no authority to make any statement, representation, or commitment of any kind or to take any action binding upon any member of the Company Group without the Company's prior written authorization and shall have no management authority with respect to any member of the Company Group.

(d) The Parties acknowledge and agree that, on the Transition Date, Executive will have had a "separation from service," within the meaning of section 409A of the Internal Revenue Code of 1986, as amended ("Section 409A"). The Parties reasonably expect that the performance of the Consulting Services will not require Executive to provide more than twenty percent (20%) of the average level of services rendered by Executive to the Company Group during the thirty-six (36) months immediately preceding the Transition Date.

6. Miscellaneous.

(a) Governing Law. The validity, interpretation, construction, performance and enforcement of this Agreement shall be governed by the laws of the State of Missouri, without application of any conflict of laws principles that would result in the application of the laws of any other jurisdiction.

(b) Severability. The provisions of this Agreement shall be deemed severable and the invalidity or unenforceability of any provision shall not affect the validity or enforceability of the other provisions hereof.

(c) Successors and Assigns. This Agreement shall be binding upon and shall inure to the benefit of the Company, its successors and permitted assigns and the Company shall require any successor or assign to expressly assume and agree to perform this Agreement in the same manner and to the same extent that the Company would be required to perform if no such succession or assignment had taken place. The Company may not assign or delegate any rights or obligations hereunder except to a successor (whether direct or indirect, by purchase, merger, consolidation or otherwise) to all or substantially all of the business and/or assets of the Company. Neither this Agreement nor any right or interest hereunder shall be assignable or transferable by Executive, Executive's beneficiaries or legal representatives, except by will or by the laws of descent and distribution. This Agreement shall inure to the benefit of and be enforceable by Executive's legal personal representatives.

(d) Notice. For the purposes of this Agreement, notices and all other communications shall be in writing and shall be deemed to have been duly given when personally delivered or sent by certified mail, return receipt requested, postage prepaid, addressed to the respective addresses last given by one Party to another Party or, if none, in the case of the Company, to the Company's headquarters directed to the attention of the Company's General Counsel and, in the case of Executive, to the most recent address shown in the personnel records of the Company or another member of the Company Group. All notices and communications shall be deemed to have been received on the date of delivery thereof.

(e) Entire Agreement; Certain Acknowledgements. This Agreement contains the entire agreement of the Parties with respect to the subject matter hereof and supersedes all prior agreements, if any, understandings and arrangements, oral or written, between or among any member of the Company Group and Executive with respect to the subject matter hereof including, for the avoidance of doubt, the Term Sheet, dated as of February 18, 2020, by and between Executive and the Company; provided, that, except as otherwise amended or superseded by this Agreement, the Offer Letter Agreement shall continue in accordance with its terms following the Effective Date. Executive hereby acknowledges and agrees that Executive has read and understands this Agreement, is fully aware of its legal effect, has not acted in reliance upon any representations or promises made by the Company other than those contained in writing herein, and has entered into this Agreement freely based on Executive's own judgment. Executive hereby

acknowledges and agrees that Executive has had the opportunity to consult with legal counsel of Executive's choice in connection with the drafting, negotiation and execution of this Agreement.

(f) Headings. The headings and captions in this Agreement are provided for reference and convenience only, shall not be considered part of this Agreement, and shall not be employed in the construction of this Agreement.

(g) Construction. This Agreement shall be deemed drafted equally by both the Parties, and any presumption or principle that the language is to be construed against either Party shall not apply.

(h) Counterparts. This Agreement may be executed in several counterparts, each of which is an original and all of which shall constitute one instrument. It shall not be necessary in making proof of this Agreement or any counterpart hereof to produce or account for any of the other counterparts.

(i) Withholding. The Company shall be entitled to withhold (or to cause the withholding of) the amount, if any, of all taxes of any applicable jurisdiction required to be withheld by an employer with respect to any amount paid to Executive hereunder. The Company, in its sole and absolute discretion, shall make all determinations as to whether it is obligated to withhold any taxes hereunder and the amount thereof.

(j) Section 409A. The Parties intend for the payments and benefits under this Agreement to be exempt from Section 409A or, if not so exempt, to be paid or provided in a manner which complies with the requirements of such section, and intend that this Agreement shall be construed and administered in accordance with such intention. If any payments or benefits due to Executive hereunder would cause the application of an accelerated or additional tax under Section 409A, such payments or benefits shall be restructured in a manner which does not cause such an accelerated or additional tax. For purposes of the limitations on nonqualified deferred compensation under Section 409A, each payment of compensation under this Agreement shall be treated as a separate payment of compensation. Without limiting the foregoing and notwithstanding anything contained herein to the contrary, to the extent required in order to avoid accelerated taxation and/or tax penalties under Section 409A amounts that would otherwise be payable and benefits that would otherwise be provided pursuant to this Agreement during the six-month period immediately following Executive's separation from service shall instead be paid on the first business day after the date that is six months following Executive's termination date (or death, if earlier). Without limiting the foregoing, Executive hereby acknowledges and agrees Executive shall be solely responsible for any taxes, penalties or interest Executive incurs under Section 409A.

(k) Centene and you will cooperate in good faith to modify the treatment of your outstanding Centene severance and equity awards to provide for treatment that minimizes or eliminates the imposition of a Section 280G golden parachute excise tax on you while maintaining as closely as possible the intended treatment of such equity awards as set forth in this Agreement. Notwithstanding the foregoing, you acknowledge that you will be solely responsible for any taxes you incur under Sections 280G or 4999 of the Internal Revenue Code of 1986, as amended (the "Golden Parachute Provisions"). The Section 280G provision of the WellCare Severance Plan shall continue to apply in the event of any taxes incurred under the Golden Parachute Provisions by reason of the Closing Date (and related equity award vesting and severance), and the parties agree that all determinations under the WellCare Severance Plan in respect of the Golden Parachute Provisions and the assumptions to be utilized in arriving at such determination shall be made by Golden Parachute Tax Solutions LLC following consultation with the parties.

[SIGNATURE PAGE FOLLOWS]

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the date and year first above written.

CENTENE CORPORATION

By: /s/ H. Robert Sanders
Name: H. Robert Sanders
Title: Senior Vice President, Human Resources

EXECUTIVE

/s/ Kenneth Burdick
Kenneth Burdick

Exhibit 10.26

CONSULTING SERVICES AGREEMENT

This Consulting Services Agreement, together with all attachments and exhibits hereto ("Agreement") is made by and between **Centene Management Company,** a Delaware corporation ("Company") and **Kenneth A. Burdick** a natural person and resident of the state of Florida ("Consultant").

RECITALS

Whereas, Company provides managed care and related services to multiple markets and through different channels; and

Whereas, Consultant possesses unique knowledge and experiences as a former executive of Company and is qualified to provide consultative services to Company; and

Whereas, Company desires to obtain the services of Consultant and Consultant desires to provide services to Company in accordance with the terms, conditions and covenants set forth in this Agreement.

