Section 1: 10-K (10-K)

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

FORM 10-K

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

For the Fiscal Year Ended December 31, 2018

OR

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

For the Transition Period From to

Commission File Number 001-32209

WellCare Health Plans, Inc.

(Exact Name of Registrant as Specified in Its Charter)

Delaware	**47-0937650**
(State or Other Jurisdiction of Incorporation or Organization)	(I.R.S. Employer Identification No.)
8735 Henderson Road, Renaissance One Tampa, Florida	**33634**
(Address of Principal Executive Offices)	(Zip Code)

(813) 290-6200
Registrant's telephone number, including area code
Securities registered pursuant to Section 12(b) of the Exchange Act:

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

Securities registered pursuant to Section 12(g) of the Exchange Act:
NONE

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

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

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

Indicate by check mark whether the registrant has submitted electronically, every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes ☒ No ☐

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

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

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

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

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

The aggregate market value of Common Stock held by non-affiliates of the registrant (assuming solely for the purposes of this calculation that all directors and executive officers of the registrant are "affiliates") as of June 30, 2018 was approximately $11.0 billion (based on the closing sale price of the registrant's Common Stock on that date as reported on the New York Stock Exchange).

As of February 11, 2019, there were 49,994,718 outstanding shares of the registrant's Common Stock, par value $0.01 per share.

Documents Incorporated by Reference: Portions of the registrant's definitive Proxy Statement for the 2019 Annual Meeting of Stockholders are incorporated by reference into Part III of this Form 10-K.

TABLE OF CONTENTS

References to the "Company," "WellCare," "we," "our," and "us" in this Annual Report on Form 10-K for the fiscal year ended December 31, 2018 (the "2018 Form 10-K") refer to WellCare Health Plans, Inc., together, in each case, with our subsidiaries and any predecessor entities unless the context suggests otherwise.

FORWARD-LOOKING STATEMENTS

Statements contained in this Form 10-K for the year ended December 31, 2018 ("2018 Form 10-K"), which are not historical fact may be forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 and Section 21E of the Securities Exchange Act of 1934, as amended, (the "Exchange Act"), and we intend such statements to be covered by the safe harbor provisions for forward-looking statements contained therein. Such statements, which may address, among other things, our financial outlook, the timing of the launch of new programs, pending new Medicaid contracts, the appropriation and payment to us by state governments of Medicaid premiums receivable, the financial effect of recent acquisitions, including integration costs, rate changes, market acceptance of our products and services, our ability to finance growth opportunities, our ability to respond to changes in laws and government regulations, including any repeal, replacement or modification of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, the "ACA"), implementation of our growth strategies, projected capital expenditures, liquidity and the availability of additional funding sources may be found in the sections of this 2018 Form 10-K entitled "*Business*," "*Risk Factors*," "*Management's Discussion and Analysis of Financial Condition and Results of Operations*" and elsewhere in this report generally. In some cases, you can identify forward-looking statements by terminology such as "may," "will," "should," "expects," "plans," "anticipates," "believes," "estimates," "targets," "predicts," "potential," "continues" or the negative of such terms or other comparable terminology. Forward-looking statements involve risks and uncertainties, including economic, regulatory, competitive and other factors that may affect our business. These forward-looking statements are inherently susceptible to uncertainty and changes in circumstances, as they are based on management's expectations and beliefs about future events and circumstances. Given the risks and uncertainties inherent in forward-looking statements, any of our forward-looking statements could be incorrect and investors are cautioned not to place undue reliance on any of our forward-looking statements. Subsequent events and developments may cause actual results to differ, perhaps materially, from our forward-looking statements. We undertake no duty and expressly disclaim any obligation to update publicly any forward-looking statements for any reason, even if new information becomes available or other events occur in the future.

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

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

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

PART I

Item 1. Business.

OVERVIEW

We are a leading managed care company, headquartered in Tampa, Florida, and focus primarily on providing government-sponsored managed care services to families, children, seniors and individuals with complex medical needs primarily through Medicaid, Medicare Advantage ("MA") and Medicare Prescription Drug Plans ("PDP"), as well as individuals in the Health Insurance Marketplace. As of December 31, 2018, we served approximately 5.5 million members nationwide. We estimate that we are among the largest managed care organizations providing Medicaid managed care services plans, MA Plans and PDPs, as measured by membership. Our broad range of experience and government focus allows us to effectively serve our members, partner with our providers, government clients and communities we serve, and efficiently manage our ongoing operations.

As of December 31, 2018, we operated Medicaid health plans, including states where we receive Medicaid premium revenues associated with dually eligible special needs plans, in Arizona, Florida, Georgia, Hawaii, Illinois, Kentucky, Michigan, Missouri, Nebraska, New Jersey, New York, South Carolina and Texas.

In addition, as of December 31, 2018, we also operated MA coordinated care plans ("CCPs") in Arizona, Arkansas, California, Connecticut, Florida, Georgia, Hawaii, Illinois, Indiana, Kentucky, Louisiana, Maine, Michigan, Mississippi, New Jersey, New York, North Carolina, Ohio, South Carolina, Tennessee and Texas. We also offered stand-alone Medicare PDPs in 50 states and the District of Columbia.

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

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

Membership Concentration

In the following table, we have summarized membership for our business segments in each state that exceeded 5% of our total membership, as well as all other states in the aggregate, as of December 31, 2018.

State	Medicaid Health Plans [2]	Medicare Health Plans [2]	Medicare PDPs	Total Membership	Percent of Total Membership
Illinois	842,000	27,000	35,000	904,000	16.3%
Florida	777,000	96,000	29,000	902,000	16.3%
Georgia	493,000	51,000	15,000	559,000	10.1%
Michigan	500,000	19,000	44,000	563,000	10.2%
Kentucky	444,000	14,000	22,000	480,000	8.7%
New York	155,000	88,000	52,000	295,000	5.3%
Other states [1]	720,000	250,000	860,000	1,830,000	33.0%
Health Insurance Marketplace[3]	—	—	—	5,000	0.1%
Total	3,931,000	545,000	1,057,000	5,538,000	100.0%

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

(2) Medicaid Health Plans and Medicare Health Plans membership includes members who are dually-eligible and participate in both our Medicaid and Medicare programs. The dually-eligible membership was 68,000 at December 31, 2018.

(3) Health Insurance Marketplace, included in our Corporate and Other category as it does not meet the quantification thresholds required by generally accepted accounting principles and therefore not individually reportable, includes members from Michigan. Total Michigan membership is 568,000 members.

Acquisitions

On November 30, 2018, we completed the purchase of Aetna Inc.'s ("Aetna") entire standalone Medicare Part D prescription drug plan membership ("Aetna Part D membership"), which Aetna divested as part of CVS Health Corporation's acquisition of Aetna, for a total consideration of $107.2 million, which is subject to certain true-up provisions. Per the terms of the agreements, Aetna will provide administrative services to, and retain financial risk of, the Aetna Part D membership through 2019. Therefore, the Aetna Part D membership will be excluded from our membership and results of operations until January 1, 2020.

On September 1, 2018, we completed the acquisition of Meridian. The estimated purchase price, subject to certain purchase price adjustments, was approximately $2.5 billion.

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

OUR VISION, MISSION AND STRATEGY

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

Mission

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

Vision

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

Strategy

Overview

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

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

Population Health and Integration

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

Regulatory and Provider Partnerships

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

Local Markets and Community Connections

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

Delivering Prudent, Profitable Long-Term Growth

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

We align our expense structure with our revenue base and continually assess opportunities to maintain appropriate medical benefit ratios, obtain actuarially-sound rates, and manage administrative costs to generate earnings that enable us to reinvest in our business and members. With respect to medical benefits expense, our initiatives are focused on quality improvement, reductions in unit costs, optimizing utilization of services, and eliminating waste and abuse. We also continue to invest in technology, regulatory compliance, and other infrastructure to improve efficiency and service quality to our members and providers. For more information regarding our SG&A ratio, please see Item 6 - *Selected Financial Data* as well as Item 7 - *Management's Discussion and Analysis of Financial Condition and Results of Operations*.

For a list of key developments and accomplishments relating to progress on our business strategy that occurred or affected our results of operations, financial condition or cash flows during 2018, and in the 2019 period prior to issuance of this 2018 Form 10-K, please see Item 7 - *Management's Discussion and Analysis of Financial Condition and Results of Operations, Key Developments and Accomplishments*.

OUR BUSINESS - MEDICAID AND MEDICARE HEALTH PROGRAMS

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

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

As of December 31, 2018, our Medicare plans are primarily offered under the WellCare name, for which we hold a federal trademark registration. In Hawaii and California, we offer our plans under the names 'Ohana and Easy Choice, respectively. Additionally, certain of our Texas and northeast plans are offered under the Texan Plus and Today's Options names, respectively. In Michigan, Indiana and Ohio, and certain plans in Illinois, we offer our plans under the Meridian name. For our Medicaid plans, we offered a number of brand names depending on the state, consisting of Care1st Arizona, Staywell in Florida, 'Ohana in Hawaii, Meridian in Illinois and Michigan, Missouri Care in Missouri and, until December 31, 2018, Harmony in Illinois, and the WellCare brand name in Georgia, Kentucky, Nebraska, New Jersey, New York and South Carolina.

Medicaid

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

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

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

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

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

Children's Health Insurance Program

The Children's Health Insurance Program is a joint federal-state program established to provide coverage to uninsured children in families whose incomes are too high to qualify for Medicaid. To encourage states to participate, CHIP provided states with enhanced federal financing and greater flexibility in program design compared to Medicaid. We provide services under CHIP in ten states. In some states, like Hawaii, those beneficiaries are served as a part of the state's Medicaid program. In other states, including New York and Florida, the state's CHIP is operated separately. CHIP was established in 1997 to serve low-income, uninsured children. In some states, the program was extended to the parents of those children. As a result of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively, the "ACA"), parents previously covered under CHIP may now instead be covered through the state's Medicaid expansion or may be eligible for premium assistance and other subsidies through the state or federal exchange, as applicable. Accordingly, CHIP programs are sometimes referred to as expansion programs. The ACA maintained CHIP eligibility standards for children in place as of enactment through 2019.

On January 22, 2018, CHIP funding was extended for six years as part of a broader continuing resolution to fund the federal government and further extended to 2027 by the Bipartisan Budget Act of 2018, on February 9, 2018. The resolution extended the requirement for states to maintain coverage for children from 2019 through 2023, but on or after October 1, 2019, the requirement is limited to children in families with incomes at or below 300% of the federal poverty level.

Medicare

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

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

PPO products offer seniors the ability to obtain services from out-of-network providers with additional out-of-pocket expenses. For the year ended December 31, 2018, we offered PPO products in Florida, Georgia, New York and South Carolina. As more seniors opt for plan flexibility, our ability to offer a choice of products will be important to attracting more customers.

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

We offer a Chronic Special Needs Plan ("C-SNP"), which limits enrollment to individuals with specific severe or disabling chronic conditions. C-SNP plans focus on monitoring health status, managing chronic diseases, avoiding inappropriate hospitalizations and helping beneficiaries move from high risk to lower risk on the care continuum. CMS has approved 15 C-SNPs specific to certain chronic conditions. Our C-SNP program targets cardiovascular disorders and is limited to certain counties in Florida.

Beneficiaries enrolled in Original Medicare can either join a stand-alone PDP plan or forgo Part D prescription drug coverage. Beneficiaries enrolled in Medicare Advantage plans can join a plan with Part D coverage (a "MA-PD" plan), select a stand-alone PDP plan or forgo Part D prescription drug coverage. Beneficiaries who are dually eligible for Medicare and Medicaid, and certain beneficiaries who qualify for a low-income subsidy ("LIS"), but who do not enroll in a MA plan with drug benefits or a PDP, are automatically assigned to a plan by CMS. These assignments are made among those PDPs that submitted bids below the applicable regional benchmarks for standard Part D plans established annually by CMS.

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

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

Dual-eligibles

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

Improved care coordination is imperative to enhance care options for dual-eligibles as an aging population and increased life expectancy among Americans with disabilities increase the dual-eligible population. As such, dual-eligible programs have become an immediate target for both spending reductions and attempts to improve the quality of care beneficiaries receive. The ACA created a federal Medicare-Medicaid Coordination Office to serve dual-eligibles. This Medicare-Medicaid Coordination Office has initiated a series of state Duals Demonstration Programs intended to provide better coordination and integration of care between Medicare and Medicaid on a capitated or fee-for-service basis, which is required to produce cost savings. As of January 1, 2019, we operate dual special needs plans ("D-SNPs") in 19 states.

General Economic and Political Environment Affecting our Business

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

The 115th Congress proposed several plans to cut or restructure Medicare including raising the Medicare eligibility age, moving Medicare to a defined contribution model, converting Medicare to a voucher system and various other modifications including cuts to provider reimbursement. Medicaid is similarly situated, consuming ever greater portions of the federal budget. As a result, the 115th Congress also considered several proposals to modify the Medicaid program including moving from a match program to block grants, moving to a per-capita capitation system, limiting the use of provider taxes to fund the state’s portion of the Medicaid program, as well as modifying the ACA Medicaid expansions. While legislative efforts to restructure Medicare and modify the Medicaid programs have stalled following the 2018 midterm elections, the current presidential administration may modify these programs through regulatory mechanisms. Consequently, we do not know whether any of these proposals will pass or the effect any such actions could have on our business.

In addition, states are looking for more flexibility to design their Medicaid programs to manage their state health care budgets, including by imposing premium and community engagement or work requirements to maintain Medicaid eligibility. For example, the State of Kentucky intends to implement new premium and community engagement or work requirements for certain members to maintain their eligibility for the Medicaid program, which may reduce our Medicaid membership in Kentucky. However, these requirements have been challenged in federal district court and their implementation is currently

stayed. Once implemented, these changes could reduce the membership in our Medicaid health plans, which could have a materially adverse effect on our results of operations, financial condition and cash flows.

In May 2016, CMS published regulations that overhauled Medicaid managed care requirements, which were further revised in November 2018. These regulations include requirements that state Medicaid programs evaluate network adequacy standards; impose a requirement of managed care organizations ("MCO") to report medical loss ratios ("MLRs") annually to states; and a requirement that states set MCO rates to reasonably achieve an MLR of greater than 85% as long as the capitation rates are actuarially sound. Additionally, these regulations expand federal financial participation reimbursement opportunities related to members with behavioral health issues who receive short term services in an alternative institute for mental health and outline requirements for value-based provider contracting. Under the regulations, the states may also be tasked with developing and publicizing plan quality rating results. To the extent we do not comply with the implementing regulations by the states, we may be subject to additional financial penalties and/or reductions in membership, which may materially adversely affect our results of operations, financial condition and cash flows.

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

Health Care Reform

In March 2010, the ACA became law and significantly reformed various aspects of the U.S. health insurance industry. Financing for these reforms comes in part from substantial additional fees and taxes on us and other health insurers, health plans and individuals, as well as reductions in certain levels of payments to us and other health plans under Medicare. The majority of regulations and interpretive guidance on provisions of the ACA have been issued by the Department of Health and Human Services ("HHS"), the Department of Labor, the Treasury Department, and the National Association of Insurance Commissioners ("NAIC"). There may be provisions of the legislation that receive additional guidance and clarification in the form of regulations and interpretations.

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

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

CMS Star Ratings

CMS developed a five-star rating system, which awards between 1.0 and 5.0 stars to MA and PDP plans based on performance in several categories, including quality of care and customer service. Certain provisions in the ACA provide additional Medicare revenue related to the achievement of higher Star Ratings that can be used to offer more attractive benefit packages to members and/or achieve higher profit margins. In addition, plans with Star Ratings of 5.0 are eligible for year-round open enrollment, whereas plans with lower Star Ratings have more restrictions on enrollment criteria and timing. Part C or Part D Medicare plans with Star Ratings of less than three stars for three consecutive years are denoted as "low performing" plans on the CMS website and in the CMS "Medicare and You" handbook. In addition, CMS could exercise its authority to terminate the MA and PDP contracts for plans rated below three stars for three consecutive years for the plan year 2021. As a result, plans that achieve higher Star Ratings may have a competitive advantage over plans with lower Star Ratings.

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

In October 2018, CMS announced 2019 MA and PDP Star Ratings. Four of our 25 active MA contracts, serving certain members in California, Florida, Texas and New York/Maine, received an overall rating of 4.0 stars or higher and served

approximately 41.2% of our total December 31, 2018 MA membership. Excluding members from our two dual demonstration MA contracts, which are not subject to star ratings, these four contracts served approximately 42.2% of our total December 31, 2018 MA membership.

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

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

Minimum Medical Loss Ratio

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

Other Provisions

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

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

Five states are currently challenging the requirement that the IRS assess the ACA industry fee on Medicaid and CHIP plans. As a result, there is uncertainty with respect to the ACA industry fee, including that the ACA industry fee could be reallocated to other health insurance products. Changes to how the ACA industry fee is assessed may have a material adverse effect on our results of operations, financial condition and cash flows.

In addition, the Medicare Access and CHIP Reauthorization Act of 2015 is gradually increasing rates on the provider fee schedule from June 30, 2015 to 2019. After 2019, the provider fee schedules will also adjust rates based on quality performance. This Act also provided for incentive payments for those providers that participate in an alternative payment model, such as a demonstration program. Beginning in 2019, the Act also provides that we are required to pay out of network providers an additional quality-related payment pursuant to the Merit Based Incentive Payment System. These increases may increase our medical expenses and adversely affect our results of operations, financial condition and cash flows.

The ACA also established Medicare Shared Savings ACOs as a tool to improve quality and lower costs through increased care coordination in the Medicare fee-for-service ("FFS") program, which covers the majority of the Medicare-eligible population. CMS established the Medicare Shared Service Program ("MSSP") to facilitate coordination and cooperation among

providers to improve the quality of care for FFS beneficiaries and reduce unnecessary costs. The MSSP shares savings with the ACOs when they generate savings above a minimum savings rate and meet quality of care performance standards. The future of the ACOs is uncertain given the uncertain funding status of the ACA, or its modification.

In December 2018, a Texas federal district court ruled that the ACA was unconstitutional. Implementation of the ruling has been stayed pending appeal. If the ruling is ultimately upheld, the membership in our states that have expanded Medicaid eligibility may be reduced, which may adversely affect our results of operations.

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

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

OUR PRODUCT SEGMENTS

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

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

	For the Years Ended December 31,					
	2018		2017		2016	
Segment	Membership	Percentage of Total	Membership	Percentage of Total	Membership	Percentage of Total
Medicaid Health Plans	3,931,000	71.0%	2,723,000	62.3%	2,544,000	65.3%
Medicare Health Plans	545,000	9.8%	496,000	11.3%	345,000	8.9%
Medicare PDPs	1,057,000	19.1%	1,152,000	26.4%	1,009,000	25.8%
Corporate and Other	5,000	0.1%	—	—%	—	—%
Total	5,538,000	100.0%	4,371,000	100.0%	3,898,000	100.0%

Medicaid Health Plans

Our Medicaid Health Plans segment includes plans for beneficiaries of TANF, SSI and ABD programs and other state-based programs that are not part of the Medicaid program, such as CHIP and LTSS. For purposes of our Medicaid Health Plans segment, we define our customer as the state and related governmental agencies that have common control over the contracts under which we operate in that particular state. As of January 1, 2019, we are the largest Medicaid health plan by membership in Florida, Georgia, Illinois, Kentucky, Michigan and Missouri.

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

In general, members are required to use our network to receive care, except in cases of emergencies, transition of care or when network providers are unavailable to meet their medical needs. Members generally do not pay any premiums, deductibles

or co-payments for most of our Medicaid plans; however, the Kentucky Medicaid program intends to implement premium and community engagement and work requirements for continued eligibility purposes.

Certain contracts expired in 2018; however, we are still serving members as if these contracts were still effective and expect the contracts to be renewed. Our other current Medicaid contracts are set to expire or renew between June 2019 and December 2023. The following table sets forth the terms and expiration dates of our Medicaid contracts with the State of Florida and the Commonwealth of Kentucky, the two states that each accounted for greater than 10% of our consolidated premium revenues during 2018.

State	Line of Business	Term of Contract
Florida	Medicaid (MMA)	February 4, 2014 - December 31, 2018
Florida	Medicaid and LTC	August 27, 2018 - December 31, 2023
Kentucky	Medicaid and CHIP	July 1, 2018 - June 30, 2019

Refer to Note 2 - *Summary of Significant Accounting Policies* to the Consolidated Financial Statements included in this 2018 Form 10-K for a complete discussion of our premium revenue recognition policy.

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

	As of December 31,		
	2018	2017	2016
Medicaid Health Plans			
TANF	3,322,000	2,278,000	2,119,000
SSI, ABD, duals, and LTSS	442,000	301,000	290,000
CHIP and other	167,000	144,000	135,000
Total	3,931,000	2,723,000	2,544,000

In the following table, we have summarized membership for our Medicaid Health Plans segment by each state that exceeded 10% of our total Medicaid Health Plans membership, as well as all other states in the aggregate, as of December 31, 2018.