Now Therefore, in consideration of the premises and the mutual covenants and undertakings set forth herein, the parties hereto hereby agree as follows:

AGREEMENT

1. **Effective Date:** This Agreement shall be effective as of January 23, 2021 ("Effective Date") or when executed by both parties, whichever is later.

2. **Relationship of the Parties.** Consultant acknowledges that he is entering into this Agreement as an Independent Contractor and not as an employee of the Company.

   a. Consultant will not be eligible for any of the employee benefits available to active employees but the "Health Benefit Continuation" pursuant to Section 5(c) of the WellCare Severance Plan remains in effect and is not affected in any way by this consulting agreement.
   b. Consultant will not be considered an employee with regard to any laws concerning Social Security, disability insurance, unemployment compensation, federal, state or local income tax withholding at local source or any other laws, regulations or orders relating to employees. Accordingly, Consultant agrees to discharge all obligations imposed upon him as an Independent Contractor by all applicable federal, state, or local laws, regulations or orders now or hereafter in force, including, without limitation, those relating to federal, state and local income taxes and worker's compensation and including the filing of all returns and reports, and the payment of all assessments, taxes and other sums required of an Independent Contractor. Consultant shall supply the Company with a duly executed IRS Form W-9 on or prior to the commencement of services. Company shall issue information returns as required by law with respect to fees paid to Consultant each year.
   c. Consultant shall obtain and maintain any and all business and professional licenses and/or certifications required to perform the services hereunder, and shall comply with any and all licensing requirements relating thereto, including but not limited to requirements relating to insurance, education, etc.
   d. Consultant shall be free to perform services in any manner he deems to be in his best judgment, and the Company shall not, nor has the right to, control the manner and means by which Consultant performs such services. Consistent with this right, Consultant warrants that he shall use his best efforts to perform the services called for by this Agreement and in compliance with the standards, if any, set forth in the applicable Statement of Work attached hereto as Appendix A, which appendix is hereby incorporated in this Agreement ("Statement of Work").

e. Consultant is free to engage others to assist in the performance of the services under this Agreement, although Consultant retains legal and financial responsibility for all work performed. Consultant understands that Company may be subject to state, federal or other statutes, regulations or obligations that impact its Consultants and subcontractors and Consultant agrees to provide Company with advance notice prior to subcontracting with other entities.
f. Consultant is free to work his own hours and set his own schedule although Company may establish reasonable deadlines for deliverables due under this contract and may restrict access to its facilities, systems, and personnel in accordance with its business and security needs.
g. The Company neither has nor reserves the right to restrict Consultant from being concurrently engaged in another trade or business, and Consultant is free to work for others and otherwise represent and sell any other goods and services.
h. Consultant shall be responsible for all normal business expenses associated with his trade or business under this Agreement, including, but not limited to leasehold expenses, salaries, telephone, technology, office supplies, travel and lodging expenses not related to work for the Company, and Company shall not be obligated to pay any such expenses or to reimburse Consultant therefore. Unique and/or Non-recurring expenses directly related to the performance of services under this Agreement will be reimbursed by Company as set forth in the Statement of Work accompanying this Agreement.

3. **Services.** Consultant agrees to provide the services set forth on the Statement of Work attached hereto as Appendix A (the "Services"), and to do so according to the schedule and under the terms set forth therein.

4. **Compensation.** In consideration for the Services and in accordance with the schedule of payment set forth in the Statement of Work, Company agrees to pay Consultant monthly by the 15th of each month. Company will not reimburse Consultant for routine business expenses or local travel as set forth in Section 2(h). Company shall have no obligation to pay any disputed amounts until such dispute is resolved. Company is not obligated to pay Consultant any other sums.

5. **Term, renewal, and termination.**

a. **Initial Term.** This Agreement shall be effective from the Effective Date through January 23, 2022.
b. **Renewal.** After the initial term, this Agreement shall terminate unless both parties provide written notice of their intent to renew by December 1 of the year in which the Agreement is in effect.
c. **Termination.** Grounds for early termination of this Agreement include: (i) Death of Consultant; (ii) Mental or physical incapacity of Consultant lasting greater than 60 contiguous calendar days that would substantially prevent consultant from performing the Services; (iii) Mutual agreement of Company and Consultant;

6. **No right to enter into contracts for the Company.** Consultant shall have neither the right nor authority to enter into any contracts or commitments on the Company's behalf without the Company's prior written approval.

7. **Confidential information.** Consultant agrees that during and after termination of this Agreement, Consultant: (i) shall keep Confidential Information (as defined below) confidential and shall not directly or indirectly, misappropriate, use, divulge, communicate, publish or otherwise disclose or allow to be disclosed any aspect of Confidential Information without Company's prior written consent; (ii) shall refrain from any action or conduct which might reasonably or foreseeably be expected to compromise the confidentiality or proprietary nature of the Confidential Information; and (iii) shall follow recommendations made by the officers or supervisors of Company from time to time regarding Confidential Information.

a. ***"Confidential Information"*** includes but is not limited to inventions, trade secrets, business plans and records; customer files and lists; sales practices and methods; strategies and plans; sources of

supply and vendors; financial matters; research; confidential personnel matters; intellectual property; know-how; technical data; knowledge or data of Company, or any of its clients, customers, Consultants, shareholders, or affiliates; and other matters which are generally considered as confidential, that Consultant may produce, obtain or otherwise acquire or have access to during the course of his engagement with Company (whether before or after the date of this Agreement). All Confidential Information and all tangible materials containing Confidential Information are and shall remain the sole property of Company. If any portion of the work performed pursuant to this Agreement is of a classified nature, or develops into such, Consultant agrees to preserve the security of such work in compliance with all applicable rules and regulations of the United States.

b. The obligation of confidentiality will not apply to information that: (a) is known to Consultant at the time of disclosure to Consultant by Company; (b) has become publicly known through no wrongful act of Consultant; (c) has been rightfully received by Consultant from a third party without restriction on disclosure and without breach of any agreement with Company; (d) has been independently developed by Consultant outside the scope of this engagement as evidenced by appropriate documentation; or (e) has been approved for release by written authorization executed by an authorized officer of Company.

c. In the event that Consultant is required to disclose Confidential Information pursuant to applicable law, regulation or court order, Consultant may make such disclosure provided that Consultant first notifies Company of the requirement to disclose the information and allows Company reasonable opportunity to seek to protect the Confidential Information in connection with such disclosure, to the extent such notice is permitted by law.

d. The confidentiality obligations described in this Paragraph shall survive termination of this Agreement.

8. **Compliance with laws and Standards.** Consultant and his/her respective agents, employees and other personnel shall abide by: (i) all applicable federal, state and local laws, rules and regulations, pertaining to Consultant's employees; (ii) all applicable federal, state and local laws, rules and regulations, including but not limited to all applicable Medicare and Medicaid laws and regulations and all applicable laws and regulations under the Health Insurance Portability and Accountability Act ("HIPAA"); and (iii) all applicable standards of any applicable accreditation organization. Consultant hereby agrees to perform any further acts and to execute and deliver any documents or engage in any Compliance training or activities which may be reasonably necessary to carry out the provisions of this Agreement, including but not limited to Business Associate provisions required under HIPAA and any other acts or documents necessary.