	As of December 31,		
	2018	2017	2016
Medicaid Health Plans			
Illinois	842,000	138,000	166,000
Florida	777,000	751,000	780,000
Michigan	500,000	—	—
Georgia	493,000	513,000	571,000
Kentucky	444,000	448,000	440,000
All other states [(1)]	875,000	873,000	587,000
Total	3,931,000	2,723,000	2,544,000

(1) "All other states" consists of Arizona, Hawaii, Missouri, New Jersey, New York, South Carolina and Texas during all years presented. In 2017 and 2018, it also includes Nebraska.

As of January 1, 2019, we served approximately 4.0 million Medicaid members. Refer to Item 7 – *Management's Discussion and Analysis of Financial Condition and Results of Operations* for membership discussion by segment for 2018, 2017 and 2016.

Medicare Health Plans

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

As of December 31, 2018, we offered MA plans in a total of 524 counties across 21 states to 545,000 members. As of January 1, 2019, we are offering MA plans in a total of 558 counties across 22 states to 567,000 members. We offer D-SNPs in 82.8% of the MA counties that we serve, and approximately 31.3% of our MA members are "dually-eligible" for Medicare and Medicaid and are enrolled in one of our D-SNPs or dual demonstration programs. We cover a wide spectrum of medical services through our MA plans. For many of our plans, we provide additional benefits not covered by Original Medicare, such as vision, dental and hearing services. Through these enhanced benefits, out-of-pocket expenses incurred by our members are generally reduced, which allows our members to better manage their health care costs. We believe that our D-SNPs are attractive to these beneficiaries due to the enhanced benefit offerings and clinical support programs.

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

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

- execution on quality and affordability initiatives;
- continued application of a disciplined portfolio approach to our MA bids, including a focus on net income; and
- improving Star Ratings, both in terms of execution on quality initiatives and our advocacy position to properly match the ratings, rules and economics with the prevalent data that demonstrates the connection between socio-economic status and lower quality ratings.

Refer to Note 2 - *Summary of Significant Accounting Policies* to the Consolidated Financial Statements included in this 2018 Form 10-K for a complete discussion of our premium revenue recognition policy.

As of December 31, 2018, 2017 and 2016, our Medicare Health Plans segment had approximately 545,000, 496,000 and 345,000 members, respectively. Refer to Item 7 – *Management's Discussion and Analysis of Financial Condition and Results of Operations* for membership discussion by segment for 2018, 2017 and 2016.

As of January 1, 2019, our Medicare Health Plans segment had approximately 567,000 members, an increase of approximately 22,000 compared with December 31, 2018.

Medicare PDPs

We have contracted with CMS to serve as a plan sponsor offering stand-alone Medicare Part D PDP plans to Medicare-eligible beneficiaries through our Medicare PDPs segment. As of January 1, 2019, we offer PDPs in 50 states and the District of Columbia. Our PDPs offer national in-network prescription drug coverage, including a preferred pharmacy network, subject to limitations in certain circumstances.

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

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

Refer to Note 2 - *Summary of Significant Accounting Policies* to the Consolidated Financial Statements included in this 2018 Form 10-K for a complete discussion of our premium revenue recognition policy.

As of December 31, 2018, 2017 and 2016, we served approximately 1,057,000, 1,152,000 and 1,009,000 PDP members, respectively. Refer to Item 7 – *Management's Discussion and Analysis of Financial Condition and Results of Operations* for membership discussion by segment for 2018, 2017 and 2016.

Our 2019 PDP bids resulted in one of our basic plans being below the benchmarks in 21 of the 34 CMS regions, and within the *de minimis* range in 10 other regions, compared with our 2018 bids, in which we were below the benchmarks in 25 of the 34 CMS regions, and within the *de minimis* range in five other regions. As of January 1, 2019, we served approximately 1,590,000 PDP members, an increase of approximately 533,000 from December 31, 2018 resulting from our 2019 bid positioning.

OUR OPERATIONS

Provider Networks and Provider Reimbursement Methods

As of December 31, 2018, we contracted with approximately 750,000 health care providers and 69,000 pharmacies to provide our members with access to medically necessary services. Our contracted providers deliver a variety of services to our members including: primary and specialty physician care; laboratory and imaging services; inpatient, outpatient, home health and skilled facility care; medication and injectable drug therapy; ancillary services; durable medical equipment and related services; mental health and chemical dependency counseling and treatment; transportation; and dental, hearing and vision care.

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

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

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

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

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

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

The Medicare Access and CHIP Reauthorization Act of 2015 is gradually increasing rates on the provider fee schedule from June 30, 2015 to 2019. After 2019, the provider fee schedules will also adjust rates based on quality performance. This Act also provided for incentive payments for those providers that participate in an alternative payment model, such as a demonstration program. Beginning in 2019, the Act also provides that we are required to pay out of network providers an additional quality-related payment pursuant to the Merit Based Incentive Payment System. These increases may increase our medical expenses and adversely affect our results of operations, financial condition and cash flows.

Physicians and Provider Groups

PCPs play an important role in coordinating and managing the care of our Medicaid and MA CCP members. This coordination includes delivering preventive services as well as referring members to other providers for medically necessary services. PCPs are typically trained in internal medicine, pediatrics, family practice, general practice or, in some markets, obstetrics and gynecology. In rare instances, a physician trained in sub-specialty care will perform primary care services for a member with a chronic condition.

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

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

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

Consistent with our long-term business priorities and emerging regulatory guidance, we have increased emphasis on aligning provider incentives with our objective of improving health care quality by employing a continuum of performance-based arrangements to incentivize providers to improve the quality of care they provide to our members. Substantially all of our contracted PCPs are eligible to participate in our quality incentive programs and/or other value-based arrangements. These arrangements consisted of additional payments for achieving specified quality of care targets. In 2018, 54% of Medicare and 35% of Medicaid hospital, professional and pharmacy payments were made through these value-based arrangements.

We also maintain shared-surplus, shared-risk and full-risk arrangements by establishing an operating fund for provider groups participating in these types of arrangements. We monitor the performance of this fund to determine whether these providers are eligible for shared savings payments or whether they should reimburse us if the contracts include shared or full risk provisions. Payments due to us are normally carried forward and offset against future potential surplus payments. PCPs participating in these specialized risk arrangements cover 53% and 31% of our MA and Medicaid membership, respectively, as of December 31, 2018.

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

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

Facilities

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

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

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

Ancillary Providers

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

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

Pharmacies

Pharmacy services are reimbursed based on a fixed fee for dispensing medication and a separate payment for the ingredients. Ingredients produced by multiple manufacturers are reimbursed based on a maximum allowable cost for the ingredient. Ingredients produced by a single manufacturer are reimbursed as a percentage of the average wholesale price. In certain instances, we may contract directly with the sole-source manufacturer of an ingredient to receive a rebate, which may vary based upon volumes dispensed during the year. Excluding our Meridian health plans, we outsource pharmacy rebate management services to a third party, including rebates processing, claims processing, pre-authorization, utilization management and other related services.

Out-of-Network Providers

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

Member Recruitment

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

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

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

We employ our own insurance agents and contract with independent, licensed insurance agents to market our MA and PDP products. We have continued to expand our use of independent agents whose cost is largely variable in nature and whose engagement is more conducive to the shortened Medicare selling season and the open enrollment period. The activities of our independently licensed insurance agents are also regulated by CMS. We also use direct mail, mass media and the Internet to market our products.

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

Quality Improvement

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

Our quality improvement activities will continue to focus on:

- Access;
- Preventive health and wellness;
- Care management and population health programs;
- Health plan accreditation;
- Provider credentialing;
- Provider education and incentives for closing care gaps;
- Member education and outreach;
- Information technology initiatives related to the above activities;
- Community Connections; and
- Oversight and audits.

Access

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

Preventive health and wellness

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

Care management and population health programs

We have enhanced our care management model to more effectively serve our most medically complex members. The model leverages both field-based and telephonic resources using state-specific, multi-disciplinary care teams. Our complex care management helps reduce the fragmentation that exists in the current health care system, improving member access to quality care. We also employ interventions that target specific populations, conditions and those that target specific quality outcomes through established best practices. For example, a prenatal care management program to help women with high-risk pregnancies; a program to reduce the number of inappropriate opioid use; and care management programs to decrease the need for emergency room visits and hospitalizations.

Health plan accreditation

Where required, our health plans are either accredited or actively seeking accreditation by the National Committee for Quality Assurance ("NCQA"). NCQA Accreditation is the most comprehensive evaluation in the industry, and the only assessment that includes results of clinical performance (i.e., HEDIS measures) and consumer experience (i.e., Consumer Assessment of Healthcare Provider and Systems measures).

Provider credentialing

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

Provider education and incentives for closing care gaps

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

Member education and outreach

We are focused on improving access for our members to a high-performing network, including PCPs, specialists and ancillary providers. This will ensure that members see the appropriate providers, based on clinical condition. We have strengthened our resources focused exclusively on outreach to Medicaid and Medicare members to educate them on care gaps and assist with care gap closure. Intervention and support activities include arranging transportation assistance, three-way calls with a member and his/her primary care physician to schedule appointments, and arranging for home visits to assess and close care gaps. In addition, our medication therapy management initiatives empower patients to take an active role in managing their medications. We are focused on enhancing our members' experience by improving service and reducing complaint levels through improved grievance and appeals processes which we believe will result in improved member satisfaction survey results. Additionally, we use a variety of multimodal techniques to reach members in the manner of their choosing and to minimize cost and maximize effectiveness. Using culturally and linguistically relevant messages, these modes include mailings, live and automated calls, texts, web portals and mobile applications. This outreach is coordinated through sophisticated systems that allow for campaign management and a single, 360 degree view of every member.

Information technology initiatives

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

Community Connections

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

Oversight and audits

Internally, our quality improvement programs benefit from executive oversight and project management processes. Each of our health plans has a Quality Improvement Committee comprised of senior members of management, medical directors and other key associates. Each of these committees reports directly to the applicable health plan board of directors, which has ultimate oversight responsibility for the quality of care rendered to our members. The Quality Improvement Committees also have a number of subcommittees that are charged with monitoring certain aspects of care and service, such as health care utilization, pharmacy services and provider credentialing and re-credentialing. Several of these subcommittees include physicians as committee members.

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

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

Information Technology

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

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

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

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

Our board of directors believes that information security is a critical component of the enterprise-wide risk management program. Our information security risk management practices are a core component of our enterprise-wide risk management program. The board's information security oversight responsibilities include providing oversight of information security strategies and risk management; and assuring financial and other resources, including insurance related to information security events, are in place to support risk management. The board's information security oversight includes regular reporting from members of senior management who are responsible for information security risk management practices. Reports cover areas such as process improvements, relevant risks and strategic initiatives. Pursuant to its charter, the Audit, Finance and Regulatory Compliance Committee (the "AFRC Committee") of the board assists the board in the oversight of the enterprise risk management function, including information security.

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

Outsourcing Arrangements

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

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

Centralized Management Services

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

Employees

As of December 31, 2018, we had approximately 12,000 full-time employees. Our employees are not represented by any collective bargaining agreement, and we have never experienced a work stoppage.

OUR COMPETITION

Competitive Environment

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

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

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

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

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

Competitive Factors—Program Participation

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

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

Competitive Factors—Network Providers

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

Medicaid Competitors

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

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

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

- *PSNs*—A Provider Service Network ("PSN") is a network of providers that is established and operated by a health care provider or group of affiliated health care providers. A PSN operates as either a fee-for-service ("FFS") health plan or

as a prepaid health plan that, like us, receives a capitated premium to provide Medicaid benefits to members. A PSN that operates as a FFS health plan is not at risk for medical benefit costs.

Medicare Competitors

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

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

- *Medicare Advantage and Prescription Drug Plans*—MA and stand-alone Part D plans are offered by national, regional and local MCOs and insurance companies that serve Medicare beneficiaries. In addition, prescription drug plans are being offered by or co-branded with retail drug store chains or other retail store chains, which may be able to offer lower priced plans and achieve benefits from integration with their pharmacy benefit management operations.

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

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

REGULATION AFFECTING OUR BUSINESS

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

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

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

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

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

Licensing and Solvency Regulation

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

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

Each of our HMO and insurance subsidiaries must maintain a minimum amount of statutory capital determined by statute or regulation. For additional information on regulatory requirements, see Item 7 – *Management's Discussion and Analysis of Financial Condition and Results of Operations – Regulatory Capital and Dividend Restrictions* and Note 16 – *Regulatory Capital and Dividend Restrictions* to the consolidated financial statements.

HIPAA, HITECH, State Privacy Laws and Breach Notification Laws

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

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

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

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

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

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

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

Covered entities must report breaches of unsecured PHI to affected individuals without unreasonable delay, but not to exceed 60 days of discovery of the breach by a covered entity or its agents. Notification must also be made to HHS and, in certain situations involving large breaches, to the media. HHS is required to publish on its website a list of all covered entities that report a breach involving more than 500 individuals. All non-permitted uses or disclosures of unsecured PHI are presumed to be breaches unless the covered entity or business associate establishes that there is a low probability the information has been compromised. Various state laws and regulations may also require us to notify affected individuals in the event of a data breach involving individually identifiable information.

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

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

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

Fraud and Abuse Laws

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

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

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

PRINCIPAL EXECUTIVE OFFICES

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

AVAILABILITY OF REPORTS AND OTHER INFORMATION

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

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

Item 1A. Risk Factors

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

Risks Related to Our Business

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

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

The ACA Medicaid expansion provisions remain optional for states. Congress and the current presidential administration may also change the operation of specific programs authorized under the ACA. Given the breadth of possible changes and the uncertainties of interpretation, implementation and timing of any such changes, the ACA (or any modification thereof) could change the way we do business, potentially affecting our pricing, benefit design, product mix and geographic mix.

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

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

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

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

Minimum Medical Loss Ratio

Beginning in 2014, the ACA established a minimum MLR for MA and Part D plans, requiring plans to spend not less than 85% of premiums on medical and pharmacy benefits. The rules implementing the minimum MLR impose financial and other penalties for failing to achieve the minimum MLR, including requirements to refund to CMS shortfalls in amounts spent on medical benefits and termination of a plan’s MA contract for prolonged failure to achieve the minimum MLR. The MLR prescribed by HHS differs from the MLR calculation under generally accepted accounting principles in the United States of America ("GAAP") and is determined by adding a plan’s spending for clinical services, prescription drugs and other direct patient benefits, plus its total spending on quality improvement activities and dividing the total by earned premiums (after subtracting specific identified taxes and other fees). These provisions have not had a material effect on our results of operations in 2016, 2017 or 2018.

Other Provisions

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

Five states are currently challenging the requirement that the IRS assess the ACA industry fee on Medicaid and CHIP plans. As a result, there is uncertainty with respect to the ACA industry fee, including that the ACA industry fee could be reallocated to other health insurance products. Changes to how the ACA industry fee is assessed may have a material adverse effect on our results of operations, financial condition and cash flows.

In December 2018, a Texas federal district court ruled that the ACA was unconstitutional. Implementation of the ruling has been stayed pending appeal. If the ruling is ultimately upheld, the membership in our states which have expanded Medicaid eligibility may be reduced, which may adversely affect our results of operations.

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

Our business and membership has grown substantially due to acquisitions, such as that of Universal American Corp. ("Universal American") in April 2017, the acquisition of Meridian Health Plan of Michigan, Inc., Meridian Health Plan of Illinois, Inc., and MeridianRx, a pharmacy benefit manager ("PBM") (collectively, “Meridian”) in September 2018, geographic expansions and organic growth, such as the statewide expansion of Medicaid in Missouri. We may not be successful in enhancing our infrastructure to support this continued growth, and delays in infrastructure improvements may have a material adverse effect on our quality scores, results of operations, financial condition and cash flows. In addition, due to the substantial initial costs related to acquisitions and expansions, such growth could adversely affect our short-term profitability and liquidity.

As part of our growth strategy, we identify potential acquisition targets, bid and negotiate acquisition terms, work with regulators to receive regulatory approval for the acquisition and once the transaction is closed, we must integrate the acquisition into our operations. For example, we completed our acquisition of Universal American in April 2017 and our acquisition of Meridian in September 2018 and our acquisition of the entire stand-alone Medicare Part D prescription drug plan membership of Aetna Inc. in November 2018.

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

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

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

- the market price of our common stock could decline;

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

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

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

- new associates who must become familiar with our operations and company culture;
- difficulty retaining legacy employees and/or attracting new employees because of potential uncertainty in our business relating to the business combination;
- acquired provider networks that operate on different terms than our existing networks and whose contracts may need to be renegotiated;
- existing members who decide to switch to another health care plan;
- separate administrative and information technology systems; and
- difficulties implementing our operations strategy to operate the acquired businesses profitably.

As a result, our acquired businesses may not perform as we anticipated, or in line with our existing businesses, may result in unforeseen expenses, and the anticipated benefits of the integration plan may be delayed or not be realized, which could materially affect our financial position, results of operations and cash flows. In addition, if the expected future profitability of the acquired business declines, we may need to write down or incur impairment charges of the acquired assets. In the future, we may incur material expenses in connection with the integration and execution of acquisitions, expansions, and other significant transactions, including the Meridian acquisition.

Our rate of expansion into new products or other geographic areas may also be affected by factors such as:

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

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

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

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

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

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

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

For example, the Medicare Access and CHIP Reauthorization Act of 2015 is gradually increasing rates on the provider fee schedule from June 30, 2015 to 2019. After 2019, the provider fee schedules will also adjust rates based on quality performance. This Act also provided for incentive payments for those providers that participate in an alternative payment model, such as a demonstration program. Beginning in 2019, the Act also provides that we are required to pay out of network providers an additional quality-related payment pursuant to the Merit Based Incentive Payment System. These increases may increase our medical expenses and adversely affect our results of operations, financial condition and cash flows.

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

Assumptions and estimates are utilized in establishing premium deficiency reserves. For example, we have established a premium deficiency reserve of $16.1 million in connection with the expanded and combined Illinois Medicaid programs as of December 31, 2018. If our assumptions in establishing reserves are inconsistent with actual experience, our reserves may be inadequate to pay medical costs. We may be required to increase our premium deficiency reserve, or establish new premium deficiency reserves in connection with other contracts, which could have a material adverse effect on our results of operations and financial condition.

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

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

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

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

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

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

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

Certain provisions in the ACA provide additional Medicare revenue related to the achievement of higher Star Ratings that can be used to offer more attractive benefit packages to members and/or achieve higher profit margins. In addition, plans with the highest Star Ratings of 5.0 are eligible for year-round open enrollment, whereas plans with lower Star Ratings have more restrictions on enrollment criteria and timing. Part C or Part D Medicare plans with Star Ratings of less than three stars for three consecutive years are denoted as "low performing" plans on the CMS website and in the CMS "Medicare and You" handbook. In addition, CMS could exercise its authority to terminate the MA and PDP contracts for plans rated below three stars for three consecutive years for the plan year 2020. As a result, plans that achieve higher Star Ratings may have a competitive advantage over plans with lower Star Ratings.

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

In October 2018, CMS announced 2019 MA and PDP Star Ratings. Four of our 25 active MA contracts, serving certain members in California, Florida, Texas and New York/Maine, received an overall rating of 4.0 stars or higher and served approximately 41.2% of our total MA membership as of December 31, 2018. Excluding members from our two dual demonstration MA contracts, which are not subject to star ratings, these four contracts served approximately 42.2% of our total MA membership as of December 31, 2018.

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

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

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

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

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

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

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

We have determined, based on an evaluation of factors, including cost, compliance, quality and procurement success, that it is more efficient to use third parties for certain functions and services. As a result, we have contracted with a number of third parties to provide significant operational support including, but not limited to, pharmacy benefit management for our members as well as certain enrollment, billing, call center, benefit administration and claims processing functions, sales and marketing, reinsurance, quality improvement efforts and certain aspects of utilization management and for MeridianRX pharmaceutical

discounts and rebates. We have limited ability to control the performance of these third parties. If a third party provides services that we are required to provide under a contract with a government client, we are responsible for such performance and will be held accountable by the government client for any failure of performance by our vendors. Significant failure by a third party to perform in accordance with the terms of our contracts or applicable law could subject us to fines or other sanctions or otherwise have a material adverse effect on our business and results of operations. In addition, upon termination of a third party contract, we may encounter difficulties in replacing the third party on favorable terms, transitioning services to another vendor, or in assuming those responsibilities ourselves, which may have a material adverse effect on our business, quality scores and results of operations. Further, we rely on state-operated systems and sub-contractors to qualify and assign eligible members into our health plan. Ineffectiveness of these state operations and sub-contractors can have a material adverse effect on our enrollment.

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

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

For the years ended December 31, 2018 and 2017 our Medicaid operations in Florida and Kentucky each accounted for greater than 10% of our consolidated premium revenue. These customers accounted for contracts that have terms of between one and three years with varying expiration dates.

Our Medicaid contracts are generally intended to run for initial terms of less than five years and in some cases may be extended for additional years if the state or other sponsoring agency elects to do so. When our state contracts expire, they may be opened for bidding by competing health care plans. In July 2018, we received a Notice of Intent to Award a contract from the Florida Department of Health to provide statewide managed care services to more than 60,000 children with medically complex conditions through the Children's Medical Services Managed Care Plan ("CMS Plan"). The five-year contract award began on February 1, 2019; however, this contract is still subject to protest and appeal. There is no guarantee that our contracts will be renewed or extended or, if renewed or extended, on what terms. Further, our contracts with the states are subject to cancellation by the state after a short notice period in the event of unavailability of state funds. Our contracts could also be terminated if we fail to perform in accordance with the standards set by state regulatory agencies. If any of our contracts are terminated, not renewed or extended, renewed or extended on less favorable terms or not renewed or extended on a timely basis or if an increased number of competitors were awarded contracts in these states, our business will suffer, and our results of operations, financial condition and cash flows may be materially affected.

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

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

State governments generally are experiencing tight budgetary conditions within their Medicaid programs. As a result, government agencies with which we contract may seek to reduce funding, which may result in changes to program design, including member eligibility and benefits for their Medicaid programs. For example, the State of Kentucky intends to

implement new premium and community engagement or work requirements for certain members to maintain their eligibility for the Medicaid program, which may reduce our Medicaid membership in Kentucky. If any state in which we operate were to decrease premiums paid to us for these reasons or any other reason, decrease members eligible to participate in the programs, reduce the benefits offered by the programs, or pay us less than the amount necessary to keep pace with our cost trends, or delay increases in premiums, these could have a material adverse effect on our revenues and results of operations. We have experienced rate decreases and rate increase delays in the past and may do so in the future. Economic conditions affecting state governments and agencies could also result in delays in receiving premium payments. For example, Illinois has delayed its premium payments for the Medicaid program. If there is a significant delay in our receipt of premiums to pay health benefit costs, it could have a material adverse effect on our results of operations, financial condition, cash flows and liquidity.

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

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

A significant portion of our PDP membership is obtained from the auto-assignment of beneficiaries in CMS-designated regions where our PDP premium bids are below benchmarks of other plans' bids. In general, our premium bids are based on assumptions regarding PDP membership, utilization, drug costs, drug rebates and other factors for each region. Our 2019 PDP bids resulted in 21 of 34 CMS regions in which we were below the benchmarks, and within the *de minimis* range in ten other regions, compared with our 2018 PDP bids in which we were below the benchmarks in 25 of the 34 CMS regions, and within the *de minimis* range in five other regions. For those regions in which we are within the *de minimis* range, we will not be eligible to have new members auto-assigned to us, but we will not lose our existing auto-assigned membership.

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

We are offering a new enhanced PDP product in 2019. In connection with the new business, the actual costs of providing prescription drugs may be higher than we estimated. If our actual costs of providing prescription drugs are higher than our estimated costs of providing prescription drugs when we provided our bids to CMS, our funds receivable from CMS could be higher than we anticipated, which could have a material adverse effect on our cash flows and liquidity.

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

As of December 31, 2018, we had approximately $2.1 billion in aggregate principal amount of total indebtedness outstanding primarily consisting of $1.2 billion senior notes due 2025 and $750.0 million senior notes due 2026 (together, the "Senior Notes") and $200.0 million outstanding under our $1.3 billion revolving credit facility (the "Amended and Restated Credit Agreement").

Our ability to make scheduled payments on or to refinance our debt obligations depends on our and our subsidiaries' financial condition and operating performance, which is subject to prevailing economic and competitive conditions and to certain financial, business, competitive, legislative, regulatory and other factors beyond our control. As a result, we may not be able to maintain a level of cash flows from operating activities or to access the cash flows of our subsidiaries in an amount sufficient to permit us to pay the principal and interest on our current indebtedness, as well as any additional debt we may incur. We cannot assure that financing sources will be available to us in amounts sufficient to enable us to pay our indebtedness, or to fund our other liquidity needs.

If our cash flows and capital resources are insufficient to fund our debt service obligations, we may be forced to reduce or delay investments and capital expenditures, or to sell assets, seek additional capital or restructure or refinance our indebtedness. These alternative measures may not be successful and may not permit us to meet our scheduled debt service obligations. Our ability to restructure or refinance our debt will depend on the condition of the capital markets and our financial condition at

such time. Any refinancing of our debt could be at higher interest rates and may require us to comply with more onerous covenants, which could further restrict our business operations. The terms of existing or future debt instruments may restrict us from adopting some or all of these alternatives. If we are unable to pay our indebtedness on time, it could result in the acceleration of our indebtedness and materially adversely affect us.

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

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

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

In May 2016, CMS published regulations that overhauled Medicaid managed care requirements. These regulations include requirements that state Medicaid programs evaluate network adequacy standards and, if a state chooses to impose a minimum MLR, requires managed care organizations ("MCO") to report MLRs annually to states, requires those states to set MCO rates to reasonably achieve an MLR of greater than 85% as long as the capitation rates are actuarially sound. Additionally, these regulations expand federal financial participation reimbursement opportunities related to members with behavioral (mental) health issues who receive short term services in an alternative institute for mental disease and outline requirements for value-based provider contracting. Under the regulations, the states may also be tasked with developing and publicizing plan quality rating results. The degree of federal oversight in implementing these regulations is uncertain, and the states may retain substantial flexibility in designing their Medicaid programs. Implementation or lack of implementation by CMS and the state Medicaid agencies of these regulations may materially adversely affect our results of operations, financial condition and cash flows.

Five states are currently challenging the requirement that the IRS assess the ACA industry fee on Medicaid and CHIP plans. As a result, there is uncertainty with respect to the ACA industry fee, including that the ACA industry fee could be reallocated to other health insurance products. Changes to how the ACA industry fee is assessed may have a material adverse effect on our results of operations, financial condition and cash flows.

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

The Medicare Access and CHIP Reauthorization Act of 2015 was enacted in April 2015, which, among other things, extended the Special Needs Program through 2018. In addition, this Act is gradually increasing rates on the provider fee schedule from June 30, 2015 to 2019. After 2019, the provider fee schedules will also adjust rates based on quality performance. This Act also provided for incentive payments for those providers that participate in an alternative payment model, such as a demonstration program. Beginning in 2019, the Act also provides that we are required to pay out of network providers an additional quality-related payment pursuant to the Merit Based Incentive Payment System. These increases may increase our medical expenses and adversely affect our results of operations, financial condition and cash flows.

On February 9, 2018, the Bipartisan Budget Act of 2018 was enacted, which extended CHIP funding through 2027 and permanently reauthorized MA special needs plans, but imposed additional requirements for care coordination and integration of long-term services and supports. This legislation followed an earlier continuing resolution that continued funding and the enhanced federal match rate for CHIP established by the ACA initially but reduced the rate over time, and extended the requirement for states to maintain coverage for children from 2019 through 2023, but limited the requirement to children in

families with incomes at or below 300% of the federal poverty level after October 1, 2019. The funding of the CHIPs and Special Needs Programs by the federal government may be limited further, and eligibility for those programs may also be further restricted. If these programs are further modified or the funding further restricted, states could cease operating these programs, or limit their eligibility or benefits, or impose new requirements, which could have a material adverse effect on our revenues, cash flow, membership and profitability.

Further, changes in existing federal or state laws or regulations or the adoption of new laws or regulations relating to patent term extensions, purchase discount and rebate arrangements with pharmaceutical manufacturers, or to formulary management or other pharmaceutical benefit management services could also reduce the discounts or rebates we receive on pharmaceutical drugs. In addition, changes in federal or state laws or regulations or the adoption of new laws or regulations relating to pharmaceutical pricing, claims processing and billing, the development and use of formularies and other utilization management tools, the use of average wholesale prices, a list of maximum allowable costs, transmission fees or other pricing benchmarks, pricing for specialty pharmaceuticals, limited access to networks and pharmacy network reimbursement methodologies, could adversely affect our profitability.

In addition, our pharmacy benefit manager provides services to sponsors of health benefit plans that are subject to ERISA. A private party or the Department of Labor, which is the agency that enforces ERISA, could assert that the fiduciary obligations imposed by the statute apply to some or all of the services provided by our pharmacy benefit manager even if it is not contractually obligated to assume fiduciary obligations and we could be subject to claims for breaches of fiduciary obligations or claims that we entered into certain prohibited transactions.

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

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

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

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

We compete for members principally on the basis of size and quality of provider network, pharmacy network, benefits provided and quality of service. We may not be able to develop innovative products and services that are attractive to members. We may not be able to comply with the service level agreements or other terms of our pharmaceutical benefit management contracts held by MeridianRx with third-parties, and lose customers, or be required to pay penalties. We may grow more, or at a faster pace, than expected, which may affect service levels. We cannot be sure that we will continue to remain competitive, nor can we be sure that we will be able to successfully retain or acquire members for our products and services at current levels of profitability.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Some courts have permitted False Claims Act suits to proceed if the claimant was out of compliance with program requirements. Liability for such matters could have a material adverse effect on our financial condition, results of operations and cash flows. *Qui tam*, or "whistleblower" actions under federal and state law can be brought by any individual on behalf of the government. These actions have increased significantly in recent years, causing greater numbers of health care companies to defend false claim actions, pay fines or be excluded from Medicare, Medicaid or other state or federal health care programs as a result of investigations arising out of such actions.

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

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

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

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

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

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

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

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

Our business strategy includes entering new markets by pursuing attractive growth opportunities for our existing product lines and pursuing acquisition opportunities. We may need to access the debt or equity markets and receive dividends from our subsidiaries to fund these growth activities, such as the $1.4 billion in equity proceeds we raised and the $750.0 million in new senior notes we issued to fund the purchase price of the Meridian acquisition.

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

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

- limit our ability to borrow additional funds for working capital, capital expenditures, acquisitions and general corporate or other purposes; and

- expose us to greater interest rate risk since the interest rate on borrowings under our Amended and Restated Credit Agreement is variable.

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

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

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

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

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

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

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

We currently maintain insurance which provides coverage for our independent directors and officers hired after January 24, 2008 for certain potential matters to the extent they occur after October 2007. We cannot provide any assurances that pending claims, or claims yet to arise, will not exceed the limits of our insurance policies, that such claims are covered by the terms of our insurance policies or that our insurance carrier will be able to cover our claims.

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

Our investment portfolio represents a significant portion of our assets and is subject to general credit, liquidity, and market and interest rate risks. Market fluctuations in the securities and credit markets could affect the value or liquidity of our

investment portfolio and adversely affect interest income. As a result, we may experience a reduction in value or loss of liquidity which may materially affect our results of operations, financial condition, cash flows and liquidity.

Risks Related to Ownership of Our Stock

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

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

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

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

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

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

The issuance of additional shares of our common stock or other equity securities, including sales of shares in connection with any future acquisitions, could be substantially dilutive to our stockholders. For instance, we issued 5,207,547 shares of common stock to fund a portion of the Meridian Acquisition. These sales may have a harmful effect on prevailing market prices for our common stock and our ability to raise additional capital in the financial markets at a time and price favorable to us. Holders of shares of our common stock have no preemptive rights that entitle them to purchase a pro rata share of any offering of shares of any class or series and, therefore, such sales or offerings could result in increased dilution to our stockholders. Our certificate of incorporation provides that we have authority to issue 100,000,000 shares of common stock and 20,000,000 shares of preferred stock.

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

Although we currently anticipate that the Meridian acquisition will be accretive to earnings per share (on an adjusted earnings basis that is not pursuant to GAAP and excluding transaction and integration costs), this expectation is based on assumptions, including about our and Meridian’s business, and preliminary estimates, each of which may change materially. As a result, the Meridian acquisition may cause dilution to our earnings per share or the expected accretive effect of the Meridian acquisition may be less than anticipated or delayed, each of which may cause a decrease in the market price of our common stock.

In addition, we could encounter additional transaction-related costs or other factors, such as the failure to realize all of the benefits anticipated in the Meridian acquisition, including cost and revenue synergies. All of these factors could cause dilution to our earnings per share or decrease or delay the expected accretive effect of the Meridian acquisition and cause a decrease in the market price of our common stock.

Risks Related to Information Technology

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

Our business depends on effective and secure information systems, applications and operations. The information gathered, processed and stored by our management information systems and our vendors' management information systems assists us in, among other things, marketing and sales, membership tracking, billing, claims processing, medical management, medical care cost and utilization trending, reinsurance, financial and management accounting, reporting, and planning and analysis. These systems also support our customer service functions, provider and member administrative functions and support tracking and extensive analysis of medical expenses and outcome data. These systems remain subject to unexpected interruptions resulting from occurrences such as hardware failures or increased demand. There can be no assurance that such interruptions will not occur in the future, and any such interruptions could have a material adverse effect on our business and results of operations. Moreover, operating and other issues can lead to data problems that affect the performance of important functions, including, but not limited to, claims payment, customer service and financial reporting.

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

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

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

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

reputational damage if we are unable to comply, which could have a material adverse effect on our business and our results of operations.

Item 1B. Unresolved Staff Comments.

None.

Item 2. Properties.

Our principal administrative, sales and marketing facilities are located at our leased corporate headquarters in Tampa, Florida. Our corporate headquarters is used in all of our lines of business. As of December 31, 2018, we also leased office space for the administration of our health plans in Arizona, Arkansas, California, Connecticut, Florida, Georgia, Hawaii, Illinois, Indiana, Kentucky, Louisiana, Maine, Michigan, Mississippi, Missouri, Nebraska, New Jersey, New York, North Carolina, South Carolina, Tennessee, Texas, Washington D.C. and Wisconsin. These properties are all in good condition and are well maintained. We believe these facilities are suitable and provide the appropriate level of capacity for our current operations. Upon expiration of the terms of the leases, we believe we could renew these leases on acceptable terms, or find suitable space elsewhere.

Item 3. Legal Proceedings.

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

Item 4. Mine Safety Disclosures.

Not Applicable.

PART II

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

Market for Common Stock

Our common stock is listed on the New York Stock Exchange under the symbol "WCG." As of February 11, 2019, we had approximately 16 holders of record of our common stock.

Unregistered Issuances of Equity Securities

None.

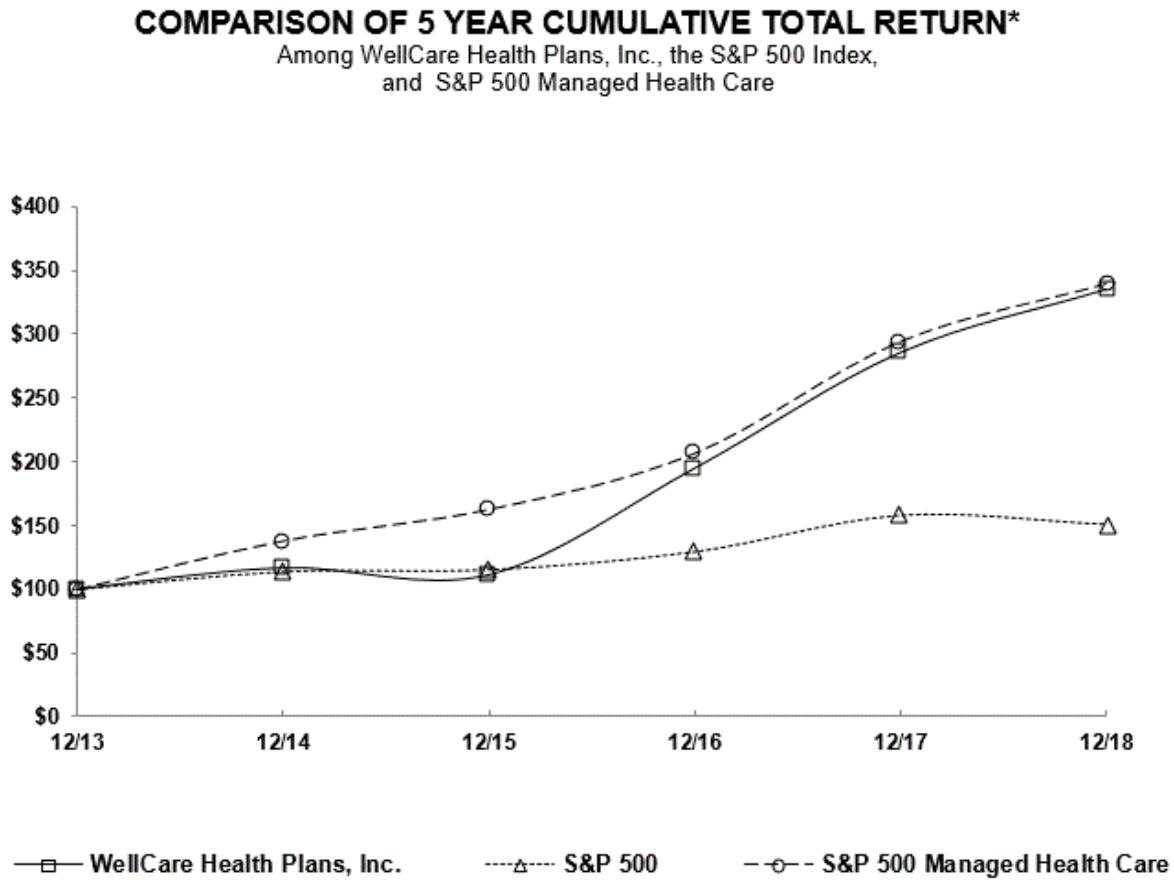
Issuer Purchases of Equity Securities

We do not have a stock repurchase program. Additionally, for the majority of restricted stock units granted, the number of shares issued on the date the units vest is net of shares withheld to meet applicable tax withholding requirements. Although these withheld shares are not issued or considered common stock repurchases under a stock repurchase program, they are treated as common stock repurchases in our financial statements as they reduce the number of shares that would have been issued upon vesting.

Performance Graph

The following graph compares the cumulative total stockholder return on our common stock for the period from December 31, 2013 to December 31, 2018, with the cumulative total return on the stocks included in the Standard & Poor's 500 Stock Index ("S&P 500") and the Standard & Poor's 500 Managed Health Care Index ("S&P MHCI") over the same period. At December 31, 2018, the companies included in the S&P MHCI were: Anthem, Inc., Centene Corporation, Humana Inc., UnitedHealth Group Incorporated and WellCare Health Plans, Inc. These companies are consistent with those that were included in the custom composite index included in our historical Form 10-K filings.

The graph assumes an investment of $100 made in our common stock, the S&P 500 and the S&P MHCI on December 31, 2013. The graph also assumes the reinvestment of dividends and is weighted according to the respective company's stock market capitalization at the beginning of each of the periods indicated. We did not pay any dividends on our common stock during the period reflected in the graph. Further, our common stock price performance shown below should not be viewed as being indicative of future performance.



*$100 invested on 12/31/13 in stock or index, including reinvestment of dividends.
Fiscal year ending December 31.

	12/31/2013	12/31/2014	12/31/2015	12/31/2016	12/31/2017	12/31/2018
WellCare Health Plans, Inc.	$ 100	$ 117	$ 111	$ 195	$ 286	$ 335
S&P 500 Index	$ 100	$ 114	$ 115	$ 129	$ 157	$ 150
S&P MHCI	$ 100	$ 138	$ 163	$ 206	$ 294	$ 339

Item 6. Selected Financial Data.

The following table sets forth our summary financial data. This information should be read in conjunction with our consolidated financial statements and the related notes and "*Management's Discussion and Analysis of Financial Condition and Results of Operations*" included in this 2018 Form 10-K.