9. **Conflicts of Interest.** Consultant will, at any time at Company's request, fully and accurately respond to Company's inquiry to evaluate whether, according to Company standards and in Company's sole discretion, any personal, professional, or financial conflicts of interest render Consultant unsuitable to perform the work described under this Agreement. If Consultant discloses or Company discovers what Company considers to be a conflict of interest, Company will provide Consultant with written notification of the conflict and whether it considers the conflict to be material in nature. Any non-material conflict of interest will be addressed in terms of Consultant Service assignment for the Company and will not be grounds for termination of this agreement. Any conflict which the Company deems material will be subject to the procedures for material breaches as set forth in Paragraph 5(c) above.

10. **Debarment.** Consultant represents and warrants that Consultant has never been sanctioned by the Office of Inspector General ("OIG") of the Department of Health and Human Services, sanctioned by any State agency charged with overseeing the sale, provision, or reimbursement of or for insurance services or products, barred from federal or state procurement programs, or convicted of a criminal offense with respect to health care reimbursement. Consultant shall notify Company immediately if the foregoing representation becomes untrue, or if Consultant is notified by the OIG or other enforcement agencies that an investigation has begun which could lead to such sanction, debarment, or conviction.

11. **Consultant's Obligations upon Termination.** Upon any termination of this Agreement, Consultant shall immediately cease holding himself out in any fashion as a Consultant for Company and shall return to Company all sales literature, price lists, customer lists and any Confidential Information as defined in Paragraph 7, documents, materials or tangible items pertaining to Company's business, with the exception of any items that may have been purchased by Consultant.

12. **Restriction on Trading Company Stock.** Consultant acknowledges that in the course of his performance of the Services, Consultant will come into possession of confidential and highly sensitive information regarding the Company. Accordingly, Consultant agrees not to use any confidential or financial information obtained in connection with performance of Services under this Agreement to trade or to advise others to trade in the Company's common stock or other securities. "Trading" includes not only purchases and sales of securities, but also put and call options.

13. **Rights in Deliverables.**
    a. Consultant agrees to promptly disclose to Company any and all Deliverables. "Deliverables" includes without limitation any and all notes, drawings, designs, technical data, marketing materials, know how, works of authorship, firmware, software, ideas, improvements, inventions, material, information, work or product conceived, created, written **or** first reduced to practice by Consultant either solely or jointly with others in the performance of consulting services for Company or resulting from use of Confidential Information (as defined in Paragraph 7 of this Agreement) by Consultant solely or jointly with others. Consultant agrees to assign and does hereby assign to Company its entire right, title and interest, including without limitation any copyright, mask work, patent, trade secret, trademark (including the good will associated therewith) or other intellectual property rights in and to the Deliverables.
    b. Any Intellectual Property, as defined below, which is conceived, reduced to practice, discovered, invented, and/or developed exclusively by Consultant and without the use of Company Confidential Information, as of or prior to the Effective Date of this Agreement, shall be owned exclusively by Consultant ("Consultant Pre-existing Intellectual Property"). Consultant hereby grants to Company a non-exclusive, irrevocable, royalty free, and worldwide license to use the Consultant Pre-existing Intellectual Property that may incorporated into the Deliverables
    c. Consultant also agrees, at the request and cost of Company, to promptly sign, execute, make and do all such deeds, documents, acts and things as Company may reasonably require or desire to perfect Company's entire right, title, and interest in and to any Deliverables . Consultant agrees that if Company is unable because of Consultant's unavailability, or for any other reason, to secure the signature of an authorized agent of Consultant to apply for or to pursue any application for any United States or foreign patents, mask work, copyright or trademark registrations covering the assignments to Company above, then Consultant hereby irrevocably designates and appoints Company and its duly authorized officers and agents as Consultant's agent and attorney in fact, to act for and in Consultant's behalf and stead to execute and file any such applications and to do all other lawfully permitted acts to further the prosecution and issuance of patents, copyright, mask work and trademark registrations thereon with the same legal force and effect as if executed by an authorized agent of Consultant. All costs associated with this section will be the responsibility of the Company.
    d. "Intellectual Property" means: a) patents, patent disclosures, ideas, developments, business methods, and inventions (whether patentable or not), (b) trademarks, service marks, trade dress, trade names, logos, corporate names, and domain names, together with all of the goodwill associated therewith, (c) copyrights and copyrightable works (including computer programs), and rights in data and databases, (d) trade secrets, know-how, and other confidential information, and (e) all other intellectual property rights, in each case whether registered or unregistered and including all applications for, and renewals or extensions of, such rights, and all similar or equivalent rights or forms of protection in any part of the world.

14. Consultant's Warranties.

a. Consultant warrants and represents that: (i) Consultant is free to enter into this Agreement. (ii) Consultant will not violate any duty of non-disclosure to any third party or use the confidential information of any third party in performing work under this Agreement for Company; and (iii) Consultant will not enter into any contract or agreement in conflict with this Agreement.

b. Consultant warrants that it has good and marketable title to any Background Material and Deliverables used or produced under this Agreement and that it shall not knowingly incorporate into any Deliverables any material that would infringe any copyright, trade secret, trademark or other intellectual property rights of any person or entity.

c. Consultant further warrants that and Background Material and Deliverables shall be free and clear of all liens, claims, encumbrances or demands of third parties, including any claims by any such third parties of any right, title or interest in or to the Background Material and/or Deliverables arising out of any patent, trade secret, copyright or other intellectual property right.

d. Consultant shall indemnify, defend and hold harmless the Company and its officers and directors, employees, members, and customers from any and all liability, loss, cost, damage, judgment or expense (including reasonable attorney's fees) resulting from or arising in any way out of any such claims by any third parties, and/or which are based upon, or are the result of any breach of, the warranties contained in this Paragraph. In the event of a breach of the warranties set forth in this Paragraph, in addition to all other remedies available to Company, Consultant shall, at no additional cost to Company, replace or modify the Deliverables within a reasonable time, with a functionally equivalent and conforming Deliverables at his own expense, or obtain for Company the right to continue using the Deliverables and in all other respects use its best efforts to remedy the breach.

15. Indemnification. Consultant agrees to take all necessary precautions to prevent injury to any persons (including employees of Company) or damage to property (including Company's property) during the term of this Agreement. Additionally, Consultant agrees to indemnify and hold Company harmless from and against any and all claims, demands, liabilities, damages, costs, or expenses (including attorney's fees) resulting from Consultant's failure to collect, withhold, or pay any and all federal or state taxes required to be withheld or paid by Consultant, including, without limitation, any and all income tax, social security, Medicare, or unemployment taxes. The Parties have agreed not to address the issues of hold harmless and indemnification for claims arising out of their criminal acts, violation of laws or regulations, negligence, gross negligence, or willful misconduct and the parties shall retain all their respective rights in law and equity.

16. Notices. Any and all notices required or permitted to be given under this Agreement shall be sufficient if furnished in writing and personally delivered or sent by registered or certified mail or by recognized courier service to the other as follows:

a. Notice to Consultant:

b. Notice to Company: Company shall be notified at

Centene Corporation
7700 Forsyth Blvd.
St. Louis, MO 63105
Attention: H. Robert Sanders

c. A copy of Notice to Company shall also be sent to:
General Counsel
Centene Corporation
7700 Forsyth Blvd
St. Louis, MO 63105

Changes to the address or person to whom notice should be given must be designated by written notice to the other party. Any notice required or permitted to be given will be deemed effective as of the date it is personally delivered or when signed for as received.

17. Miscellaneous.

a. **Governing law.** This Agreement shall be governed and construed in accordance with the substantive and procedural laws of the State of Missouri and Consultant consents to the jurisdiction of St. Louis County Courts for any disputes arising under or about this Agreement.

b. **Entire Agreement.** This document, including attachments and appendices referenced herein, supersedes any previous document or agreements between Consultant and Company relating to the services performed under this Agreement, sets **forth the parties' full understanding,** and contains all promises and representations between the parties as to the subject matter of this Agreement.

c. **Non-Waiver.** The failure of either party to enforce any rights hereunder shall not be deemed to be a waiver of such rights. Waiver of one breach shall not be deemed a waiver of any other breach of the same or any other provision of this Agreement.

d. **Amendment.** No modification, amendment or waiver of any of the provisions of this Agreement shall be effective unless made in writing specifically referring to this Agreement with the signed consent of all parties.

e. **Severabilitv.** If any part of this Agreement is deemed unenforceable, such portion shall be severed and the remainder of this Agreement construed without such portion.

f. **Assignment.** This Agreement shall not be assignable by Consultant without the express written permission of the Company. If Company shall merge or consolidate with or into, or sell or otherwise transfer substantially ail of its assets to, another corporation or entity, the Company may assign its rights hereunder to such other corporation or entity without the prior written consent of Consultant.

g. **Headings.** The headings of the several sections are inserted for convenience of reference only and are not intended to be a part of, or to affect the meaning or interpretation of, this Agreement.

h. **Plain meaning.** This Agreement shall be construed and interpreted fairly in accordance with the plain meaning of its terms, and there shall be no presumption or inference against the party drafting this Agreement in construing or interpreting the provisions hereof.

i. **Opportunity to consider.** Each party further acknowledges and agrees that such party has had the opportunity to consult with, or have consulted with, attorneys of its/his/her own choice regarding each term and condition of this Agreement, that they such party understands the meaning and effect of each provision contained in this Agreement, and that such party has voluntarily and knowingly entered into this Agreement. Further, Company and Consultant expressly represent and warrant that in executing this Agreement they have not relied upon any representation or statement not set forth or reflected herein made by the Company's or Consultant's agents, representatives, or attorneys with regard to the subject matter, basis, or effect of this Agreement or otherwise.

j. **Counterparts.** This Agreement may be executed in two counterparts, each signed by one party, which shall be deemed an original and together constitute one and the same Agreement.

THIS SPACE INTENTIONALLY LEFT BLANK

IN WITNESS WHEREOF, Company and Consultant have entered into this Agreement as of the Effective Date.

"Company"	"Consultant"
By: /s/ H. Robert Sanders	By: /s/ Kenneth A. Burdick
Print Name: H. Robert Sanders	Print Name: Kenneth A. Burdick
Title: EVP, Human Resources	

APPENDIX A
STATEMENT OF WORK

SERVICE TO BE PROVIDED: Provide strategic advice and counsel on issues and projects for Company and its related entities that Consultant was involved in while employed by the Company or for which Consultant has unique or specific skills or knowledge as a result of her employment with the Company including but not limited to:

- **Medicare rebranding**
- **HLK Marketing transition**
- **Coaching and mentoring of David Thomas**

These services are illustrative and it is understood by both parties that Consultant will be available for additional assignments where his knowledge and experience would be valuable to the Company.

PERIOD OF PERFORMANCE: January 23, 2021 — January 22, 2022

REQUIRED DOCUMENTATION: Consultant will create, maintain, and/or direct the creation and maintenance of documentation and business records as appropriate for the matters on which she consults.

REMUNERATION:
In consideration for the services described herein, Company agrees to pay Consultant as follows:

- **$350,000 per quarter to be paid by the 15th of February, May and September of 2021 and the final $350,000 payment to be made by January 15, 2022 but to be adjusted to reflect the estimated financial tax impact attributed to the unintended delay of Consultant's RSU grant from December 2020 to January 2021.**

If additional services are required that exceed the expected nature of the scope of the**Service to Be Provided** stated above, the Consultant may request additional remuneration above and beyond the terms described above that can be mutually agreed upon with the Company

EXPENSES:
Consultant will be reimbursed for non-standard expenses incurred in connection with provision of the services described above, including travel and lodging outside the Tampa metropolitan area. For any required air travel, Centene will provide the use of corporate aircraft on an as-available basis In accordance with the policies of Centene Corporation as stated in Section 6 of your employment letter dated May 30, 2019.

All reimbursement requests must be accompanied by receipts, invoices, purchase orders, and/or other appropriate forms of verification and must be submitted within 60 days of expenditure or 30 days of the termination of the Agreement, whichever is shorter. Company will not reimburse Consultant for routine business expenses or for meals, mileage, parking and other expenses associated with local travel.

CONTACT INFORMATION:
Primary contact for Consultant:
Name: Ken Burdick
Primary contact for Company:
Name: H. Robert Sanders