	For the Years Ended December 31,				
	2018	2017	2016	2015	2014
	(In millions, except per share data)				
Consolidated operating results:					
Total revenues	$ 20,414.1	$ 17,007.2	$ 14,237.1	$ 13,890.2	$ 12,959.9
Income from operations	698.3	469.0	529.5	336.1	148.3
Income before income taxes	692.8	461.6	529.5	336.1	177.8
Net income	$ 439.8	$ 373.7	$ 242.1	$ 118.6	$ 63.7
Net income per share:					
Basic	$ 9.40	$ 8.40	$ 5.47	$ 2.69	$ 1.45
Diluted	$ 9.29	$ 8.31	$ 5.43	$ 2.67	$ 1.44
Operating Statistics:					
Medical benefits ratio:					
Medicaid Health Plans (GAAP)	86.0%	87.8%	86.2%	86.7%	88.2%
Medicaid Health Plans (adjusted) [1]	88.9%	88.8%	89.5%	89.8%	90.5%
Medicare Health Plans	84.7%	86.0%	84.6%	87.2%	88.5%
Medicare PDPs	72.4%	82.4%	73.7%	78.7%	92.9%
SG&A ratio (GAAP) [2]	8.3%	8.7%	8.0%	8.2%	7.9%
Adjusted SG&A ratio [2] [3]	8.3%	8.5%	8.0%	7.9%	7.7%
Membership:					
Medicaid Health Plans	3,931,000	2,723,000	2,544,000	2,388,000	2,310,000
Medicare Health Plans	545,000	496,000	345,000	354,000	417,000
Medicare PDPs	1,057,000	1,152,000	1,009,000	1,025,000	1,392,000
Corporate and Other	5,000	—	—	—	—
Total Membership	5,538,000	4,371,000	3,898,000	3,767,000	4,119,000
Consolidated cash flows:					
Operating activities	$ 279.0	$ 1,050.0	$ 748.3	$ 712.6	$ 299.3
Investing activities[4]	(2,568.0)	(1,736.5)	61.1	(172.6)	(16.0)
Financing activities	1,742.6	828.2	833.1	505.1	(392.7)
Balance Sheet Data (in millions, as of December 31):					
Cash and cash equivalents	$ 3,653.9	$ 4,198.6	$ 3,961.4	$ 2,407.0	$ 1,313.5
Total assets	11,764.7	8,364.6	6,152.8	5,145.8	4,446.5
Long-term debt, including current maturities	2,126.4	1,182.4	997.6	1,199.1	888.6
Total liabilities	7,524.7	5,947.9	4,152.7	3,417.5	2,850.6
Total stockholders' equity	4,240.0	2,416.7	2,000.1	1,728.3	1,595.9

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

(2) Effective January 1, 2018, the Company redefined our SG&A ratio (GAAP) to be a percentage of total revenues. Adjusted SG&A ratio was redefined to be a percentage of total revenues excluding Medicaid premium tax reimbursement and Medicaid ACA industry fee reimbursement. Accordingly, results for the years ended 2017, 2016, 2015 and 2014 were adjusted to conform to this presentation. Our SG&A ratio (GAAP)

decreased by 0.1% for the year ended December 31, 2017. Our SG&A ratio was unaffected for years ended 2016, 2015 and 2014. Our Adjusted SG&A ratio was unaffected for each period.

(3) Our Adjusted SG&A expense ratio measures selling, general and administrative expense as a percentage of total revenues, excluding Medicaid premium tax reimbursement for all years presented and the Medicaid ACA industry fee reimbursements for the years ended December 31, 2018, 2016, 2015 and 2014. The Medicaid ACA industry fee reimbursement was not applicable for the year ended December 31, 2017 due to the one-year moratorium. The ratio also excludes the effect of investigation costs for all years presented, Sterling divestiture, Iowa SG&A and pharmacy benefit manager ("PBM") transitory costs; and certain costs associated with our acquisitions of Meridian, Universal American and the Aetna Part D membership, as applicable.

(4) Net cash used in investment activities has been retrospectively adjusted to reflect the adoption of ASU 2016-18, *"Statement of Cash Flows (Topic 230): Restricted Cash"* effective January 1, 2018. Accordingly, investment activities for years ended 2017, 2016, 2015 and 2014 were adjusted by $95.5 million, ($88.1) million, $48.4 million and ($59.6) million, respectively. See Note 2 - *Summary of Significant Accounting Policie*s for further discussion.

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

The following discussion and analysis of our financial condition and results of operations should be read in conjunction with Item 6 – *Selected Financial Data* and our consolidated financial statements and related notes appearing elsewhere in this 2018 Form 10-K. The following discussion contains forward-looking statements that involve risks, uncertainties and assumptions that could cause our actual results to differ materially from management's expectations. Factors that could cause such differences include those set forth under Part I, Item 1 – *Business* and Part I, Item 1A – *Risk Factors*, as well as *Forward-Looking Statements* discussed earlier in this 2018 Form 10-K.

OVERVIEW

Introduction

WellCare Health Plans, Inc. (the "Company," "we," "us," "our") focuses primarily on providing government-sponsored managed care services to families, children, seniors and individuals with complex medical needs, primarily through Medicaid, Medicare Advantage ("MA") and Medicare Prescription Drug Plans ("PDP"), as well as individuals in the Health Insurance Marketplace. As of December 31, 2018, we served approximately 5.5 million members. During the twelve months ended December 31, 2018, we operated Medicaid health plans, including states where we receive Medicaid premium revenues associated with dually eligible special needs plans, in Arizona, Florida, Georgia, Hawaii, Illinois, Kentucky, Michigan, Missouri, Nebraska, New Jersey, New York, South Carolina and Texas.

As of December 31, 2018, we operated MA coordinated care plans ("CCPs") in Arizona, Arkansas, California, Connecticut, Florida, Georgia, Hawaii, Illinois, Indiana, Kentucky, Louisiana, Maine, Michigan, Mississippi, New Jersey, New York, North Carolina, Ohio, South Carolina, Tennessee and Texas, as well as stand-alone Medicare prescription drug plans ("PDP") nationwide.

We began serving Medicaid and Medicare members in Arizona, effective December 31, 2016, in connection with the acquisition of Care1st Health Plan Arizona, Inc. and One Care by Care1st Health Plan of Arizona, Inc. (together "Care1st Arizona"). Effective January 1, 2017, we began serving Medicaid members statewide in Nebraska. In connection with the acquisition of Meridian Health Plan of Michigan, Inc., Meridian Health Plan of Illinois, Inc., and MeridianRx, a pharmacy benefit manager ("PBM") (collectively, “Meridian”) we began serving Medicaid and Medicare members in Michigan, as well as MA members in Indiana and Ohio.

Summary of Consolidated Financial Results

Summarized below are the key financial highlights for the year ended December 31, 2018. For additional information, refer to the "Results of Operations" section, which discusses both consolidated and segment results.

- ***Membership*** increased by 1,167,000 members, or 26.7%, in 2018 compared with 2017, as discussed below in "*Results of Operations*." The growth was primarily driven by our September 2018 acquisition of Meridian, as well as organic growth in our Medicaid Health Plans and Medicare Health Plans segments. These increases were partially offset by decreased membership in our Medicare PDP segment resulting from our 2018 bid positioning.

- ***Premiums*** increased $3.2 billion, or 18.8%, in 2018 compared with 2017, primarily reflecting our acquisitions of Meridian in September 2018 and Universal American in April 2017. The increase is also attributed to the assignment of additional members in our Illinois Medicaid health plan, effective January 1, 2018, participation in the Missouri Medicaid program expansion, effective May 1, 2017, organic growth in our Medicare Health Plans segment and the expiration of the 2017 ACA industry fee moratorium (discussed in *Key Development and Accomplishments* below), which reestablished the associated Medicaid ACA industry fee reimbursements from our state government partners for 2018. These increases were partially offset by the previously discussed membership declines in our PDP segment.

- ***Net Income*** increased $66.1 million, or 17.7%, in 2018 compared with 2017 driven by continued improvement in operational execution across all of our segments, the acquisition of Universal American in April 2017 and the effect of the *Tax Cuts and Jobs Act of 2017* ("TCJA"), which reduced the U.S. federal statutory corporate income tax rate from 35% to 21% effective January 1, 2018. These increases are partially offset by the favorable effect of revaluing our deferred tax assets and liabilities in 2017 as a result of the *TCJA*, the expiration of the 2017 ACA industry fee moratorium and reestablishment of the ACA industry fee for 2018, which is nondeductible for tax purposes.

Key Developments and Accomplishments

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

- In February 2019, we received notice from the North Carolina Department of Health and Human Services (“DHHS”) that we were awarded a contract to administer the state’s Medicaid Prepaid Health Plans, which is subject to a protest process. DHHS has selected four health plans, including us, to serve North Carolina's Medicaid beneficiaries on a statewide basis. One additional health plan led by providers was selected to operate health plans in certain regions. The state is expected to implement the new managed care program, in two phases, for its 1.6 million Medicaid beneficiaries beginning November 1, 2019.

- In November 2018, we completed the asset purchase of Aetna Inc.'s ("Aetna") entire standalone Medicare Part D prescription drug plan membership ("Aetna Part D membership"), which Aetna divested as part of CVS Health Corporation's acquisition of Aetna, for total approximate consideration of $107.2 million in cash, which is subject to certain true-up provisions. Per the terms of the agreements, Aetna will provide administrative services to, and retain financial risk of, the Aetna Part D membership through 2019. Therefore, the Aetna Part D membership will be excluded from our membership and results of operations until January 1, 2020.

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

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

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

- In August 2018, $225.0 million was drawn on our Revolving Credit Facility to partially fund the Meridian acquisition, of which $25.0 million was repaid during September 2018. As of December 31, 2018, $200.0 million was outstanding under the Revolving Credit Facility.

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

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

- In March 2018, we announced that our Arizona subsidiary, Care1st Health Plan Arizona, Inc., was selected to enter into a contract with the Arizona Health Care Cost Containment System ("AHCCCS") to coordinate the provision of physical and behavioral healthcare services in the Central and North geographic service areas ("GSAs"). Under the

new program, health plans were eligible to be awarded two of the three GSAs. Services under the new contract began on October 1, 2018. The initial term of the contract with AHCCCS is three years. The parties may extend the term upon mutual consent for up to two additional two-year terms.

- Effective January 1, 2017, the *Consolidated Appropriations Act, 2016* provided for a one-year moratorium on the ACA industry fee, which also eliminated the associated Medicaid ACA industry fee reimbursements from our state government partners. This 2017 moratorium expired effective January 1, 2018. Accordingly, we incurred $344.1 million of ACA industry fee expense for 2018. We did not incur ACA industry fee expense for 2017. Additionally, we recognized $302.2 million in Medicaid ACA industry fee reimbursement revenue for 2018. We did not receive any Medicaid ACA industry fee reimbursement revenue during 2017.

General Economic Environment, Political Environment and Health Care Reform

Please refer to Part I, Item 1 – *Business, General Economic and Political Environment Affecting our Business* and *Health Care Reform* for a further discussion of the current economic and political environment that is affecting our business.

Refer to the risks and uncertainties related to health care reform as discussed in Part I, Item 1A – *Risk Factors.*

RESULTS OF OPERATIONS

Consolidated Financial Results

The following table sets forth condensed data from our consolidated statements of operations data, as well as other key data used in our results of operations discussions for the years ended December 31, 2018, 2017 and 2016.

	For the Years Ended December 31,		
	2018	**2017**	**2016**
Revenues:	(Dollars in millions)		
Premium	$ 20,146.3	$ 16,960.3	$ 14,220.9
Products and services	154.1	—	—
Investment and other income	113.7	46.9	16.2
Total revenues	20,414.1	17,007.2	14,237.1
Expenses and other:			
Medical benefits	17,128.1	14,744.8	12,089.4
Costs of products and services	148.6	—	—
Selling, general and administrative	1,701.0	1,484.7	1,133.1
ACA industry fee	344.1	—	228.4
Medicaid premium taxes	126.8	119.8	110.0
Depreciation and amortization	179.7	120.4	87.6
Interest	87.5	68.5	59.1
Total expenses, net	19,715.8	16,538.2	13,707.6
Income from operations	698.3	469.0	529.5
Loss on extinguishment of debt	—	26.1	—
Income before income taxes and equity in earnings of unconsolidated subsidiaries	698.3	442.9	529.5
Equity in (losses) earnings of unconsolidated subsidiaries	(5.5)	18.7	—
Income before income taxes	692.8	461.6	529.5
Income tax expense	253.0	87.9	287.4
Net income	$ 439.8	$ 373.7	$ 242.1
Effective tax rate	36.5%	19.0%	54.3%
Membership by Segment			
Medicaid Health Plans	3,931,000	2,723,000	2,544,000
Medicare Health Plans	545,000	496,000	345,000
Medicare PDPs	1,057,000	1,152,000	1,009,000
Total Membership by Segment	5,533,000	4,371,000	3,898,000
Health Insurance Marketplace	5,000	—	—
Total Membership	5,538,000	4,371,000	3,898,000

Membership

2018 vs. 2017

As of December 31, 2018, membership increased approximately 1,167,000, or 26.7%, compared with December 31, 2017. Membership discussion by segment follows:

- *Medicaid Health Plans*. Membership increased by 1,208,000, or 44.4%, to 3.9 million members as of December 31, 2018.The increase was primarily driven by the acquisition of Meridian, as well as organic membership growth primarily in our Illinois Medicaid health plan as a result of a new contract with the Illinois Department of Health Care and Family Services ("HFS") to administer the Health Choice Illinois Medicaid managed care program statewide, effective January 1, 2018.

- *Medicare Health Plans*. Membership increased by 49,000, or 9.9%, to 545,000 members as of December 31, 2018. The increase is partially a result of the acquisition of Meridian, which expanded our membership through the addition of Michigan, Indiana and Ohio, as well as deepened our presence in Illinois. Additionally, the increase reflects our organic growth.

- *Medicare PDPs*. Membership decreased by 95,000, or 8.2%, to 1.1 million members as of December 31, 2018. The decrease was primarily the result of our 2018 bid positioning. Our 2018 PDP bids resulted in one of our basic plans being below CMS benchmarks in 25 of the 34 CMS regions, and within the *de minimis* range in five other regions, compared with our 2017 bids, in which we were below the benchmarks in 30 of the 34 CMS regions, and within the *de minimis* range in three other regions.

2017 vs. 2016

As of December 31, 2017, membership increased approximately 473,000, or 12.1%, compared with December 31, 2016. Membership discussion by segment follows:

- *Medicaid Health Plans*. Membership increased by 179,000, or 7.0%, to 2.7 million members as of December 31, 2017. The increase was primarily driven by our participation in Missouri's Medicaid program statewide expansion, our new Nebraska Medicaid plan, and membership acquired from Phoenix Health Plan in our Arizona market. The increase was partially offset by declines in our Georgia health plan membership because the State added a fourth managed care organization, effective July 1, 2017.

- *Medicare Health Plans*. Membership increased by 151,000, or 43.8%, to 496,000 members as of December 31, 2017. The increase primarily reflects our acquisition of Universal American, our 2017 bid positioning and continued execution on sales and retention initiatives, partially offset by planned service area reductions for the 2017 plan year.

- *Medicare PDPs*. Membership increased by 143,000, or 14.2%, to 1.2 million members as of December 31, 2017. The increase was primarily the result of our 2017 bid positioning. Our 2017 PDP bids resulted in one of our basic plans being below the benchmarks in 30 of the 34 CMS regions, and within the *de minimis* range in three other regions. Our 2016 PDP bids resulted in one of our basic plans being below the benchmarks in 17 of the 34 CMS regions, and within the *de minimis* range in nine other regions.

Net income

2018 vs. 2017

For the year ended December 31, 2018, our net income increased by $66.1 million, or 17.7%, compared with the same period in 2017 driven by continued improvement in operational execution across all of our segments, the acquisitions of Universal American in April 2017 and the effect of the TCJA, which reduced the U.S. federal statutory corporate income tax rate from 35% to 21% effective January 1, 2018 (discussed in Note 14 - *Income Taxes* to the consolidated financial statements of this 2018 Form 10-K). These increases are partially offset by the expiration of the 2017 ACA industry fee moratorium and reestablishment of the ACA industry fee for 2018, which is nondeductible for tax purposes and the favorable effect of revaluing our deferred tax assets and liabilities in 2017 as a result of the *TCJA.* Refer to *Segment Reporting* below for a discussion of current developments, operating results and other key performance measures by reportable segment.

2017 vs. 2016

For the year ended December 31, 2017, our net income increased by $131.6 million, or 54.4%, compared with the same period in 2016 driven by continued improvement in operational execution, primarily in the Medicaid Health Plans and Medicare Health Plans segments, as well as the acquisitions of Universal American and Care1st Arizona. The increase is also attributed to the effect of the ACA industry fee moratorium for 2017, the effect of the TCJA, and the recognition of certain earnings related to unconsolidated subsidiaries. These increases are partially offset by $37.5 million in one-time transaction and integration costs related to the acquisition of Universal American, and a $26.1 million loss on extinguishment of debt, primarily related to the early redemption, on April 7, 2017, of our 2020 Notes.

Premium revenue

2018 vs. 2017

Premium revenue for the year ended December 31, 2018, increased approximately $3.2 billion, or 18.8%, compared with the same period in 2017, reflecting our acquisitions of Meridian in September 2018 and Universal American in April 2017, the assignment of additional members in our Illinois Medicaid health plan, organic growth in our Medicare Health Plans segment and the expiration of the 2017 ACA industry fee moratorium, which reestablished the associated Medicaid ACA industry fee reimbursements from our state government partners for 2018 as discussed in "*Key Developments and Accomplishments*." These increases were partially offset by the previously discussed membership declines in our Medicare PDP segment.

2017 vs. 2016

Premium revenue for the year ended December 31, 2017, increased $2.7 billion, or 19.3%, from 2016 compared with the same period in 2016, reflecting our acquisitions of Universal American and Care1st Arizona, our participation in the Missouri Medicaid program expansion, net rate increases in certain of our Medicaid markets, and organic growth across all three lines of business. These increases were partially offset by the effect of the ACA industry fee moratorium for 2017, which resulted in the elimination of any associated Medicaid ACA industry fee reimbursements from our state government partners.

Medical benefits expense

2018 vs. 2017

Medical benefits expense for the year ended December 31, 2018, increased $2.4 billion, or 16.2%, from 2017 primarily driven by the previously noted 2018 and 2017 acquisitions, the assignment of additional members in our Illinois Medicaid health plan and additional organic membership growth in our Medicaid Health Plans and Medicare Health Plans segments. The increases were partially offset by the previously discussed membership declines in our Medicare PDP segment and the favorable result of continued performance in clinical and pharmacy execution.

2017 vs. 2016

Medical benefits expense for the year ended December 31, 2017, increased $2.7 billion, or 22.0%, primarily driven by the previously noted 2017 and 2016 acquisitions, our participation in the Missouri Medicaid program expansion, and additional organic membership growth across all lines of business. The increase was partially offset by the favorable result of continued performance in clinical and pharmacy execution.

Selling, general and administrative expense ("SG&A")

SG&A expense, under generally accepted accounting principles in the United States of America ("GAAP"), includes aggregate costs related to previously disclosed government investigations and related litigation and resolution costs ("Investigation costs"). Refer to Note 13–*Commitments and Contingencies* within the consolidated financial statements included in this 2018 Form 10-K for additional discussion of these Investigation costs.

SG&A expense also included certain costs associated with our 2018 acquisitions of Meridian and Aetna Part D membership as well as the 2017 acquisition of Universal American ("Transaction and integration costs"); certain activities relating to the divestiture of Sterling Life Insurance Company ("Sterling divestiture costs"), our prior Medicare Supplement business; transitory costs related to our decision to change our pharmacy benefit manager ("PBM") as of January 1, 2016 ("PBM transitory costs"); and certain non-recurring Iowa related SG&A expenses relating to readiness costs, certain wind-down costs of WellCare's Iowa operations and certain legal costs ("Iowa SG&A costs"). Although the above items may recur, we believe that by providing non-GAAP measurements exclusive of these items, we facilitate period-over-period comparisons and provide additional clarity about events and trends affecting our core operating performance, as well as providing comparability to competitor results. The Investigation costs are related to a discrete incident, which we do not expect to re-occur. The other costs mentioned above are related to specific events, which do not reflect the underlying ongoing performance of our business. The non-GAAP financial measures should be considered in addition to, but not as a substitute for, or superior to, financial measures prepared in accordance with GAAP. Below is a reconciliation of these non-GAAP measures with the most directly comparable financial measure calculated in accordance with GAAP.

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

	For the Years Ended December 31,		
	2018	2017	2016
	(In millions)		
SG&A expense	$ 1,701.0	$ 1,484.7	$ 1,133.1
Adjustments:			
Investigation costs	(0.4)	(7.9)	(16.0)
Transaction and integration costs	(33.1)	(37.5)	—
Sterling divestiture costs	—	—	(1.7)
PBM transitory costs	—	—	(4.9)
Iowa SG&A costs	—	—	(5.2)
Adjusted SG&A Expense	$ 1,667.5	$ 1,439.3	$ 1,105.3
SG&A ratio [1] [3]	8.3%	8.7%	8.0%
Adjusted SG&A ratio [2] [3]	8.3%	8.5%	8.0%

(1) SG&A expense, as a percentage of total revenues.

(2) Adjusted SG&A expense, as a percentage of total revenue, excluding Medicaid premium tax reimbursement and Medicaid ACA industry fee reimbursement. Because reimbursements for Medicaid premium tax and ACA industry fee are both included in the premium rates or reimbursement established in certain of our Medicaid contracts and also recognized separately as a component of expense, we exclude these reimbursements from total revenue when calculating key ratios as we believe that these components are not indicative of operating performance.

(3) Effective January 1, 2018, the Company redefined our SG&A ratio (GAAP) to be a percentage of total revenues. Adjusted SG&A ratio was redefined to be a percentage of total revenues excluding Medicaid premium tax reimbursement and Medicaid ACA industry fee reimbursement. Accordingly, results for the years ended December 31, 2017 and 2016 were adjusted to conform to this presentation, which decreased our SG&A ratio (GAAP) by 0.1% and 0.0% for each year, respectively. Adjusted SG&A ratio was unaffected for each year.

2018 vs. 2017

Our SG&A expense for the year ended December 31, 2018, increased approximately $216.3 million, or 14.6%, compared with the same period in 2017, primarily reflecting our 2018 acquisition of Meridian, staffing and infrastructure costs to support organic growth, our 2017 acquisition of Universal American and variable management incentive compensation due to improved company performance. Our SG&A ratio decreased by 40 basis points for the year ended December 31, 2018, compared with the same period in 2017, primarily reflecting the expiration of the 2017 ACA industry fee moratorium, which reestablished the associated Medicaid ACA industry fee reimbursements from our state government partners for 2018, continued improvements in operating efficiency, and lower year-over-year transaction and integration costs; partially offset by higher variable management incentive compensation in 2018.

Our Adjusted SG&A expense for the year ended December 31, 2018, increased approximately $228.2 million, or 15.9%, compared with the same period in 2017, primarily reflecting our 2018 acquisition of Meridian, our 2017 acquisition of Universal American and variable management incentive compensation due to improved company performance. Our Adjusted SG&A ratio decreased by 20 basis points for the year ended December 31, 2018, compared with the same period in 2017, primarily reflecting continued improvements in operating efficiency, partially offset by higher variable management incentive compensation in 2018.

2017 vs. 2016

Our SG&A expense for the year ended December 31, 2017, increased approximately$351.6 million or 31.0%, compared with the same period in 2016. Additionally, our SG&A ratio increased by 70 basis points for the year ended December 31, 2017, compared with the same period in 2016. These increases were primarily the result of our acquisitions of Universal American, including one-time transaction and integration costs, and Care1st Arizona, staffing and infrastructure costs to support organic growth, and variable management incentive compensation due to improved company performance. The increase in the SG&A ratio is also due to the effect of the ACA industry fee moratorium for 2017, which resulted in the elimination of any associated Medicaid ACA industry fee reimbursements from our state government partners.

Our Adjusted SG&A expense for the year ended December 31, 2017, increased approximately$334.0 million, or 30.2%, compared with the same period in 2016. Additionally, our Adjusted SG&A ratio increased by 50 basis points for the year ended December 31, 2017, compared with the same period in 2016. These increases were primarily the result of our acquisitions of Universal American and Care1st Arizona as well as variable management incentive compensation due to improved company performance.

ACA Industry Fee

2018 vs. 2017

Effective January 1, 2017, the *Consolidated Appropriations Act, 2016* provided for a one-year moratorium on the ACA industry fee, which also eliminated the associated Medicaid ACA industry fee reimbursements from our state government partners. This 2017 moratorium expired effective January 1, 2018. Accordingly, we incurred $344.1 million for the ACA industry fee for the year ended December 31, 2018. We did not incur ACA industry fee expense for 2017.

2017 vs. 2016

Due to the effect of the previously noted ACA industry fee moratorium for 2017, we did not incur ACA industry fee expense for the year ended December 31, 2017, compared with $228.4 million for the same period in 2016.

Loss on extinguishment of debt

The loss on extinguishment of debt of $26.1 million primarily related to the early redemption of our $900.0 million aggregate principal amount of our 5.75% senior notes due 2020 Notes (the "2020 Notes") on April 7, 2017 (discussed further in Note 10 - *Debt* to the consolidated financial statements in this 2018 Form 10-K). In connection with the redemption we incurred a one-time loss on extinguishment of debt related to the redemption premium, the write-off of associated deferred financing costs and the write-off of the unamortized portion of associated premiums paid on the 2020 Notes.

Income Tax Expense

2018 vs. 2017

Income tax expense for the year ended December 31, 2018, increased $165.1 million, or 187.8%, compared with the same period in 2017, while our effective tax rate for the year ended December 31, 2018, increased to 36.5% compared with 19.0% for the same period in 2017. These increases were primarily driven by the favorable effect of revaluing our deferred tax assets and liabilities in 2017 as a result of the TCJA, the recognition of certain previously unrecognized tax benefits in 2017, and the effect of the nondeductible ACA industry fee incurred in 2018 as a result of the expiration of the 2017 ACA industry fee moratorium. These increases were partially offset by the effect of federal income tax rate decreases in 2018 associated with the TCJA. Refer to Note 14 - *Income Taxes* to the consolidated financial statements in this 2018 Form 10-K for further discussion regarding the recognition of previously unrecognized tax benefits in 2017 and the current year tax effect of the TCJA.

2017 vs. 2016

Income tax expense for the year ended December 31, 2017, decreased $199.5 million, or 69.4%, compared with the same period in 2016, while the effective tax rate for the year ended December 31, 2017, decreased to 19.0% compared with 54.3% for the same period in 2016. The decrease in income tax expense was primarily driven by the one-year moratorium on the non-deductible ACA industry fee for 2017, higher excess tax benefits resulting from the settlement of stock-compensation awards in 2017 and the favorable effect of the recognition of certain previously unrecognized tax benefits during 2017. The decrease is also related to the effect of revaluing the Company's deferred tax assets and liabilities as a result of the TCJA.

Segment Reporting

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

Segment Financial Performance Measures

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

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

For further information regarding premium revenues and medical benefits expense, please refer below to "*Premium Revenue Recognition and Premiums Receivable*" and "*Medical Benefits Expense and Medical Benefits Payable*" under "*Critical Accounting Estimates.*"

Reconciling Segment Results

The following table reconciles our reportable segment results with our income from operations (before income taxes), as reported in accordance with generally accepted accounting principles in the United States of America ("GAAP").

	For the Years Ended December 31,		
	2018	2017	2016
Gross Margin[1]:		(In millions)	
Medicaid Health Plans	$ 1,478.4	$ 1,192.4	$ 1,052.8
Medicare Health Plans	856.6	742.9	533.9
Medicare PDPs	211.9	160.4	206.4
Corporate and other[2]	5.9	—	—
Total gross margin	2,552.8	2,095.7	1,793.1
Investment and other income	113.7	46.9	16.2
Other expenses, net [3]	(1,968.2)	(1,673.6)	(1,279.8)
Income from operations	$ 698.3	$ 469.0	$ 529.5

(1) Effective January 1, 2018, the Company redefined gross margin as total revenues less investment and other income, medical benefits expense, costs of products and services, the ACA industry fee expense, and Medicaid premium tax expense. Accordingly, results for the years ended December 31, 2017 and 2016 were adjusted to include Medicaid premium taxes, which decreased gross margin by $119.8 million and $110.0 million, respectively.

(2) Corporate and other category includes businesses that are not individually reportable because they do not meet the quantitative thresholds required by generally accepted accounting principles.

(3) Effective January 1, 2018, other expenses include SG&A expenses, depreciation, amortization and interest. Accordingly, results for the years ended December 31, 2017 and 2016 were adjusted to exclude Medicaid premium taxes, which decreased other expenses by $119.8 million and $110.0 million, respectively.

Medicaid Health Plans

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

Medicaid Health Plans Results of Operations

The following table sets forth the summarized results of operations and other relevant performance measures for our Medicaid Health Plans segment for the years ended December 31, 2018, 2017 and 2016:

	For the Years Ended December 31,		
	2018	**2017**	**2016**
	(In millions)		
Premium revenue [1]	$ 12,563.8	10,606.5	9,144.4
Medicaid premium tax reimbursement [1]	126.8	119.8	110.0
Medicaid ACA industry fee reimbursement [1]	302.2	—	244.9
Total premiums	12,992.8	10,726.3	9,499.3
Medical benefits expense	11,171.3	9,414.1	8,188.5
Medicaid premium tax	126.8	119.8	110.0
ACA industry fee	216.3	—	148.0
Gross margin[2]	$ 1,478.4	$ 1,192.4	$ 1,052.8
Medicaid Health Plans MBR [1]	86.0%	87.8 %	86.2%
Effect of:			
Medicaid premium taxes	0.9%	1.1 %	1.0%
Medicaid ACA industry fee reimbursement	2.0%	— %	2.3%
Medicaid Health Plans Adjusted MBR [1]	88.9%	88.8 %	89.5%
Medicaid Health Plans Membership:			
Illinois	842,000	138,000	166,000
Florida	777,000	751,000	780,000
Michigan	500,000	—	—
Georgia	493,000	513,000	571,000
Kentucky	444,000	448,000	440,000
Other states [3]	875,000	873,000	587,000
	3,931,000	2,723,000	2,544,000

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

(2) Effective January 1, 2018, the Company redefined gross margin as total revenues less investment and other income, medical benefits expense, costs of products and services, the ACA industry fee expense, and Medicaid premium tax expense. Accordingly, results for the years ended December 31, 2017 and 2016 were adjusted to include Medicaid premium taxes, which decreased gross margin by $119.8 million and $110.0 million, respectively.

(3) "All other states" consists of Arizona, Hawaii, Missouri, New Jersey, New York, South Carolina and Texas. In 2017 and 2018, it also includes Nebraska.

2018 vs. 2017

Medicaid total premiums increased $2.3 billion, or 21.1%, for the year ended December 31, 2018, compared with the same period in 2017, primarily driven by our September 2018 acquisition of Meridian; the expiration of the 2017 ACA industry fee moratorium, which reestablished the associated Medicaid ACA industry fee reimbursements from our state government partners in 2018; the assignment of additional members in our Illinois Medicaid health plan, effective January 1, 2018; and net premium rate increases in certain of our Medicaid markets. The increase is also attributable to organic growth in certain markets including Arizona, Missouri and New York, which are partially offset by eligibility decreases in certain of our Medicaid markets. The increases are also partially offset by lower average membership in our Georgia health plan due to the introduction of a fourth managed care organization in the State, effective July 1, 2017.

Excluding Medicaid premium taxes and Medicaid ACA industry fee reimbursements, Medicaid premium revenue increased $2.0 billion, or 18.5%, for the year ended December 31, 2018, compared with the same period in 2017. The increase is a result of our 2018 acquisition of Meridian, the assignment of additional members in our Illinois Medicaid health plan, effective January 1, 2018, and net premium rate increases in certain of our Medicaid markets. The increases were partially offset by the lower Georgia membership and net eligibility decreases in certain of our Medicaid markets noted above.

Medical benefits expense increased by approximately $1.8 billion, or 18.7% for the year ended December 31, 2018, compared with the same period in 2017, primarily resulting from the previously discussed acquisition of Meridian, the assignment of additional members in our Illinois Medicaid health plan, effective January 1, 2018, and organic growth in certain markets, including Arizona, Missouri and New York. These increases are partially offset by the previously discussed lower average membership in our Georgia health plan, eligibility decreases in certain of our Medicaid markets and the favorable result of continued performance in clinical and pharmacy execution.

Our Medicaid Health Plans segment MBR decreased by 180 basis points for the year ended December 31, 2018, compared with the same period in 2017. The decrease is primarily a result of the expiration of the 2017 ACA industry fee moratorium, which reestablished the associated Medicaid ACA industry fee reimbursements from our state government partners for 2018, net premium rate increases in certain of our Medicaid markets and the favorable result of continued performance in clinical and pharmacy execution.

Excluding the effect of Medicaid premium taxes and Medicaid ACA industry fee reimbursements, our Medicaid Health Plans Adjusted MBR is consistent with the same period in 2017.

2017 vs. 2016

Medicaid total premiums increased $1.2 billion, or 12.9%, for the year ended December 31, 2017, compared with the same period in 2016, primarily driven by membership acquired from our Arizona acquisitions, our new Nebraska Medicaid plan and our participation in Missouri's Medicaid program statewide expansion. The increase is also attributable to net rate increases in certain of our existing Medicaid markets. These increases were partially offset by the effect of the previously noted ACA industry fee moratorium for 2017, which resulted in the elimination of any associated Medicaid ACA industry fee reimbursements from our state government partners.

Excluding Medicaid premium taxes and Medicaid ACA industry fee reimbursements, Medicaid premium revenue increased $1.5 billion, or 16.0%, for the year ended December 31, 2017, compared with the same period in 2016. The increase is a result of our previously discussed 2017 and 2016 Medicaid acquisitions, our new Nebraska Medicaid program and our participation in the Missouri Medicaid program statewide expansion. The increase is also attributable to net increases in certain of our existing Medicaid markets.

Medical benefits expense increased by approximately $1.2 billion, or 15.0%, for the year ended December 31, 2017, compared with the same period in 2016, primarily resulting from the previously discussed net increase in membership, including growth from acquisitions and organic growth resulting from our new Nebraska market and Missouri's statewide expansion.

Our Medicaid Health Plans segment MBR increased by 160 basis points for the year ended December 31, 2017, compared with the same period in 2016. The increase is primarily a result of the effect of the ACA industry fee moratorium, and, as a result the elimination of associated Medicaid reimbursement revenue, the addition of our new Medicaid businesses in Arizona and Nebraska, and new members from the statewide expansion of the Missouri Medicaid program. This increase was partially offset by continued operational execution and net rate increases in certain Medicaid markets.

Excluding the effect of Medicaid premium taxes and Medicaid ACA industry fee reimbursements, our Medicaid Health Plans Adjusted MBR decreased by 70 basis points for the year ended December 31, 2017, compared with the same period in 2016. The decrease is primarily the result of continued operational execution and net rate increases in certain Medicaid markets, partially offset by the addition of our new Medicaid businesses in Arizona and Nebraska, and new members from the statewide expansion of the Missouri Medicaid program.

Medicare Health Plans

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

In 2018, we operated our MA CCPs in 524 counties across 21 states, including Arizona, Arkansas, California, Connecticut, Florida, Georgia, Hawaii, Illinois, Indiana, Kentucky, Louisiana, Maine, Michigan, Mississippi, New Jersey, New York, North Carolina, Ohio, South Carolina, Tennessee and Texas. We cover a wide spectrum of medical services through our MA plans. For many of our plans, we provide additional benefits not covered by Original Medicare, such as vision, dental and hearing services. Through these enhanced benefits, out-of-pocket expenses incurred by our members are generally reduced, which better allows our members to manage their health care costs.

Medicare Health Plans Results of Operations

The following table sets forth the summarized results of operations and other relevant performance measures for our Medicare Health Plans segment for the years ended December 31, 2018, 2017 and 2016:

	For the Years Ended December 31,		
	2018	**2017**	**2016**
	(In millions)		
Premium revenue	$ 6,313.8	$ 5,320.2	$ 3,876.6
Medical benefits expense	5,347.8	4,577.3	3,278.5
ACA industry fee	109.4	—	64.2
Gross margin	$ 856.6	$ 742.9	$ 533.9
Medicare Health Plans Membership	545,000	496,000	345,000
Medicare Health Plans MBR	84.7%	86.0%	84.6%

2018 vs. 2017

Medicare Health Plans premium revenue increased by $1.0 billion, or 18.7%, for the year ended December 31, 2018, compared with the same period in 2017, primarily driven by our 2018 bid strategy, organic growth, and the acquisitions of Meridian in September 2018 and Universal American in April 2017.

Medicare Health Plans medical benefits expense increased $0.8 billion, or 16.8%, for the year ended December 31, 2018, compared with the same period in 2017, primarily due to increased membership acquired from the acquisitions of Meridian in September 2018 and Universal American in April 2017, as well as organic growth in certain markets. The Medicare Health Plans MBR decreased by 130 basis points for the year ended December 31, 2018, compared with the same period in 2017, primarily resulting from our 2018 bid positioning and the favorable result of continued performance in clinical and pharmacy execution.

2017 vs. 2016

Medicare Health Plans premium revenue increased by $1.4 billion, or 37.2%, for the year ended December 31, 2017, compared with the same period in 2016, primarily driven by our acquisition of Universal American, our 2017 bid strategy and organic growth.

Medicare Health Plans medical benefits expense increased $1.3 billion, or 39.6%, for the year ended December 31, 2017, compared with the same period in 2016, primarily due to increased membership acquired from the acquisition of Universal American and increased membership as a result of our 2017 bid positioning. The Medicare Health Plans MBR increased by 140 basis points for the year ended December 31, 2017, compared with the same period in 2016, primarily resulting from the acquisition of Universal American, bid considerations due to the ACA industry fee moratorium in 2017 and increased investments in quality program initiatives.

Medicare PDPs

We have contracted with CMS to serve as a plan sponsor offering stand-alone Medicare Part D PDPs to Medicare eligible beneficiaries through our Medicare PDPs segment. The PDP benefit design generally results in our incurring a greater portion of the responsibility for total prescription drug costs in the early stages of a plan year and less in the latter stages of a plan year due to the members' share of cumulative out-of-pocket costs increasing throughout the plan year. As a result, the Medicare PDPs MBR is generally lower in the second half of the year as compared with the first half. In addition, the level and mix of members who are auto-assigned to us and those who actively choose our PDPs will affect the segment MBR pattern across periods.

Medicare PDPs Results of Operations

The following table sets forth the summarized results of operations and other relevant performance measures for our Medicare PDPs segment for the years ended December 31, 2018, 2017 and 2016:

	For the Years Ended December 31,		
	2018	**2017**	**2016**
	(In millions)		
Premium revenue	$ 835.0	$ 913.8	$ 845.0
Medical benefits expense	604.8	753.4	622.4
ACA industry fee	18.3	—	16.2
Gross margin	$ 211.9	$ 160.4	$ 206.4
Medicare PDPs membership	1,057,000	1,152,000	1,009,000
Medicare PDPs MBR	72.4%	82.4%	73.7%

2018 vs. 2017

The Medicare PDPs premium revenue decreased $78.8 million, or 8.6%, for the year ended December 31, 2018, compared with the same period in 2017. Medical benefits expense decreased $148.6 million, or 19.7%, for the year ended December 31, 2018, compared with the same period in 2017. The decreases were primarily a result of our 2018 bid positioning and, related to the decrease in medical benefits, continued performance in pharmacy execution. The Medicare PDPs MBR decreased by 1,000 basis points for the year ended December 31, 2018, compared with the same period in 2017 reflecting the effect of our 2018 bid strategy.

2017 vs. 2016

The Medicare PDPs premium revenue increased $68.8 million, or 8.1%, for the year ended December 31, 2017, compared with the same period in 2016. Medical benefits expense increased $131.0 million, or 21.0%, for the year ended December 31, 2017, compared with the same period in 2016. The increases were primarily due to the increase in membership resulting from

our 2017 bid strategy. The Medicare PDPs MBR increased by 870 basis points for the year ended December 31, 2017 compared with the same period in 2016 reflecting the effect of our 2017 bid strategy.

Business Trends and Inflation

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

2019 Outlook

The guidance below does not reflect teh recently announced North Carolina award, as discussed in "*Key Developments and Accomplishments*."

Medicaid Health Plans - We expect premium revenue (GAAP) for our Medicaid Health Plans segment to be in the range of $17.1 billion to $17.6 billion for 2019, compared with $13.0 billion for 2018. We expect premium revenue for our Medicaid Health Plans, excluding $130.0 million to $135.0 million in Medicaid premium taxes to be in the range of $17.0 billion to $17.5 billion for 2019, compared with $12.6 billion reported for 2018, excluding $126.8 million in Medicaid premium taxes and $302.2 million Medicaid ACA industry fee reimbursements.

The Medicaid Health Plans MBR (GAAP) is expected to be in the range of 88.8% to 89.3% for 2019, compared with 86.0% for 2018. The Medicaid Health Plans Adjusted MBR is expected to be in the range of 89.5% to 90.0%, compared to 88.9% reported in 2018. These increases reflect new business mix as a result of the company’s expanded Medicaid contract in Florida and the acquisition of Meridian in 2018. Additionally, the GAAP Medicaid Health Plans MBR reflects the absence of Medicaid ACA industry fee reimbursement in 2019.

Medicare Health Plans - We expect premium revenue for our Medicare Health Plans segment to be in the range of $7.2 billion to $7.5 billion for 2019, compared with $6.3 billion reported for 2018. Our Medicare Health Plans MBR is expected to be in the range of 85.0% to 85.8% for 2019, compared with 84.7% in 2018, reflecting our 2019 bid strategy, partially offset by continued operational execution.

Medicare PDPs - We expect premium revenue for our Medicare PDPs segment to be in the range of $1.05 billion to $1.15 billion for 2019, compared with $835.0 million for 2018. The premium revenue increase is due to the introduction of a new enhanced product in 2019. Medicare PDPs MBR is expected to be in the range of 82.5% to 83.5% for 2019, compared with 72.4% for 2018 due to bid positioning for the 2019 plan year.