Exhibit 21

List of Subsidiaries

Absolute Total Care, Inc., a South Carolina corporation
AcariaHealth Pharmacy #11, Inc., a Texas corporation
AcariaHealth Pharmacy #12, Inc., a New York corporation
AcariaHealth Pharmacy #13, Inc., a California corporation
AcariaHealth Pharmacy #14, Inc., a California corporation
AcariaHealth Pharmacy, Inc., a California corporation
AcariaHealth Solutions, Inc., a Delaware corporation
AcariaHealth, Inc., a Delaware corporation
Access Medical Acquisition, LLC, a Delaware LLC
Access Medical Group of Florida City, LLC, a Florida LLC
Access Medical Group of Hialeah, LLC, a Florida LLC
Access Medical Group of Lakeland, LLC, a Florida LLC
Access Medical Group of Miami, LLC, a Florida LLC
Access Medical Group of North Miami Beach, LLC, a Florida LLC
Access Medical Group of Opa-Locka, LLC, a Florida LLC
Access Medical Group of Perrine, LLC, a Florida LLC
Access Medical Group of Tampa, LLC, a Florida LLC
Access Medical Group of Tampa II, LLC, a Florida LLC
Access Medical Group of Tampa III, LLC, a Florida LLC
Access Medical Group of Westchester, LLC, a Florida LLC
Accountable Care Coalition Direct Contracting, LLC, a Florida LLC
Accountable Care Coalition of Chesapeake, LLC, a Maryland LLC
Accountable Care Coalition of Community Health Centers, LLC, a Texas LLC
Accountable Care Coalition of Community Health Centers II, LLC, a Texas LLC
Accountable Care Coalition of Elite Providers II, LLC, a Delaware LLC
Accountable Care Coalition of Elite Providers, III, LLC, a Delaware LLC
Accountable Care Coalition of Elite Providers IV, LLC, a Delaware LLC
Accountable Care Coalition of Elite Providers LLC, a Hawaii LLC
Accountable Care Coalition of Elite Providers V, LLC, a Delaware LLC
Accountable Care Coalition of Elite Providers VI, LLC, a Delaware LLC
Accountable Care Coalition of Elite Providers VII, LLC, an Arizona LLC
Accountable Care Coalition of Florida Partners, LLC, a Florida LLC
Accountable Care Coalition of Georgia , LLC, a Georgia LLC
Accountable Care Coalition of Maryland, LLC, a Maryland LLC
Accountable Care Coalition of Maryland Primary Care, LLC, a Maryland LLC
Accountable Care Coalition of Mississippi, LLC, a Mississippi LLC
Accountable Care Coalition of New Jersey, Inc., a New Jersey corporation
Accountable Care Coalition of North Texas, LLC, a Texas LLC
Accountable Care Coalition of Northeast Georgia, LLC, a Georgia LLC
Accountable Care Coalition of Northeast Partners, LLC, a Pennsylvania LLC
Accountable Care Coalition of Northwest Florida, LLC, a Florida LLC
Accountable Care Coalition of Prime Health, LLC, an Oregon LLC
Accountable Care Coalition of Quality Health, LLC, an Oregon LLC
Accountable Care Coalition of Quality Health II, LLC, a Delaware LLC
Accountable Care Coalition of Quality Health III, LLC, a Delaware LLC

Accountable Care Coalition of Southeast Partners, LLC, a Georgia LLC
Accountable Care Coalition of Southeast Physician Partners, LLC, a South Carolina LLC
Accountable Care Coalition of Southeast Texas, Inc., a Texas corporation
Accountable Care Coalition of Southeast Wisconsin, LLC, a Wisconsin LLC
Accountable Care Coalition of Tennessee, LLC, a Tennessee LLC
Accountable Care Coalition of Texas, Inc., a Texas corporation
Agate Resources, Inc., an Oregon corporation
Ambetter of Magnolia, Inc., a Mississippi corporation
Ambetter of North Carolina, Inc., a North Carolina corporation
Ambetter of Peach State Inc., a Georgia corporation
America's 1st Choice California Holdings, LLC, a Florida corporation
American Progressive Life and Health Insurance Company of New York, a New York corporation
Apixio, Inc, a Delaware corporation
APS Parent, Inc., a Delaware corporation
Arch Personalized Medicine Initiative, LLC, a Missouri LLC
Arkansas Health & Wellness Health Plan, Inc., an Arkansas corporation
Arkansas Total Care, Inc., an Arkansas corporation
Arkansas Total Care Holding Company, LLC, a Delaware LLC
AWC of Syracuse, Inc., a New York corporation
B2B Gestion Integra S.L.U., a Spanish S.L.U.
B2B Salud S.L.U., a Spanish S.L.U.
Bankers Reserve Life Insurance Company of Wisconsin, a Wisconsin corporation
Blackcrow Asistencia Medica, S.L, a Spanish S.L.
Bridgeway Health Solutions LLC, a Delaware LLC
Bridgeway Health Solutions of Arizona, Inc., an Arizona corporation
Buckeye Community Health Plan, Inc., an Ohio corporation
Buckeye Health Plan Community Solutions, Inc., an Ohio corporation
Calibrate Acquisition Company, a Delaware corporation
California Health and Wellness Plan, a California corporation
Cantina Laredo Clayton, LP, a Delaware limited partnership
Care1st Health Plan Administrative Services, Inc., an Arizona corporation
Care 1st Health Plan of Arizona, Inc., an Arizona corporation
Carolina Complete Health Holding Company Partnership, a Delaware partnership
Carolina Complete Health, Inc., a North Carolina corporation
Casenet S.R.O., a Czech Republic S.R.O.
Casenet, LLC, a Delaware LLC
CCTX Holdings, LLC, a Texas LLC
Celtic Group, Inc., a Delaware corporation
Celtic Insurance Company, an Illinois corporation
CeltiCare Health Plan Holdings LLC, a Delaware LLC
CeltiCare Health Plan of Massachusetts, Inc., a Massachusetts corporation
Cenpatico Behavioral Health of Arizona, LLC, an Arizona LLC
Cenpatico Behavioral Health, LLC, a California LLC
Cenpatico of Arizona Inc., an Arizona corporation
Centene Center, LLC, a Delaware LLC
Centene Center I, LLC, a Delaware LLC
Centene Center II, LLC, a Delaware LLC
Centene Company of Texas, LP, a Texas limited partnership
Centene Europe Finance Company Limited, a limited liability Malta company

Centene Health Plan Holdings, Inc., a Delaware corporation
Centene Institute for Advanced Health Education, LLC, a Delaware LLC
Centene International Ventures, LLC, a Delaware LLC
Centene Investments, LLC, a Delaware LLC
Centene Management Company, LLC, a Wisconsin LLC
Centene Venture Company Alabama Health Plan, Inc., an Alabama corporation
Centene Venture Company Florida, Inc., a Florida corporation
Centene Venture Company Illinois, Inc., an Illinois corporation
Centene Venture Company Indiana, Inc., an Indiana corporation
Centene Venture Company Kansas, Inc., a Kansas corporation
Centene Venture Company Michigan, Inc., a Michigan corporation
Centene Venture Company Tennessee, Inc., a Tennessee corporation
Centro Inmunologocia De La Comunidad Valenciana, S.L., a Spanish S.L.
Centurion Correctional Healthcare of New Mexico, LLC, a New Mexico LLC
Centurion Detention Health Services, LLC, a Delaware LLC
Centurion of Arizona, LLC, an Arizona LLC
Centurion of Delaware, LLC, a Delaware LLC
Centurion of Florida, LLC, a Florida LLC
Centurion of Kansas, LLC, a Kansas LLC
Centurion of Minnesota, LLC, a Minnesota LLC
Centurion of Mississippi, LLC, a Mississippi LLC
Centurion of New Hampshire, LLC, a Delaware LLC
Centurion of Pennsylvania, LLC, a Pennsylvania LLC
Centurion of Tennessee, LLC, a Tennessee LLC
Centurion of Vermont, LLC, a Vermont LLC
Centurion of West Virginia, LLC, a West Virginia LLC
Centurion of Wyoming, LLC, a Wyoming LLC
Centurion, LLC, a Delaware LLC
Chrysalis Medical Services, LLC, a New Jersey LLC
Clinica Santo Domingo De Lugo, S.L., a Spanish S.L.
CMC Real Estate Company, LLC, a Delaware LLC
Collaborative Health Systems, LLC, a New York LLC
Collaborative Health Systems IPA, LLC, a Florida LLC
Collaborative Health Systems of Maryland, LLC, a Maryland LLC
Collaborative Health Systems of Virginia, LLC, a Virginia LLC
Comfort Hospice of Missouri, LLC, a Michigan LLC
Comfort Hospice of Texas, LLC, a Michigan LLC
ComfortBrook Hospice, LLC, an Ohio LLC
Community Medical Holdings Corporation, a Delaware corporation
Comprehensive Health Management, Inc., a Florida corporation
Comprehensive Reinsurance, Ltd., a Cayman Islands corporation
Coordinated Care Corporation, an Indiana corporation
Coordinated Care of Washington, Inc., a Washington corporation
Country Style Health Care, LLC, a Texas LLC
CT Poprad, s.r.o., a Slovakia S.R.O.
CT Presov s.r.o., a Slovakia S.R.O.
Discare CZ, a.s., a Czech Republic A.S.
District Community Care, Inc., a Washington D.C. corporation
Dr Magnet s.r.o., a Slovakia S.R.O.