Consolidated SG&A - Our consolidated SG&A ratio (GAAP) is not estimable as we currently are not able to project future amounts associated with Transaction and Integration costs associated with our acquisitions, as defined earlier. We expect that our consolidated Adjusted SG&A ratio for 2019 will be approximately 7.65% to 7.80%, compared with 8.3% for 2018, resulting from improved operating leverage associated with premium revenue growth and continued synergies from our acquisitions.

Income Taxes - Our consolidated effective income tax rate (GAAP) is not estimable as we currently are not able to project future amounts associated with Transaction and Integration costs associated with our acquisitions, as defined earlier. However, we expect our effective income tax rate to decrease in 2019 compared to 2018 due to the one-year moratorium of the ACA industry fee in 2019. The ACA industry fee, which was reinstated in 2018 and was nondeductible for tax purposes, had the effect of increasing our income tax rate in 2018.

LIQUIDITY AND CAPITAL RESOURCES

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

Liquidity

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

Regulated subsidiaries

Our regulated subsidiaries' primary liquidity requirements include:

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

Our regulated subsidiaries meet their liquidity needs by:

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

We refer collectively to the cash, cash equivalents and investment balances maintained by our regulated subsidiaries as "regulated cash and investments." Our regulated subsidiaries generally receive premiums in advance of payments of claims for medical and other health care services; however, regulated cash, cash equivalents and investments can fluctuate significantly in a particular period depending on the timing of receipts for premiums from our government partners. Our unrestricted regulated cash, cash equivalents and investments was $4.8 billion at both December 31, 2018 and December 31, 2017, primarily due to cash and investments acquired with the Meridian acquisition, earnings from operations and contributions received from the parent and non-regulated subsidiaries, offset by $742.1 million paid to CMS in November 2018 for the 2017 Medicare Part D program plan year (see discussion in Medicare Part D Funding and Settlements below), the ACA industry fee payment remitted to the IRS in September 2018, cash on hand used to fund the acquisition of Aetna’s PDP membership and dividends paid to the parent and non-regulated subsidiaries.

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

Parent and Non-regulated Subsidiaries

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

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

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

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

Unregulated cash, cash equivalents and investments totaled approximately $516.0 million at December 31, 2018, a decrease of approximately $101.0 million from $617.0 million at December 31, 2017. The decrease is primarily due to capital contributions to our regulated subsidiaries, the interest payments for our 2025 Notes and cash on hand used to fund the Meridian acquisition, partially offset by cash acquired in the Meridian acquisition and dividends from certain of our regulated subsidiaries.

Medicare Part D Funding and Settlements

Funding may be provided to certain regulated subsidiaries from our unregulated subsidiaries to cover any shortfall resulting from the amount of Part D benefits paid for members on behalf of CMS that exceeds the prospective subsidy payments that these regulated subsidiaries receive from CMS. We receive certain Part D prospective subsidy payments from CMS for our MA and PDP members as a fixed monthly per member amount, based on the estimated costs of providing prescription drug benefits over the plan year, as reflected in our bids. A discussion of the subsidy components under Part D is included in Note 2- *Significant Accounting Policies* to the consolidated financial statements included in this 2018 Form 10-K. The benefits include the catastrophic reinsurance, premium and cost sharing for low income Part D members ("LICS"), for which CMS will fully reimburse these subsidies, or recoup overpaid subsidies made during the plan year, as part of its annual settlement process that typically occurs in the fourth quarter of the subsequent year.

Cash Flow Activities

Our cash flows are summarized as follows:

	For the Years Ended December 31,		
	2018	**2017**	**2016**
		(In millions)	
Net cash provided by operating activities	$ 279.0	$ 1,050.0	$ 748.3
Net cash used in investing activities[(1)]	(2,568.0)	(1,736.5)	61.1
Net cash provided by financing activities	1,742.6	828.2	833.1
(Decrease) increase in cash, cash equivalents and restricted cash and cash equivalents[(1)]	$ (546.4)	$ 141.7	$ 1,642.5

(1) Net cash used in investment activities and the increase in cash and cash equivalents have been retrospectively adjusted to reflect the adoption of ASU 2016-18, "*Statement of Cash Flows (Topic 230): Restricted Cash*" effective January 1, 2018. See Note 2 - *Summary of Significant Accounting Policies* for further discussion.

Cash Flows from Operating Activities

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

2018 vs. 2017

Net cash provided by operating activities for 2018 was $279.0 million, compared with $1.1 billion for 2017. The decrease is primarily due to the timing of Medicaid premium receivable receipts, the ACA industry fee payment made in September 2018; partially offset by the timing of the Medicaid ACA industry fee reimbursement payments and cash flows from operations.

2017 vs. 2016

Net cash provided by operating activities for 2017 was $1.1 billion, compared with $748.3 million for 2016. The increase is primarily due to improved operating earnings and the timing of claim payments, as well as the one-year moratorium on the ACA industry fee in 2017.

Cash Flows from Investing Activities

2018 vs. 2017

Net cash used in investing activities for 2018 was $2.6 billion compared with $1.7 billion for the same period in 2017. The increase primarily due to the September 2018 acquisition of Meridian and Aetna's PDP membership, partially offset by the 2017 Universal American acquisition and higher sales of investments during 2018.

2017 vs. 2016

Net cash used in investing activities for 2017 was $1.7 billion compared with cash provided by $61.1 million for the same period in 2016. The increase primarily resulted from higher purchases of investments in 2017 to improve investment income, as well as the acquisitions of Universal American during 2017. Net cash used in investing activities for 2016 included the acquisition of Care1st Arizona.

Cash flows from financing activities

2018 vs. 2017

Cash flows from financing activities are primarily affected by debt-related activity, as well as net funds received or paid for the benefit of members of our MA and PDP plans. Cash provided by financing activities for 2018 was $1.7 billion, compared with $828.2 million for the same period in 2017, primarily driven by the following:

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

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

- Net funds paid for the benefit of members was approximately $520.6 million for 2018, compared with net funds received of $671.6 million during 2017. These funds represent the net amounts we paid for related prescription drug benefits, described above in "*Medicare Part D Funding and Settlements"*, net of the amounts of subsidies we received from CMS in connection with the low-income cost sharing, catastrophic reinsurance and coverage gap discount components of the Medicare Part D program related to the government's portion of financial responsibility. The increase in funds paid in 2018 compared with the same period in 2017 is due to $742.1 million paid to CMS in November 2018 to settle the 2017 Medicare Part D program plan year, compared with $92.8 million paid in 2017 to settle the 2016 plan year, as well as the effect of our 2018 bids, resulting in lower payments received for 2018 net subsidies.

2017 vs. 2016

Cash flows from financing activities are primarily affected by debt-related activity, as well as net funds received or paid for the benefit of members of our MA and PDP plans. Cash provided by financing activities for 2017 was $828.2 million, compared with $833.1 million for the same period in 2016, primarily driven by the following:

- Net funds received for the benefit of members was approximately $671.6 million for 2017, compared with $1.0 billion during 2016. These funds represent the net amounts of subsidies we received from CMS in connection with the low-income cost sharing, catastrophic reinsurance and coverage gap discount components of the Medicare Part D program related to the government's portion of financial responsibility, net of the amounts we paid for related prescription drug benefits, described above in "Medicare Part D Funding and Settlements." The decrease in funds received in 2017

compared with the same period in 2016 is due to the effect of our 2017 bids, as well as the timing of pharmacy claims payments in 2016.

- Aggregate net proceeds of $156.1 million resulting from debt transactions executed during 2017 reflecting net proceeds of $1.2 billion received from the issuance of our 2025 Notes in March 2017, partially offset by the early redemption in full of our $900.0 million principal amount of 2020 notes in April 2017, including the $25.9 million redemption premium, and a $100.0 million repayment of outstanding borrowings under our Revolving Credit Facility. Refer to "Capital Resources" below for further discussion of our 2017 debt transactions. Debt-related activity for 2016 reflects $200.0 million drawn from our Revolving Credit Facility, which, along with $100.0 million in cash, was used to repay in full the $300.0 million term loan under our prior credit facility.

Capital Resources

Debt

5.375% Senior Notes due 2026

On August 13, 2018, we completed the offering and sale of our 2026 Notes. The aggregate net proceeds from the issuance of the 2026 Notes were $739.0 million, with the net proceeds from the offering being used to fund a portion of the cash consideration for our acquisition of Meridian.

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

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

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

In addition, the 2026 Indenture requires that for the Company to merge, consolidate or sell all or substantially all of its assets, (i) either the Company must be the surviving entity, or the surviving entity or purchaser must be a U.S. entity; (ii) the surviving entity or purchaser must assume all the obligations of the Company under the 2026 Notes and the 2026 Indenture; (iii) no default or event of default (as defined under the Indenture) exits and (iv) the surviving entity, after giving pro forma effect to the transaction, (x) may incur at least $1.00 of additional indebtedness pursuant to the fixed charge coverage ratio or (y) have a fixed charge coverage ratio that is no worse than the fixed charge coverage ratio of the Company without giving pro forma effect to the transactions.

5.25% Senior Notes due 2025

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

The 2025 Notes were issued under an indenture, dated as of March 22, 2017 (the "Base Indenture"), as supplemented by the First Supplemental Indenture, dated as of March 22, 2017 (the "First Supplemental Indenture" and, together with the Base

Indenture, the "2025 Indenture"), each between the Company and The Bank of New York Mellon Trust Company, N.A. (“BNY Mellon”), as trustee. The 2025 Indenture under which the notes were issued contains covenants that, among other things, limit our ability and the ability of our subsidiaries under certain circumstances to:

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

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

5.75% Senior Notes due 2020

In November 2013, we issued $600.0 million in aggregate principal amount of our 2020 Notes. In June 2015, we issued an additional $300.0 million of 2020 Notes, pursuant to a reopening of such notes. Refer to Note 10 - *Debt* to the consolidated financial statements included in this 2018 Form 10-K for additional information regarding these 2020 Notes.

In April 2017, we redeemed the full $900.0 million in aggregate principal amount outstanding of our 2020 Notes at a redemption price of 102.875% of the principal amount, plus accrued and unpaid interest. Our obligations under the related base indenture, each dated as of November 14, 2013, by and among us and BNY Mellon, as trustee, were satisfied and discharged on April 7, 2017. In connection with the redemption of the 2020 Notes, we incurred a one-time loss on extinguishment of debt of approximately $25.9 million related to the redemption premium, the write-off of associated deferred financing costs and the write-off of the unamortized portion of associated premiums paid on the 2020 Notes. The loss on extinguishment of debt is reflected in our results of operations for 2017.

Credit Agreement

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

Unutilized commitments under the Amended and Restated Credit Agreement are subject to a fee of 0.20% to 0.30% depending upon our ratio of total debt to consolidated earnings before interest, taxes, depreciation and amortization ("EBITDA"), as calculated in accordance with the Amended and Restated Credit Agreement.

Revolving Credit Loans designated by us at the time of borrowing as “ABR Loans” that are outstanding under the Credit Agreement bear interest at a rate per annum equal to (i) the greatest of (a) the Prime Rate (as defined in the Credit Agreement) in effect on such day; (b) the Federal Reserve Bank of New York Rate (as defined in the Credit Agreement) in effect on such day plus 1/2 of 1%; and (c) the Adjusted LIBO Rate (as defined in the Credit Agreement) for a one-month interest period on such day plus 1%; plus (ii) the Applicable Rate. Revolving Credit Loans designated by us at the time of borrowing as “Eurodollar Loans” that are outstanding under the Credit Agreement bear interest at a rate per annum equal to the Adjusted LIBO Rate (as defined in the Credit Agreement) for the interest period in effect for such borrowing plus the Applicable Rate. Pursuant to the Amended and Restated Credit Agreement, the “Applicable Rate” decreased to a range of (A) 0.375% to 1.00% per annum for ABR Loans and (B) 1.375% to 2.00% per annum for Eurodollar Loans, in each case depending on our ratio of

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

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

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

As of December 31, 2018, $200.0 million was outstanding under our Revolving Credit Facility. Additionally, we were in compliance with all covenants under the 2026 Notes, the 2025 Notes and the Amended and Restated Credit Agreement. For additional information on our long-term debt, see Note 10 - *Debt* to the consolidated financial statements included in this 2018 Form 10-K.

Shelf Registration Statement

In November 2018, we filed a shelf registration statement on Form S-3 with the SEC that became automatically effective covering the registration, issuance and sale of an indeterminate amount of our securities, including common stock, preferred stock, senior or subordinated debt securities, depository shares, securities purchase contracts, units or warrants. We may publicly offer securities in the future at prices and terms to be determined at the time of the offering.

Initiatives to Increase Our Unregulated Cash

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

Regulatory Capital and Dividend Restrictions

Each of our HMO and insurance subsidiaries must maintain a minimum amount of statutory capital determined by statute or regulation. The minimum statutory capital requirements differ by state and are generally based on a percentage of annualized premium revenue, a percentage of annualized health care costs, a percentage of certain liabilities, a statutory minimum, risk-based capital ("RBC") requirements or other financial ratios. The RBC requirements are based on guidelines established by the National Association of Insurance Commissioners ("NAIC") and have been adopted by most states. The statutory framework for our regulated subsidiaries' minimum capital requirements could change over time. For instance, RBC requirements may be adopted by more of the states in which we operate. In addition, regulators could require our subsidiaries to maintain minimum levels of statutory net worth in excess of the amount required under the applicable state laws if the regulators determine that maintaining such additional statutory net worth is in the best interest of our members and other constituencies. Failure to maintain these requirements would trigger regulatory action by the state. To the extent our HMO and insurance subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. Based upon current statutes and regulations, the minimum capital and surplus requirement, or net assets, for these subsidiaries that may not be transferable to us in the form of loans, advances, or cash dividends was approximately $1.6 billion at December 31, 2018, and $1.2 billion at December 31, 2017. The combined statutory capital and surplus of our HMO and insurance subsidiaries was $2.7 billion and $2.0 billion at December 31, 2018 and 2017. These increases were primarily the result of the Meridian acquisition, as well as organic growth in all of our lines of business. Our HMO and insurance subsidiaries were in compliance with and in excess of the minimum capital requirements as of both December 31, 2018 and 2017.

Such statues, regulations and capital requirements also restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. Dividend restrictions vary by state, but the maximum amount of dividends which can be paid without prior approval from the applicable state is subject to restrictions relating to statutory capital, surplus and net income for the previous year. Some states require prior approval of all dividends, regardless of amount. States may disapprove any dividend that, together with other dividends paid by a subsidiary in the prior 12 months, exceeds the regulatory maximum as computed for the subsidiary based on its statutory surplus and net income. We received $335.6 million, $335.0 million and $241.0 million in dividends from our regulated subsidiaries during the years ended December 31, 2018, 2017, and 2016, respectively. The 2018 amount included $65.6 million not requiring prior regulatory approval, and $270.0 million paid after obtaining prior regulatory approval. Under applicable regulatory requirements at December 31, 2018, the amount of dividends that may be paid through the end of 2019 by our HMO and insurance subsidiaries without prior approval by regulatory authorities is approximately $420.7 million in the aggregate. Actual dividends paid may vary due to consideration of excess statutory capital and surplus and expected future surplus requirements related to, for example, premium volume and product mix.

For additional information on regulatory requirements, see Note 16 – *Regulatory Capital and Dividend Restrictions* to the consolidated financial statements in this 2018 Form 10-K.

Commitments and Contingencies

The following table sets forth information regarding our contractual obligations as of December 31, 2018.

	Payments due to period				
	Total	**Less Than 1 Year**	**1 - 3 Years**	**3 - 5 Years**	**More than 5 Years**
			(In millions)		
Operating leases	$ 364.3	$ 42.4	$ 89.9	$ 80.6	$ 151.4
Purchase obligations [1]	94.1	65.7	25.8	2.6	—
Long-term debt [2]	2,150.0	—	—	—	2,150.0
Interest on debt [3]	700.6	103.3	206.6	206.6	184.1
Total	$ 3,309.0	$ 211.4	$ 322.3	$ 289.8	$ 2,485.5

(1) Our purchase obligations include commitments under contracts for equipment leases and software maintenance.
(2) Represents the principal amount of the 2025 Notes and 2026 Notes and borrowings outstanding under our Revolving Credit Facility as of December 31, 2018. This amount excludes $23.6 million of unamortized debt issuance costs, which is reflected as a reduction to our long-term debt in our consolidated balance sheet.
(3) Represents projected interest on the 2025 Notes and 2026 Notes. These projections exclude the variable interest on the $200.0 million principal amount drawn under the Revolving Credit Facility.

We are not an obligor under or guarantor of any indebtedness of any other party; however, we may have to pay referral claims of health care providers under contract with us who are not able to pay costs of medical services provided by other providers.

OFF BALANCE SHEET ARRANGEMENTS

At December 31, 2018, we did not have any off-balance sheet financing arrangements except for operating leases as described in the table above.

CRITICAL ACCOUNTING ESTIMATES

In the ordinary course of business, we make a number of estimates and assumptions relating to the reporting of our results of operations and financial condition in conformity with GAAP. We base our estimates on historical experience and on various other assumptions that we believe to be reasonable under the circumstances. Actual results could differ significantly from those estimates under different assumptions and conditions. We believe that our accounting estimates relating to premium revenue recognition and premiums receivable, medical benefits expense and medical benefits payable, and goodwill and intangible assets, are those that are most important to the portrayal of our financial condition and results and require management's most difficult, subjective and complex judgments, often as a result of the need to make estimates about the effect of matters that are inherently uncertain.

Premium Revenue Recognition and Premiums Receivable

We earn premium revenue through our participation in Medicaid, Medicaid-related and Medicare programs. Our Medicaid contracts with state agencies generally are multi-year contracts subject to annual renewal provisions, while our Medicare contracts with CMS renew annually. Our Medicare and Medicaid contracts establish fixed, monthly premium rates per member ("PMPM"), which are generally determined at the beginning of each new contract renewal period; however, premiums may be adjusted by CMS and state agencies throughout the terms of the contracts in certain cases. Premium rate changes are recognized in the period the change becomes effective, when the effect of the change in the rate is reasonably estimable and collection is assured. Our contracts also have additional provisions as described in the sections below.

We recognize premium revenue in the period in which we are obligated to provide services to our members. We are generally paid by CMS and state agencies in the month in which we provide services. On a monthly basis, we bill members for any premiums for which they are responsible according to their respective plan. We record premiums earned but not received as premiums receivable and record premiums received in advance of the period of service as unearned premiums in the consolidated balance sheets. Unearned premiums are recognized as revenue when we provide the related services. Member premiums are recognized as revenue in the period of service. We estimate, on an on-going basis, the amount of members' billings that may not be collectible, based on our evaluation of historical trends. An allowance is established for the estimated amount that may not be collectible. In addition, we routinely monitor the collectability of specific premiums receivable from CMS and state agencies, including Medicaid receivables for obstetric deliveries and newborns and net receivables for member retroactivity and reduce revenue and premiums receivable by the amount we estimate may not be collectible.

Premium payments are based upon eligibility lists produced by CMS and state agencies. We verify these lists to determine whether we have been paid for the correct premium category and program. From time to time, CMS and state agencies require us to reimburse them for premiums that we received for individuals who were subsequently determined to be ineligible for any government-sponsored program or to belong to a plan other than ours. Additionally, the verification of membership may result in additional premiums due to us from CMS and state agencies for individuals who were subsequently determined to belong to our plan for periods in which we received no premium for those members. We estimate the amount of outstanding retroactivity adjustments and adjust premium revenue based on historical trends, premiums billed, the volume of member and contract renewal activity and other information. We record amounts receivable in premiums receivable, net and amounts payable in other accrued expenses and liabilities in the consolidated balance sheets.

Supplemental Medicaid Premiums

We earn supplemental premium payments for eligible obstetric deliveries and/or newborns for our Medicaid members in several states. We also earn supplemental Medicaid premium payments in some states for high cost drugs and other eligible services. Each state Medicaid contract specifies how and when these supplemental payments are earned and paid. We recognize supplemental premium revenue in the period we provide related services to our members.

Medicaid ACA Industry Fee Reimbursement

The ACA industry fee began in 2014. For 2016 and 2018, we received amendments, written agreements or other documentation from all of our state Medicaid customers that commit them to reimburse us for the portion of the ACA industry fee attributable to our Medicaid plans, including its non-deductibility for income tax purposes. We recognized $302.2 million and $244.9 million of reimbursement for the ACA industry fee as premium revenue for the years ended December 31, 2018 and 2016, respectively. The Consolidated Appropriations Act, provided for a one-year moratorium on the ACA industry fee in 2017, and, as a result, eliminated the associated Medicaid ACA industry fee reimbursements from our state government partners for 2017. Accordingly, we did not recognize any Medicaid ACA industry fee reimbursement revenue for the year ended December 31, 2017.

Medicaid Risk-Adjusted Premiums and Retroactive Rate Changes

As previously discussed, Medicaid premium rate changes are recognized in the period the change becomes effective, when the effect of the change in the rate is reasonably estimable and collection is assured. In some instances, our Medicaid premiums are subject to risk score adjustments based on the health profile of our membership. Generally, the risk score is determined by the state agency's analysis of encounter submissions of processed claims data to determine the acuity of our membership relative to the entire state's Medicaid membership. The frequency of when states adjust premiums varies, but is usually done quarterly or semi-annually on a retrospective basis. We recognize periodic changes to risk-adjusted premiums as revenue when the amounts are determinable and collection is reasonably assured. Historically, we have not experienced significant differences between our estimates and amounts ultimately paid or received.

Medicare Risk-Adjusted Premiums

CMS provides risk-adjusted payments for MA Plans and PDPs based on the demographics and health severity of enrollees. The risk-adjusted premiums we receive are based on claims and encounter data that we submit to CMS within prescribed deadlines. We develop our estimates for risk-adjusted premiums utilizing historical experience, or other data, and predictive models as sufficient member risk score data becomes available over the course of each CMS plan year. We recognize periodic changes to risk-adjusted premiums as revenue when the amounts are determinable and collection is reasonably assured, which is possible as additional diagnosis code information is reported to CMS, when the ultimate adjustment settlements are received from CMS or we receive notification of such settlement amounts. CMS adjusts premiums on two separate occasions on a retrospective basis. The first retrospective adjustment for a given plan year generally occurs during the third quarter of that year. This initial settlement represents the update of risk scores for the current plan year based on the severity of claims incurred in the prior plan year. CMS then issues a final retrospective risk adjusted premium settlement for that plan year in the following year. We develop our estimates for risk-adjusted premiums utilizing historical experience and predictive models as sufficient member risk score data becomes available over the course of each CMS plan year. We populate our models with available risk score data on our members and base risk-adjusted premiums on risk score data from the previous year. We are not privy to risk score data for members new to our plans in the current plan year; therefore, we include assumptions regarding these members' risk scores. We periodically revise our estimates of risk-adjusted premiums as additional diagnosis code information is reported to CMS and adjust our estimates to actual amounts when the ultimate adjustment settlements are either received from CMS or we receive notification from CMS of such settlement amounts. As a result of the variability of factors that determine our estimates for risk-adjusted premiums, the actual amount of the CMS retroactive payment could be materially more or less than our estimates and could have a material effect on our results of operations, financial position and cash flows. We record any changes in estimates in current operations as adjustments to premium revenue. Historically, we have not experienced significant differences between our estimates and amounts ultimately received. The data provided to CMS to determine members' risk scores is subject to audit by CMS even after the annual settlements occur. An audit may result in the refund of premiums to CMS. While our experience to date has not resulted in a material refund, future refunds could materially reduce premium revenue in the year in which CMS determines a refund is required and could be material to our results of operations, financial position and cash flows.

Minimum Medical Expense and Risk Corridor Provisions

We may be required to refund certain premium revenue to state agencies and CMS under various contractual and plan arrangements. We estimate the effect of the following arrangements on a monthly basis and reflect any adjustments to premium revenues in current operations. We report the estimated net amounts due to state agencies and CMS in other payables to government partners in the consolidated balance sheets.

Certain of our Medicaid contracts require us to expend a minimum percentage of premiums on eligible medical benefits expense. To the extent that we expend less than the minimum percentage of the premiums on eligible medical benefits, we are required to refund to the state all or some portion of the difference between the minimum and our actual allowable medical benefits expense. Additionally, certain of our Medicaid contracts include other types of risk sharing arrangements (e.g., profit sharing arrangements) that require return of revenue to the state or receipt of revenue from the state, based on certain pre-tax earnings, net earnings or other results of operations-based calculations. In all arrangements, we estimate the amounts due from or to the state agencies based on the terms of our contracts with the applicable state agency and record the amounts as a change in premium. Historically, we have not experienced material differences between our recorded estimates and the subsequent state agencies settlement amounts.

Our MA and PDP premiums are subject to risk sharing through the CMS Medicare Part D risk corridor provisions. The risk corridor calculation compares our actual experience to the target amount of prescription drug costs, limited to costs under the

standard coverage as defined by CMS, less rebates included in our submitted plan year bid. We receive additional premium from CMS if our actual experience is more than 5% above the target amount. We refund premiums to CMS if our actual experience is more than 5% below the target amount. Based on the risk corridor provision and PDP activity-to-date, an estimated risk-sharing receivable or payable is recorded as an adjustment to premium revenue. After the close of the annual plan year, CMS performs the risk corridor calculation and any differences are settled between CMS and our plans. Historically, we have not experienced material differences between the subsequent CMS settlement amount and our recorded estimates.

Beginning in 2014, the ACA required the establishment of a minimum medical loss ratio ("MLR") for MA plans and Part D plans, requiring them to spend not less than 85% of premiums on medical benefits. The rules implementing the minimum MLR impose financial and other penalties for failing to achieve the minimum MLR, including requirements to refund to CMS shortfalls in amounts spent on medical benefits and termination of a plan's MA contract for prolonged failure to achieve the minimum MLR. MLR is determined by adding a plan's spending for clinical services, prescription drugs and other direct patient benefits, plus its total spending on quality improvement activities and dividing the total by earned premiums (after subtracting specific identified taxes and other fees). These provisions did not have a material effect on our results of operations in 2018, 2017 or 2016.

A summary of other net payables to government partners is as follows (in millions):

	As of December 31,	
	2018	2017
Liability to states under Medicaid risk sharing provisions	$ (178.5)	$ (142.5)
Liability to CMS under risk corridor and other provisions	(232.0)	(179.1)
Liability to CMS under MA/PDP minimum MLR provisions of the ACA	(19.9)	(1.2)
Net payables to government partners[1]	$ (430.4)	$ (322.8)

(1) The components of net payables to government partners are classified in the consolidated balance sheets as $28.5 million and $458.9 million in current assets and current liabilities, respectively, as of December 31, 2018 and $44.2 million and $367.0 million in current assets and current liabilities, respectively, as of December 31, 2017.

Medicare Part D Subsidies

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 MA and PDP members as a fixed monthly per member amount, based on the estimated costs of providing prescription drug benefits over the plan year, as reflected in our bids. 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. The subsidy components under Part D are described below.

Low-Income Cost Sharing Subsidy ("LICS") - For qualifying low income members, CMS reimburses us for all or a portion of the low income member's deductible, coinsurance and co-payment amounts above the out-of-pocket threshold.

Catastrophic Reinsurance Subsidy - CMS reimburses plans for 80% of the drug costs after a member reaches his or her out-of-pocket catastrophic threshold through a catastrophic reinsurance subsidy.

Coverage Gap Discount Subsidy ("CGDS") - CMS provides monthly prospective payments for pharmaceutical manufacturer discounts made available to members.

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

CGDS advance payments are recorded within Funds receivable/held for the benefit of members in the consolidated balance sheets. Receivables are set up for manufacturer-invoiced amounts. Manufacturer payments reduce the receivable as payments

are received. After the end of the contract year, during the Medicare Part D Payment reconciliation process for the CGD, CMS will perform a cost-based reconciliation to ensure the Medicare Part D sponsor is paid for gap discounts advanced at the point of sale, based on accepted prescription drug event data.

Funds payable for the benefit of members, net consisted of the following (in millions):

	As of December 31,	
	2018	2017
Low-income cost sharing subsidy	$ 97.7	$ (47.7)
Catastrophic reinsurance subsidy	(583.2)	(987.1)
Coverage gap discount subsidy	(20.5)	(13.6)
Funds payable for the benefit of members, net[(1)]	$ (506.0)	$ (1,048.4)

(1) The components of net funds payable for the benefit of members, net are classified in the consolidated balance sheets as $187.3 million and $693.3 million in current assets and current liabilities, respectively, as of December 31, 2018, and as $27.5 million and $1.1 billion in current assets and current liabilities, respectively, as of December 31, 2017.

Estimating Medical Benefits Expense and Medical Benefits Payable

We recognize the cost of medical benefits in the period in which services are provided, including an estimate of the cost of medical benefits incurred but not reported ("IBNR"). Medical benefits expense includes direct medical expenses and certain medically-related administrative costs. Direct medical expenses include amounts paid or payable to hospitals, physicians, pharmacy benefit managers and providers of ancillary services. Recorded direct medical expenses are reduced by the amount of pharmacy rebates earned, which are estimated based on historical utilization of specific pharmaceuticals, current utilization and contract terms. Pharmacy rebates earned but not yet received from pharmaceutical manufacturers are included in pharmacy rebates receivable in the accompanying consolidated balance sheets. Direct medical expenses may also include reserves for estimated referral claims related to health care providers under contract with us who are financially troubled or insolvent and who may not be able to honor their obligations for the costs of medical services provided by other providers. In these instances, we may be required to honor these obligations for legal or business reasons. Based on our current assessment of providers under contract with us, such losses have not been and are not expected to be significant. Also included in direct medical expense are our estimates for provider settlements due to clarification of contract terms, out-of-network reimbursement, claims payment differences and amounts due to contracted providers under risk-sharing and/or value-based arrangements.

Consistent with the criteria specified and defined in guidance issued by the Department of Health and Human Services ("HHS") for costs that qualify to be reported as medical benefits under the minimum MLR provision of the ACA, we record certain medically-related administrative costs such as preventive health and wellness, care management, and other quality improvement costs, as medical benefits expense. All other medically-related administrative costs, such as utilization review services, network and provider credentialing and claims handling costs, are recorded in selling, general, and administrative expense.

Medical benefits payable represents amounts for claims fully adjudicated but not yet paid and estimates for IBNR. Our estimate of IBNR is the most significant estimate included in our consolidated financial statements. We determine our best estimate of the base liability for IBNR utilizing consistent standard actuarial methodologies based upon key assumptions, which vary by business segment. Our assumptions include current payment experience, trend factors and completion factors. Trend factors in our standard actuarial methodologies include contractual requirements, historic utilization trends, the interval between the date services are rendered and the date claims are paid, denied claims activity, disputed claims activity, benefit changes, expected health care cost inflation, seasonality patterns, maturity of lines of business, changes in membership and other factors.

The following table provides a detail of the components of medical benefits payable:

	December 31, 2018	% of Total	December 31, 2017	% of Total
	(In millions)			
IBNR	$ 2,029.8	70%	$ 1,412.3	66%
Other medical benefits payable	867.6	30%	734.0	34%
Total medical benefits payable	$ 2,897.4	100%	$ 2,146.3	100%

The factors and assumptions that are used to develop our estimate of medical benefits expense and medical benefits payable inherently are subject to greater variability when there is more limited experience or information available to us. The ultimate claims payment amounts, patterns and trends for new products and geographic areas cannot be precisely predicted at their onset since we, the providers and the members do not have experience in these products or geographic areas. Standard accepted actuarial methodologies, discussed above, would allow for this inherent variability. This can result in larger differences between the originally estimated medical benefits payable and the actual claims amounts paid. Conversely, during periods where our products and geographies are more stable and mature, we have more reliable claims payment patterns and trend experience. With more reliable data, we should be able to more closely estimate the ultimate claims payment amounts; therefore, we may experience smaller differences between our original estimate of medical benefits payable and the actual claim amounts paid.

In developing our estimates, we apply different estimation methods depending on the month for which incurred claims are being estimated. For the more recent months, which constitute the majority of the amount of the medical benefits payable, we estimate claims incurred by applying observed trend factors to the fixed fee PMPM costs for prior months, which costs have been estimated using completion factors in order to estimate the PMPM costs for the most recent months. We validate our estimates of the most recent PMPM costs by comparing the most recent months' utilization levels to the utilization levels in prior months and actuarial techniques that incorporate a historical analysis of claim payments, including trends in cost of care provided and timeliness of submission and processing of claims.

Many aspects of the managed care business are not predictable. Medical cost trends potentially are more volatile than other segments of the economy. Therefore, we must continually monitor our historical experience in determining our trend assumptions to reflect the ever-changing mix, needs and size of our membership. External factors such as government-mandated benefits or other regulatory changes, catastrophes and epidemics may affect medical cost trends. Other internal factors such as system conversions and claims processing changes may affect our ability to accurately predict estimates of historical completion factors or medical cost trends. We believe that the amount of medical benefits payable as of December 31, 2018 is adequate to cover our ultimate liability for unpaid claims as of that date; however, actual payments may differ from established estimates. If the completion factors we used in estimating our IBNR for the year ended December 31, 2018 were decreased by 1%, our medical benefits expense would increase by approximately $229.7 million. If the completion factors were increased by 1%, our medical benefits expense would decrease by approximately $224.4 million.

After determining an estimate of the base liability for IBNR, we make an additional estimate, also using standard actuarial techniques, to account for adverse conditions that may cause actual claims to be higher than the estimated base reserve. We refer to this additional liability as the provision for moderately adverse conditions. Our estimate of the provision for moderately adverse conditions captures the potential adverse development from factors such as:

- our entry into new geographical markets;
- our provision of services to new populations such as the aged, blind and disabled;
- variations in utilization of benefits and increasing medical costs, including higher drug costs;
- changes in provider reimbursement arrangements;
- variations in claims processing speed and patterns, claims payment and the severity of claims; and
- health epidemics or outbreaks of disease such as the flu or enterovirus.

We evaluate our estimates of medical benefits payable as we obtain more complete claims information and medical expense trend data over time. We record differences between actual experience and estimates used to establish the liability, which we refer to as favorable and unfavorable prior year reserve developments, as increases or decreases to medical benefits expense in the period we identify the differences.

The following table provides a reconciliation of the beginning and ending balance of our consolidated medical benefits payable:

	Years Ended December 31,		
	2018	2017	2016
	(In millions)		
Balances as of beginning of period	$ 2,146.3	$ 1,690.5	$ 1,536.0
Acquisitions (divestitures)	534.3	128.1	37.3
Medical benefits incurred related to:			
Current year [1]	17,603.4	15,112.4	12,374.1
Prior year	(475.3)	(367.6)	(284.7)
Total	17,128.1	14,744.8	12,089.4
Medical benefits paid related to:			
Current year	(15,486.3)	(13,355.9)	(10,925.0)
Prior year	(1,425.0)	(1,061.2)	(1,047.2)
Total	(16,911.3)	(14,417.1)	(11,972.2)
Balances as of end of year	$ 2,897.4	$ 2,146.3	$ 1,690.5

(1) Incurred amounts for 2018 and 2017 include a premium deficiency reserve for our Illinois Medicaid programs ("Illinois PDR"), which amounted to $16.1 million and $45.6 million, respectively, as discussed further in Note 2 - *Summary of Significant Accounting Policies* to the consolidated financial statements included in this 2018 Form 10-K.

Medical benefits payable recorded developed favorably by approximately $475.3 million, $367.6 million and $284.7 million in 2018, 2017 and 2016, respectively. The release of the provision for moderately adverse conditions included in our prior year estimates was substantially offset by the provision for moderately adverse conditions established for claims incurred in the current year. Accordingly, the favorable development in our estimate of medical benefits payable related to claims incurred in prior years does not directly correspond to a decrease in medical benefits expense recognized during the period in which the favorable development is recognized.

Excluding the prior year development related to the release of the provision for moderately adverse conditions, our estimates of consolidated medical benefits expense recorded developed favorably by approximately $243.8 million, $224.6 million, and $154.3 million in 2018, 2017 and 2016, respectively. Such amounts are net of the development relating to refunds due to government customers in connection with minimum loss ratio provisions. The net favorable development recognized in 2018, 2017 and 2016 was primarily in our Medicaid Health Plans segment and, to a lesser extent, in our Medicare Health Plans segment. The net favorable development resulted primarily from a number of operational and clinical initiatives planned and executed, that contributed to lower than expected pharmacy and medical trends, and actual claim submission time being faster than we originally assumed (i.e. our completion factors were higher than we originally assumed) in establishing our medical benefits payable in the prior years. This development does not directly correspond to an increase in our current year operating results as these reductions were offset by estimated current period medical benefits expense when we established our estimate of the current year medical benefits payable. Both completion factor and medical trend assumptions are influenced by utilization levels, unit costs, mix of business, provider reimbursement levels, processing system conversions and changes, claim inventory levels, claim processing patterns, our ability and practices to manage medical and pharmaceutical costs, claim submission patterns and operational changes resulting from business combinations, among others. Our actual costs were ultimately less than expected.

Premium Deficiency Reserves

We evaluate our contracts to determine if it is probable that a loss will be incurred. We establish a premium deficiency reserve ("PDR") when it is probable that expected future medical benefits and administrative expenses will exceed future premiums and reinsurance recoveries for the remainder of a contract period. For purposes of determining a PDR, we do not consider investment income and contracts are grouped in a manner consistent with our method of acquiring, servicing and measuring the profitability of such contracts. A PDR is recorded as medical benefits expense and in medical benefits payable. Once established, a PDR is reduced over the contract period as an offset to actual losses. We re-evaluate our PDR estimates each reporting period and, if estimated future losses differ from those in the current PDR estimate, we adjust the liability through medical benefits expense, as necessary.

We recorded a premium deficiency reserve for our Illinois Medicaid programs ("Illinois PDR") of $16.1 million and $45.6 million as of December 31, 2018 and 2017, respectively, in connection with our new Medicaid managed care contract with the Illinois Department of Health Care and Family Services ("HFS") that was effective on January 1, 2018 (the "Illinois PDR"). The Illinois PDR reflects the initial premium rate structure, estimated medical benefits and other costs expected to be incurred during the initial four-year contractual term of the contract.

Goodwill and Other Intangible Assets

Our acquisitions typically result in goodwill, which represents the excess of the acquisition cost over the fair value of net assets acquired. Goodwill is assigned to reporting units, which we determined to be the same as our operating segments. Goodwill recorded at December 31, 2018 was $2.2 billion compared with $660.7 million at December 31, 2017. Goodwill attributable to our Medicaid reporting unit was $274.7 million and $274.7 million at December 31, 2018 and 2017, respectively. Goodwill attributable to our MA reporting unit was $392.3 million and $386.0 million at December 31, 2018 and 2017, respectively. Additionally, we recorded $1.6 billion attributed to the Meridian acquisition that has not been assigned to a reporting unit as of December 31, 2018. The increases in goodwill for the various reporting unit from December 31, 2017 primarily resulted from our acquisition Meridian during 2018. Refer to Note 3 - *Acquisitions*, included in the consolidated financial statements in this 2018 Form 10-K for additional discussion.

We test goodwill for impairment at the reporting unit level at least annually, or more frequently if events or circumstances indicate that it would be more likely than not that the fair value of a reporting unit is below its carrying value. Such events or circumstances could include a significant adverse change in business climate, an adverse action or assessment by a regulator, unanticipated competition and the testing for recoverability of a significant asset group within a reporting unit, among others. To determine whether goodwill is impaired, we compare an estimate of the fair value of the applicable reporting unit to its carrying value, including goodwill. If the carrying value exceeds the estimated fair value, we compare the implied fair value of the applicable goodwill to its carrying value to measure the amount of goodwill impairment, if any. We perform our annual goodwill impairment test based on our financial position and results of operations as of June 30 of each year, which generally coincides with the finalization of federal and state contract negotiations and our initial budgeting and planning process. The annual impairment tests are based on an evaluation of estimated future discounted cash flows. The estimated discounted cash flows are based on the best information available to us at the time, including supportable assumptions and projections we believe are reasonable. Our discounted cash flow estimates use discount rates that correspond to a weighted-average cost of

capital consistent with a market-participant view. The discount rates are consistent with those used for investment decisions and take into account the operating plans and strategies of our operating segments. Certain other key assumptions utilized, including changes in membership, premium, health care costs, operating expenses, fees, assessments and taxes and effective tax rates, are based on estimates consistent with those utilized in our annual budgeting and planning process that we believe are reasonable. However, if we do not achieve the results reflected in the assumptions and estimates, our goodwill impairment evaluations could be adversely affected, and we may impair a portion of our goodwill, which would adversely affect our operating results in the period of impairment. Impairments, if any, would be classified as an operating expense. Based on the results of our annual impairment testing in 2018, we determined that the fair value of each reporting unit substantially exceeded its carrying value and no further goodwill impairment assessment was necessary.