Elche-Crevillente Salud, a Spanish S.A.
Envolve Benefits Options, Inc., a Delaware corporation
Envolve Captive Insurance Company, Inc., a South Carolina corporation
Envolve Dental, Inc., a Delaware corporation
Envolve Dental of Florida, Inc., a Florida corporation
Envolve Dental of Texas, Inc., a Texas corporation
Envolve Dental IPA of New York, Inc., a New York corporation
Envolve Holdings, Inc., a Delaware corporation
Envolve, Inc., a Delaware corporation
Envolve PeopleCare, Inc., a Delaware corporation
Envolve Pharmacy IPA, LLC, a New York LLC
Envolve Pharmacy Solutions, Inc., a Delaware corporation
Envolve Optical, Inc. a Delaware corporation
Envolve Total Vision, Inc., a Delaware corporation
Envolve Vision Benefits, Inc., a Delaware corporation
Envolve Vision, Inc., a Delaware corporation
Envolve Vision IPA of New York, Inc., a New York corporation
Envolve Vision of Florida, Inc., a Florida corporation
Envolve Vision of Texas, Inc., a Texas corporation
Essential Care Partners, LLC, a Texas LLC
Exactus Pharmacy Solutions, Inc., a Delaware corporation
Family Nurse Care II, LLC, a Michigan LLC
Family Nurse Care of Ohio, LLC, a Michigan LLC
Family Nurse Care, LLC, a Michigan LLC
Forensic Health Services, LLC, a Delaware LLC
Foundation Care, LLC, a Missouri LLC
Godgrace Asistencia Medica, S.L., a Spanish S.L.
Golden Triangle Physician Alliance, a Texas not-for-profit corporation
Grace Hospice of Austin, LLC, a Michigan LLC
Grace Hospice of Grand Rapids, LLC, a Michigan LLC
Grace Hospice of Illinois, LLC, an Illinois LLC
Grace Hospice of Indiana, LLC, a Michigan LLC
Grace Hospice of San Antonio, LLC, a Michigan LLC
Grace Hospice of Virginia, LLC, a Michigan LLC
Grace Hospice of Wisconsin, LLC, a Michigan LLC
Granite State Health Plan, Inc., a New Hampshire corporation
Growly Asistencia Sanitaria, S.L., a Spanish S.L.
Hallmark Life Insurance Company, an Arizona corporation
Harmony Behavioral Health, Inc., a Florida corporation
Harmony Behavioral Health IPA, Inc., a New York corporation
Harmony Health Management, Inc., a New Jersey corporation
Harmony Health Plan, Inc., an Illinois corporation
Harmony Health Systems Inc., a New Jersey corporation
Health Care Enterprises, LLC, a Delaware LLC
Health Net Access, Inc., an Arizona corporation
Health Net Community Solutions, Inc., a California corporation
Health Net Community Solutions of Arizona, Inc., an Arizona corporation
Health Net Federal Services, LLC, a Delaware LLC
Health Net Health Plan of Oregon, Inc., an Oregon corporation

Health Net Life Insurance Company, a California corporation
Health Net Life Reinsurance Company, a Cayman Islands corporation
Health Net, LLC, a Delaware LLC
Health Net of Arizona, Inc., an Arizona corporation
Health Net of California, Inc., a California corporation
Health Net Pharmaceutical Services, a California corporation
Health Plan Real Estate Holdings, Inc., a Missouri corporation
HealthSmart Benefit Solutions, Inc., an Illinois corporation
HealthSmart Benefits Management, LLC, a Texas LLC
HealthSmart Care Management Solutions, LP, a Texas partnership
HealthSmart Information Systems, Inc., a Texas corporation
HealthSmart Preferred Care II, LP, a Texas partnership
HealthSmart Preferred Network II Inc., a Delaware corporation
HealthSmart Primary Care Clinics, LP, a Texas partnership
HealthSmart Rx Solutions, Inc., an Ohio corporation
Healthy Louisiana Holdings, LLC, a Delaware LLC
Healthy Missouri Holdings, Inc., a Missouri corporation
Healthy Washington Holdings, Inc., a Delaware corporation
Heritage Health Systems, Inc., a Texas corporation
Heritage Health Systems of Texas, Inc., a Texas corporation
Heritage Home Hospice, LLC, a Michigan LLC
Heritage Physician Networks, a Texas not-for-profit corporation
HHS Texas Management, Inc., a Texas corporation
HHS Texas Management, LP, a Texas limited partnership
Home State Health Plan, Inc., a Missouri corporation
HomeScripts.com, LLC, a Michigan LLC
Hospice DME Company, LLC, a Michigan LLC
Hospinet, S.L.,a Spanish S.L.
Hospital Polusa, S.A., a Spanish S.A.
Hospital Povisa, S.A., a Spanish S.A.
Hudson Accountable Care, LLC, a New York LLC
IAH of Florida, LLC, a Florida LLC
Illinois Health Practice Alliance, LLC, a Delaware corporation
Infraestructuras y Servicios de Alzira S. L., a Spanish S.L.
Integrated Care Network of Florida, LLC, a Delaware LLC
Integrated Mental Health Management LLC, a Texas LLC
Integrated Mental Health Services, a Texas corporation
Interpreta Holdings, Inc., a Delaware corporation
Interpreta, Inc., a Delaware corporation
Iowa Total Care, Inc., an Iowa corporation
Kentucky Spirit Health Plan, Inc., a Kentucky corporation
LBB Industries, Inc., a Texas corporation
LifeShare Management Group, LLC, a New Hampshire LLC
LiveHealthier, Inc., a Delaware corporation
Louisiana Healthcare Connections, Inc., a Louisiana corporation
Magnolia Health Plan, Inc., a Mississippi corporation
Managed Health Network, a California corporation
Managed Health Network, LLC, a Delaware LLC
Managed Health Services Insurance Corporation, a Wisconsin corporation

Maryland Collaborative Care, LLC, a Maryland LLC
Maryland Collaborative Care Transformation Organization, Inc., a Delaware corporation
Mauli Ola Health and Wellness, Inc., a Hawaii corporation
Medicina NZ, spol s.r.o., a Slovakia S.R.O.
Meridian Health Plan of Illinois, Inc., an Illinois corporation
Meridian Health Plan of Michigan, Inc., a Michigan corporation
Meridian Management Company, LLC (a/k/a Meridian Administration Company, LLC), a Michigan LLC
Meridian Network Services, LLC, a Michigan LLC
MeridianRx, LLC, a Michigan LLC
MeridianRx IPA, LLC, a New York LLC
MeridianRx of Indiana, LLC, a Michigan LLC
MH Services International Holdings (UK) Limited, an English and Welsh private company
MHM Services, Inc., a Delaware corporation
MHM Correctional Services, LLC, a Delaware LLC
MHM Services of California, LLC, a California LLC
MHM Solutions, LLC, a Delaware LLC
MHM Health Professionals, LLC, a Delaware LLC
MHN Government Services LLC, a Delaware LLC
MHN Services, LLC, a California LLC
MHS Consulting International, Inc., a Delaware corporation
MHS Travel & Charter, Inc., a Wisconsin corporation
Michigan Complete Health, a Michigan corporation
Mid-Atlantic Collaborative Care, LLC, a Maryland LLC
MR Centrum Melnick, s.r.o., a Czech Republic S.R.O.
MR Poprad, s.r.o., a Slovakia S.R.O.
MR Zilina, s.r.o., a Slovakia S.R.O.
Nebraska Total Care, Inc., a Nebraska corporation
Network Providers, LLC, a Delaware LLC
New York Quality Healthcare Corporation, a New York corporation
Next Door Neighbors, Inc., a Delaware corporation
Next Door Neighbors, LLC., a Delaware LLC
nirvanaHealth, LLC, a Delaware LLC
Northern Maryland Collaborative Care, LLC, a Maryland LLC
North Florida Health Services, Inc., a Florida corporation
Novasys Health, Inc., a Delaware corporation
OB Care, a Czech Republic S.R.O.
OB Klinika, a Czech Republic A.S.
Ohana Health Plan, Inc., a Hawaii corporation
Oklahoma Complete Health Inc., an Oklahoma corporation
One Care by Care 1st Health Plans of Arizona, Inc, an Arizona corporation
Operose Health (Group) Ltd., an English and Welsh private company
Operose Health (Group) UK Ltd., an English and Welsh private company
Operose Health Ltd., an English and Welsh private company
Pantherx Access Services, LLC, a Pennsylvania LLC
Panther Pass Co, LLC, a Pennsylvania LLC
Pantherx Specialty, LLC, a Pennsylvania LLC
Panther Specialty Holding Co, LLC, a Pennsylvania LLC
Parker LP, LLC, a Nevada LLC
Peach State Health Plan, Inc., a Georgia corporation

Penn Marketing America, LLC, a Delaware LLC
Pennsylvania Health and Wellness, Inc., a Pennsylvania corporation
Phoenix Home Health Care, LLC, a Delaware LLC
Pinnacle Home Care, LLC, a Texas LLC
Pinnacle Senior Care of Illinois, LLC, an Illinois LLC
Pinnacle Senior Care of Indiana, LLC, a Michigan LLC
Pinnacle Senior Care of Kalamazoo, LLC, a Michigan LLC
Pinnacle Senior Care of Missouri, LLC, a Michigan LLC
Pinnacle Senior Care of Wisconsin, LLC, a Wisconsin LLC
Premier Marketing Group, LLC, a Delaware LLC
PrimeroSalud, S.L., a Spanish S.L.
Pro Diagnostic Group, A.S., a Slovakia A.S.
Pro Magnet, s.r.o, a Slovakia S.R.O.
Pro Magnet CZ, s.r.o., a Czech Republic S.R.O.
Pro RTG, s.r.o, a Slovakia S.R.O.
Progress Medical A.S., a Czech Republic A.S.
Prowl Holdings, LLC, a Delaware LLC
QCA Healthplan, Inc., an Arkansas corporation
Qualchoice Life and Health Insurance Company, and Arkansas company
Quincy Coverage Corporation, a New York corporation
R&C Healthcare, LLC, a Texas LLC
Rapid Respiratory Services, LLC, a Delaware LLC
Ribera Lab, S.L.U., a Spanish S.L.U.
Ribera Salud II, a Spanish UTE
Ribera Slaud Infraestructuras S.L.U., a Spanish S.L.U.
Ribera Salud Proyectos S.L., a Spanish S.L.
Ribera Salud Tecnologias S.L.U., a Spanish S.L.U.
Ribera Salud, S.A., a Spanish S.A.
Ribera-Quilpro UTE, a Spanish UTE
RMED, LLC, a Florida LLC
RX Direct, Inc., a Texas corporation
Salus Administrative Services, Inc., a New York corporation
Salus IPA, LLC, a New York LLC
Secure Capital Solutions 2000, S.L.U., a Spanish S.L.U.
SelectCare Health Plans, Inc., a Texas corporation
SelectCare of Texas, Inc., a Texas corporation
Seniorcorps Peninsula, LLC, a Virginia LLC
Servicios De Mantenimiento Prevencor, S.L.U., a Spanish S.L.U.
SilverSummit Healthplan, Inc., a Nevada corporation
Social Health Bridge Trust, a Delaware trust
Social Health Bridge, LLC, a Delaware LLC
Specialty Therapeutic Care Holdings, LLC, a Delaware LLC
Specialty Therapeutic Care, GP, LLC, a Texas LLC
Specialty Therapeutic Care, LP, a Texas limited partnership
Sunflower State Health Plan, Inc., a Kansas corporation
Sunshine Health Community Solutions, Inc., a Florida corporation
Sunshine Health Holding, LLC, a Florida LLC
Sunshine State Health Plan, Inc., a Florida corporation
Superior HealthPlan, Inc., a Texas corporation

Superior HealthPlan Community Solutions, Inc., a Texas corporation
The Practice Properties Limited, an English and Welsh private company
The WellCare Management Group, Inc., a New York corporation
Torrejon Salud, S.A., a Spanish S.A.
Torrevieja Salud S.L.U., a Spanish S.L.U.
Torrevieja Salud UTE, a Spanish UTE
Traditional Home Health Services, LLC, a Texas LLC
Trillium Community Health Plan, Inc., an Oregon corporation
UAM Agent Services Corp., an Iowa corporation
Universal American Corp., a Delaware corporation
Universal American Holdings, LLC, a Delaware LLC
Universal American Financial Services, Inc., a Delaware corporation
U.S. Medical Management Holdings, Inc., a Delaware corporation
U.S. Medical Management, LLC, a Delaware LLC
USMM Accountable Care Partners, LLC, a Delaware LLC
WCG Health Management, Inc., a Delaware corporation
Windsor Health Group, Inc., a Tennessee corporation
WellCare Health Insurance Company of America, an Arkansas corporation
WellCare Health Insurance Company of Kentucky, Inc., a Kentucky corporation
WellCare Health Insurance Company of Louisiana, Inc., a Louisiana corporation
WellCare Health Insurance Company of Nevada, Inc., a Nevada corporation
WellCare Health Insurance Company of Oklahoma, Inc., an Oklahoma corporation
WellCare Health Insurance Company of Washington, Inc., a Washington corporation
WellCare Health Insurance Company of Wisconsin, Inc., a Wisconsin corporation
WellCare Health Insurance Company of New Hampshire, Inc., a New Hampshire corporation
WellCare Health Insurance Company of New Jersey, Inc., a New Jersey corporation
WellCare Health Insurance of Arizona, Inc., an Arizona corporation
WellCare Health Insurance of Connecticut, Inc., a Connecticut corporation
WellCare Health Insurance of Hawaii, Inc., a Hawaii corporation
WellCare Health Insurance of New York, Inc., a New York corporation
WellCare Health Insurance of North Carolina, Inc., a North Carolina corporation
WellCare Health Insurance of Southwest, Inc., an Arizona corporation
WellCare Health Insurance of Tennessee, Inc., a Tennessee corporation
WellCare Health Plans, Inc., a Delaware corporation
WellCare Health Plans of Arizona, Inc., an Arizona corporation
WellCare Health Plans of California, Inc., a California corporation
WellCare Health Plans of Kentucky, Inc., a Kentucky corporation
WellCare Health Plans of Massachusetts, Inc., a Massachusetts corporation
WellCare Health Plans of Missouri, Inc., a Missouri corporation
WellCare Health Plans of New Jersey, Inc., a New Jersey corporation
WellCare Health Plans of Rhode Island, Inc., a Rhode Island corporation
WellCare Health Plans of Tennessee, Inc., a Tennessee corporation
WellCare Health Plans of Vermont, Inc., a Vermont corporation
WellCare Health Plans of Wisconsin, Inc., a Wisconsin corporation
WellCare National Health Insurance Company, a Texas corporation
WellCare of Alabama, Inc., an Alabama corporation
WellCare of Arkansas, Inc., an Arkansas corporation
WellCare of California, Inc., a California corporation
WellCare of Connecticut, Inc., a Connecticut corporation

WellCare of Florida, Inc., a Florida corporation
WellCare of Georgia, Inc., a Georgia corporation
WellCare of Illinois, Inc., an Illinois corporation
WellCare of Indiana, Inc., an Indiana corporation
WellCare of Kansas, Inc., a Kansas corporation
WellCare of Maine, Inc., a Maine corporation
WellCare of Michigan Holding Company, a Michigan corporation
WellCare of Missouri Health Insurance Company, Inc., a Missouri corporation
WellCare of Mississippi, Inc., a Mississippi corporation
WellCare of New Hampshire, Inc., a New Hampshire corporation
WellCare of New York, Inc., a New York corporation
WellCare of North Carolina, Inc., a North Carolina corporation
WellCare of Ohio, Inc., an Ohio corporation
WellCare of Oklahoma, Inc., an Oklahoma corporation
WellCare of Pennsylvania, Inc., a Pennsylvania corporation
WellCare of Puerto Rico, Inc., a Puerto Rico corporation
WellCare of South Carolina, Inc., a South Carolina corporation
WellCare of Texas, Inc., a Texas corporation
WellCare of Virginia, Inc., a Virginia corporation
WellCare of Washington, Inc., a Washington corporation
WellCare Pharmacy Benefits Management, Inc., a Delaware corporation
WellCare Prescription Insurance, Inc., an Arizona corporation
Western Sky Community Care, Inc., a New Mexico corporation
Winning Security, S.L., a Spanish S.L.
Worlco Management Services, Inc., a New York corporation

Exhibit 23

Consent of Independent Registered Public Accounting Firm

The Board of Directors
Centene Corporation:

We consent to the incorporation by reference in the registration statements on Form S-8 (Nos. 333-238597, 333-236036, 333-217634, 333-210376, 333-197737, 333-180976, 333-108467 and 333-90976) and in the registration statements on Form S-3 (Nos. 333-238050 and 333-209252) of Centene Corporation of our reports dated February 22, 2021, with respect to the consolidated balance sheets of Centene Corporation and subsidiaries as of December 31, 2020 and 2019, the related consolidated statements of operations, comprehensive earnings, stockholders' equity, and cash flows for each of the years in the three-year period ended December 31, 2020 and the related notes (collectively, the consolidated financial statements), and the effectiveness of internal control over financial reporting as of December 31, 2020, which reports appear in the December 31, 2020 annual report on Form 10-K of Centene Corporation.

/s/ KPMG LLP

St. Louis, Missouri
February 22, 2021

EXHIBIT 31.1

CERTIFICATION

I, Michael F. Neidorff, certify that:

1. I have reviewed this Annual Report on Form 10-K of Centene Corporation;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

    a. Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

    b. Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

    c. Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

    d. Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

    a. All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

    b. Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: February 22, 2021

/s/ MICHAEL F. NEIDORFF

Chairman, President and Chief Executive Officer
(principal executive officer)

EXHIBIT 31.2

CERTIFICATION

I, Jeffrey A. Schwaneke, certify that:

1. I have reviewed this Annual Report on Form 10-K of Centene Corporation;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

    a. Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

    b. Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

    c. Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

    d. Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting;

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

    a. All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

    b. Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: February 22, 2021

/s/ JEFFREY A. SCHWANEKE

Executive Vice President and Chief Financial Officer
(principal financial officer)

EXHIBIT 32.1

CERTIFICATION PURSUANT TO 18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Annual Report on Form 10-K of Centene Corporation (the Company) for the period ended December 31, 2020, as filed with the Securities and Exchange Commission on the date hereof (the Report), the undersigned, Michael F. Neidorff, Chairman and Chief Executive Officer of the Company, hereby certifies, pursuant to 18 U.S.C. Section 1350, that:

(1) the Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: February 22, 2021

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

EXHIBIT 32.2

CERTIFICATION PURSUANT TO 18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Annual Report on Form 10-K of Centene Corporation (the Company) for the period ended December 31, 2020, as filed with the Securities and Exchange Commission on the date hereof (the Report), the undersigned, Jeffrey A. Schwaneke, Executive Vice President and Chief Financial Officer of the Company, hereby certifies, pursuant to 18 U.S.C. Section 1350, that:

(1) the Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: February 22, 2021

/s/ JEFFREY A. SCHWANEKE

Executive Vice President and Chief Financial Officer
(principal financial officer)