Other intangible assets resulting from our acquisitions include provider networks, broker networks, trademarks, state contracts, non-compete agreements, licenses and permits. We amortize other intangible assets over their estimated useful lives ranging from approximately one to 15 years. These assets are allocated to reporting units for impairment testing purposes. We review our other intangible assets for impairment when events or changes in circumstances occur, which may potentially affect the estimated useful life or recoverability of the remaining balances of our intangible assets. Such events and changes in circumstances would include significant changes in membership, state funding, federal and state government contracts and provider networks. Upon such an occurrence, recoverability of assets to be held and used is measured by comparing the carrying amount of an asset to current forecasts of undiscounted future net cash flows expected to be generated by the assets. Identifiable cash flows are measured at the lowest level for which they are largely independent of the cash flows of other groups of assets and liabilities. If these assets are determined to be impaired, the amount of impairment recognized is measured by the amount by which the carrying amount of the assets exceeds their fair value. During 2018, 2017 and 2016, no events or circumstances have occurred, which may potentially affect the estimated useful life or recoverability of the remaining balances of our other intangible assets. Accordingly, there were no impairment losses recognized during these periods.

RECENTLY ADOPTED ACCOUNTING STANDARDS

Refer to Note 2 – *Summary of Significant Accounting Policies*, included in the consolidated financial statements for information and disclosures related to new accounting standards which are incorporated herein by reference.

Item 7A. Qualitative and Quantitative Disclosures about Market Risk.

Investment Return Market Risk

As of December 31, 2018, we had cash and cash equivalents of $3.7 billion, investments classified as current assets of $830.1 million, long-term investments of $813.2 million and restricted investments on deposit for licensure of $234.7 million. The short-term investments classified as current assets consist of highly liquid securities with maturities between three and twelve months that are considered available for sale. Restricted assets consist of cash and cash equivalents and U.S. Treasury instruments deposited or pledged to state agencies in accordance with state rules and regulations. These restricted assets are classified as long-term regardless of the contractual maturity date due to the nature of the states' requirements. The investments classified as long term are subject to interest rate risk and will decrease in value if market rates increase. Because of their contractual maturity dates, however, we would not expect the value of these investments to decline significantly as a result of a sudden change in market interest rates. Assuming a hypothetical and immediate 1% increase in market interest rates at December 31, 2018, the fair value of our fixed income investments would decrease by approximately $25.0 million. Similarly, a 1% decrease in market interest rates at December 31, 2018 would increase the fair value of our investments by approximately $25.0 million.

Item 8. Financial Statements and Supplementary Data.

Our consolidated financial statements and related notes required by this item are set forth in the WellCare Health Plans, Inc. financial statements included in Part IV, Item 15 of this filing.

Item 9. Changes In and Disagreements with Accountants on Accounting and Financial Disclosure.

None.

Item 9A. Controls and Procedures.

(a) ***Evaluation of Disclosure Controls and Procedures***

Management, under the leadership of our Chief Executive Officer ("CEO") and our Chief Financial Officer ("CFO"), is responsible for maintaining disclosure controls and procedures (as defined in Rules 13a-15(e) and 15d-15(e) under the Exchange Act) that are designed to ensure that information required to be disclosed in reports filed or submitted under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in the SEC rules and forms and that such information is accumulated and communicated to management, including our CEO and CFO, to allow timely decisions regarding required disclosures.

In connection with the preparation of this 2018 Form 10-K, our management, under the leadership of our CEO and CFO, evaluated the effectiveness of our disclosure controls and procedures ("Disclosure Controls"). Based on that evaluation, our CEO and CFO concluded that, as of December 31, 2018, our Disclosure Controls were effective in timely alerting them to material information required to be included in our reports filed with the SEC.

(b) Management's Report on Internal Control Over Financing Reporting

Our management is responsible for establishing and maintaining adequate internal control over financial reporting (as such term is defined in Rule 13a-15(f) under the Exchange Act). An evaluation was performed under the supervision and with the participation of our management, including our CEO and CFO, of the effectiveness of our internal control over financial reporting based on the framework *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission and updated in 2013 (the "COSO Framework"). Based on our evaluation under the COSO Framework, our management concluded that our internal control over financial reporting was effective as of December 31, 2018. Our independent registered public accounting firm, Deloitte & Touche, LLP, has issued an attestation report on the effectiveness of our internal control over financial reporting as of December 31, 2018, that is included herein.

As previously disclosed in this 2018 Form 10-K, on September 1, 2018, we acquired Meridian Health Plan of Michigan, Inc., Meridian Health Plan of Illinois, Inc. and MeridianRx, a pharmacy benefit manager (collectively "Meridian"), which is included in the 2018 consolidated financial statements and constituted 11.5% of total consolidated assets as of December 31, 2018 and 8.4% of total consolidated revenues for the year then ended. Refer to Note 3 - *Acquisitions* of this 2018 Form 10-K for further discussion of the acquisition. We are currently in the process of integrating the internal controls and procedures of Meridian into our internal controls over financial reporting. Changes to certain processes, information technology systems and other components of internal control over financial reporting (as defined in Rule 13a - 15(f) promulgated under the Securities and Exchange Act of 1934) resulting from the acquisition of Meridian may occur and will be evaluated by management as such integration activities are implemented. As provided under the Sarbanes-Oxley Act of 2002 and the applicable rules and regulations of the Securities and Exchange Commission, we intend to include the internal controls and procedures of Meridian in our annual assessment of the effectiveness of our internal control over financial reporting for our 2019 fiscal year.

(c) ***Changes in Internal Controls***

There has not been any change in our internal control over financial reporting (as defined in Rule 13a-15(f) of the Exchange Act) identified in connection with the evaluation required by Rule 13a-15(d) under the Exchange Act during the quarter ended December 31, 2018, that has materially affected, or is reasonably likely to materially affect, those controls.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the stockholders and the Board of Directors of
WellCare Health Plans, Inc. and subsidiaries

Opinion on Internal Control over Financial Reporting

We have audited the internal control over financial reporting of WellCare Health Plans, Inc. and subsidiaries (the "Company") as of December 31, 2018, based on criteria established in *Internal Control — Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2018, based on criteria established in *Internal Control - Integrated Framework (2013)* issued by COSO.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated financial statements as of and for the year ended December 31, 2018, of the Company and our report dated February 12, 2019, expressed an unqualified opinion on those financial statements.

As described in Management's Report on Internal Control Over Financing Reporting, management excluded from its assessment the internal control over financial reporting at Meridian Health Plan of Michigan, Inc., Meridian Health Plan of Illinois, Inc. and MeridianRx, a pharmacy benefit manager (collectively "Meridian"), which was acquired on September 1, 2018 and whose financial statements constitute 8.4% of total consolidated revenue and 11.5% of total consolidated assets of the consolidated financial statement amounts as of and for the year ended December 31, 2018. Accordingly, our audit did not include the internal control over financial reporting at Meridian.

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 included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and 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/ Deloitte and Touche LLP

Tampa, Florida
February 12, 2019

Item 9B. Other Information.

None

PART III

Items 10, 11, 12, 13 and 14.

The information required by Items 10, 11, 12, 13 and 14 is omitted because, no later than 120 days after December 31, 2018, we will file and distribute our definitive proxy statement for our annual meeting of stockholders containing the information required by such Items. Such omitted information is incorporated herein by reference.

PART IV

Item 15. Exhibits, Financial Statement Schedules.

(a) Financial Statements and Financial Statement Schedules

(1) Financial Statements are listed in the Index to Consolidated Financial Statements on page F-1 of this report.
(2) Financial Statement Schedules are listed in the Index to Consolidated Financial Statements on Page F-1 of this report.

(b) Exhibits

For a list of exhibits to this 2018 Form 10-K, see the Exhibit Index which is incorporated herein by reference.

(c) Financial Statements

We file as part of this report the financial schedules listed on the index immediately preceding the financial statements at the end of this report.

Index to Consolidated Financial Statements and Schedules

WellCare Health Plans, Inc.

Financial Statement Schedules

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the stockholders and the Board of Directors of
WellCare Health Plans, Inc. and subsidiaries

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of WellCare Health Plans, Inc. and subsidiaries (the "Company") as of December 31, 2018 and 2017, the related consolidated statements of comprehensive income, changes in stockholders' equity, and cash flows for each of the three years in the period ended December 31, 2018, and the related notes and the schedules listed in the Index at Item 15 (collectively referred to as the "financial statements"). In our opinion, the financial statements present fairly, in all material respects, the financial position of the Company as of December 31, 2018 and 2017, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2018, in conformity with accounting principles generally accepted in the United States of America.

We have also 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, 2018, 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 12, 2019, expressed an unqualified opinion on the Company's internal control over financial reporting.

Basis for Opinion

These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's 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 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 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 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 financial statements. We believe that our audits provide a reasonable basis for our opinion.

/s/ Deloitte and Touche LLP

Tampa, Florida
February 12, 2019

We have served as the Company's auditor since 2003.

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

	For the Years Ended December 31,		
	2018	**2017**	**2016**
Revenues:			
Premium	$ 20,146.3	$ 16,960.3	$ 14,220.9
Products and services	154.1	—	—
Investment and other income	113.7	46.9	16.2
Total revenues	20,414.1	17,007.2	14,237.1
Expenses and other:			
Medical benefits	17,128.1	14,744.8	12,089.4
Costs of products and services	148.6	—	—
Selling, general and administrative	1,701.0	1,484.7	1,133.1
ACA industry fee	344.1	—	228.4
Medicaid premium taxes	126.8	119.8	110.0
Depreciation and amortization	179.7	120.4	87.6
Interest	87.5	68.5	59.1
Total expenses, net	19,715.8	16,538.2	13,707.6
Income from operations	698.3	469.0	529.5
Loss on extinguishment of debt	—	26.1	—
Income before income taxes and equity in earnings of unconsolidated subsidiaries	698.3	442.9	529.5
Equity in (losses) earnings of unconsolidated subsidiaries	(5.5)	18.7	—
Income before income taxes	692.8	461.6	529.5
Income tax expense	253.0	87.9	287.4
Net income	$ 439.8	$ 373.7	$ 242.1
Other comprehensive income, before tax:			
Change in net unrealized gains and losses on available-for-sale securities	(9.1)	(2.2)	1.8
Income tax (benefit) expense related to other comprehensive (loss) income	(2.9)	(0.5)	0.6
Other comprehensive (loss) income, net of tax	(6.2)	(1.7)	1.2
Comprehensive income	$ 433.6	$ 372.0	$ 243.3
Earnings per common share (see Note 5):			
Basic	$ 9.40	$ 8.40	$ 5.47
Diluted	$ 9.29	$ 8.31	$ 5.43
Weighted average common shares outstanding:			
Basic	46,767,626	44,474,016	44,248,778
Diluted	47,354,536	44,967,061	44,619,589

See notes to consolidated financial statements.

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

	December 31,	
Assets	**2018**	**2017**
Current Assets:		
Cash and cash equivalents	$ 3,653.9	$ 4,198.6
Short-term investments	830.1	469.5
Premiums receivable, net	1,223.4	453.4
Pharmacy rebates receivable, net	460.6	335.0
Funds receivable for the benefit of members	187.3	27.5
Prepaid expenses and other current assets, net	477.1	335.2
Total current assets	6,832.4	5,819.2
Property, equipment and capitalized software, net	428.2	319.5
Goodwill	2,227.7	660.7
Other intangible assets, net	996.2	367.9
Long-term investments	813.2	766.2
Restricted cash, cash equivalents and investments	234.7	211.0
Other assets	18.7	4.9
Assets of discontinued operations	213.6	215.2
Total Assets	$ 11,764.7	$ 8,364.6
Liabilities and Stockholders' Equity		
Current Liabilities:		
Medical benefits payable	$ 2,897.4	$ 2,146.3
Unearned premiums	1.4	65.9
Accounts payable and accrued expenses	964.6	788.1
Funds payable for the benefit of members	693.3	1,075.9
Other payables to government partners	458.9	367.0
Total current liabilities	5,015.6	4,443.2
Deferred income tax liability	134.2	93.4
Long-term debt, net	2,126.4	1,182.4
Other liabilities	34.9	13.7
Liabilities of discontinued operations	213.6	215.2
Total Liabilities	7,524.7	5,947.9
Commitments and contingencies (see Note 13)	—	—
Stockholders' Equity:		
Preferred stock, $0.01 par value (20,000,000 authorized, no shares issued or outstanding)	—	—
Common stock, $0.01 par value (100,000,000 authorized, 49,993,219 and 44,522,988 shares issued and outstanding at December 31, 2018 and December 31, 2017, respectively)	0.5	0.4
Paid-in capital	1,981.1	591.5
Retained earnings	2,267.3	1,827.5
Accumulated other comprehensive loss	(8.9)	(2.7)
Total Stockholders' Equity	4,240.0	2,416.7
Total Liabilities and Stockholders' Equity	$ 11,764.7	$ 8,364.6

See notes to consolidated financial statements.

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

	Common Stock		Paid in Capital	Retained Earnings	Accumulated Other Comprehensive Loss	Total Stockholders' Equity
	Shares	Amount				
Balance at January 1, 2016	44,113,328	$ 0.4	$ 518.4	$ 1,211.7	$ (2.2)	$ 1,728.3
Common stock issued for vested stock-based compensation awards	255,143	—	—	—	—	—
Repurchase and retirement of shares to satisfy tax withholding requirements	(74,590)	—	(7.0)	—	—	(7.0)
Stock-based compensation expense, net of forfeitures	—	—	35.5	—	—	35.5
Comprehensive income	—	—	—	242.1	1.2	243.3
Balance at December 31, 2016	44,293,881	0.4	546.9	1,453.8	(1.0)	2,000.1
Common stock issued for vested stock-based compensation awards	332,508	—	—	—	—	—
Repurchase and retirement of shares to satisfy tax withholding requirements	(103,401)	—	(15.2)	—	—	(15.2)
Stock-based compensation expense, net of forfeitures	—	—	59.8	—	—	59.8
Comprehensive income (loss)	—	—	—	373.7	(1.7)	372.0
Balance at December 31, 2017	44,522,988	0.4	591.5	1,827.5	(2.7)	2,416.7
Issuance of common stock, net of issuance costs	5,207,547	0.1	1,342.2	—	—	1,342.3
Common stock issued for vested equity-compensation awards	377,688	—	—	—	—	—
Repurchase and retirement of shares to satisfy tax withholding requirements	(115,004)	—	(23.4)	—	—	(23.4)
Stock-based compensation expense, net of forfeitures	—	—	70.8	—	—	70.8
Comprehensive income (loss)	—	—		439.8	(6.2)	433.6
Balance at December 31, 2018	49,993,219	$ 0.5	$ 1,981.1	$ 2,267.3	$ (8.9)	$ 4,240.0

See notes to consolidated financial statements.

WELLCARE HEALTH PLANS, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS
(In millions)

	For the Years Ended December 31,		
	2018	**2017**	**2016**
Cash flows from operating activities:			
Net income	$ 439.8	$ 373.7	$ 242.1
Adjustments to reconcile net income to cash flows from operating activities:			
Depreciation and amortization	179.7	120.4	87.6
Loss on extinguishment of debt	—	26.1	—
Stock-based compensation expense	70.8	59.8	35.5
Deferred taxes, net	1.1	(47.1)	11.6
Other, net	23.0	18.2	16.8
Changes in operating accounts, net of effects from acquisitions and divestitures:			
Premiums receivable, net	(399.9)	136.4	95.2
Pharmacy rebates receivable, net	(104.7)	(44.1)	(25.5)
Medical benefits payable	216.8	328.3	117.2
Unearned premiums	(94.1)	63.9	(26.6)
Other receivables/payables to government partners	129.1	8.0	69.8
Accrued liabilities and other, net	(182.6)	6.4	124.6
Net cash provided by operating activities	$ 279.0	$ 1,050.0	$ 748.3
Cash flows from investing activities:			
Acquisitions and acquisition-related settlements, net of cash acquired	$ (2,142.9)	$ (728.3)	$ (68.9)
Purchases of investments	(1,832.7)	(1,395.5)	(156.7)
Proceeds from sales and maturities of investments	1,561.1	515.7	392.0
Additions to property, equipment and capitalized software, net	(153.5)	(128.4)	(105.3)
Net cash (used in) provided by investing activities	$ (2,568.0)	$ (1,736.5)	$ 61.1
Cash flows from financing activities:			
Proceeds from debt, net of financing costs paid	$ 739.0	$ 1,182.2	$ 196.9
Borrowings on Revolving Credit Facility, net of financing costs paid	221.3	—	—
Payments on debt	(25.0)	(1,026.1)	(400.0)
Proceeds from issuance of common stock, net of issuance fees paid	1,342.3	—	—
Repurchase and retirement of shares to satisfy tax withholding requirements	(23.4)	(15.2)	(7.0)
Funds (paid) received for the benefit of members, net	(520.6)	671.6	1,031.1
Other, net	9.0	15.7	12.1
Net cash provided by financing activities	$ 1,742.6	$ 828.2	$ 833.1
(Decrease) increase in cash, cash equivalents and restricted cash and cash equivalents	(546.4)	141.7	1,642.5
Balance at beginning of period[(1)]	4,263.0	4,121.3	2,478.8
Balance at end of period[(1)]	$ 3,716.6	$ 4,263.0	$ 4,121.3
SUPPLEMENTAL DISCLOSURES OF CASH FLOW INFORMATION:			
Cash paid for taxes, net of refunds	$ 221.3	$ 167.2	$ 222.3
Cash paid for interest	$ 68.2	$ 57.0	$ 57.3
SUPPLEMENTAL DISCLOSURES OF NON-CASH TRANSACTIONS:			
Non-cash additions to property, equipment, and capitalized software	$ 13.8	$ 3.5	$ 6.2

(1) Beginning and ending cash, cash equivalents and restricted cash and cash equivalents balances have been retrospectively adjusted to reflect the adoption of ASU 2016-18, "*Statement of Cash Flows (Topic 230): Restricted Cash*" effective January 1, 2018. See Note 2 - *Significant Accounting Policies* for further discussion.

See notes to consolidated financial statements.

1. ORGANIZATION AND BASIS OF PRESENTATION

WellCare Health Plans, Inc. (the "Company," "we," "us," or "our") focuses primarily on providing government-sponsored managed care services to families, children, seniors and individuals with complex medical needs primarily through Medicaid, Medicare Advantage ("MA") and Medicare Prescription Drug Plans ("PDP"), as well as individuals in the Health Insurance Marketplace. As of December 31, 2018, we served approximately 5.5 million members nationwide.

As of December 31, 2018, we operated Medicaid health plans, including states where we receive Medicaid premium revenues associated with dually eligible special needs plans, in Arizona, Florida, Georgia, Hawaii, Illinois, Kentucky, Michigan, Missouri, Nebraska, New Jersey, New York, South Carolina and Texas.

In addition, as of December 31, 2018, we also operated MA coordinated care plans ("CCPs") in Arizona, Arkansas, California, Connecticut, Florida, Georgia, Hawaii, Illinois, Indiana, Kentucky, Louisiana, Maine, Michigan, Mississippi, New Jersey, New York, North Carolina, Ohio, South Carolina, Tennessee and Texas. We also offered stand-alone Medicare PDPs nationwide.

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

Basis of Presentation and Use of Estimates

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

The accompanying consolidated financial statements have been prepared in accordance with generally accepted accounting principles in the United States ("GAAP"), which requires us to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. We base these estimates on our knowledge of current events and anticipated future events and evaluate and update our assumptions and estimates on an ongoing basis; however, actual results may differ from our estimates. We evaluated all material events subsequent to the date of these consolidated financial statements. Certain reclassifications were made to 2016 and 2017 financial information to conform with 2018 presentation.

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

Unconsolidated Subsidiaries

We work with physicians and other health care professionals to operate Accountable Care Organizations (“ACOs”) under the Medicare Shared Saving Program ("MSSP") and Next Generation ACO Models. ACOs were established by the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (the "ACA") to

reward integrated, efficient care and allow providers to share in any savings they achieve as a result of improved quality and operational efficiency.

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

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

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Recently Adopted Accounting Standards

In June 2018, the Financial Accounting Standards Board ("FASB") issued Accounting Standard Update ("ASU") 2018-07, *"Compensation-Stock Compensation (Topic 718) - Improvements to Nonemployee Share-Based Payment Accounting."* This update expands the scope of Topic 718, which currently only includes share-based payments issued to employees, to include share-based payments issued to non-employees for goods and services. This guidance is effective for interim and annual periods beginning after December 15, 2018. Early adoption is permitted, but no earlier than the Company's adoption of ASU 2014-09. We adopted this guidance on January 1, 2019. We do not anticipate the adoption of this guidance to have a material effect on our consolidated results of operations, financial condition or cash flows.

In February 2018, the FASB issued ASU 2018-02 "*Income Statement – Reporting Comprehensive Income (Topic 220): Reclassification of Certain Tax Effects from Accumulated Other Comprehensive Income",* which allows entities to reclassify stranded tax effects resulting from the *Tax Cuts and Jobs Act of 2017* from accumulated other comprehensive income to retained earnings. The guidance is effective for interim and annual periods beginning after December 15, 2018, with early adoption permitted. We adopted this guidance prospectively on January 1, 2019. We do not anticipate the adoption of this guidance to have a material effect on our consolidated results of operations, financial condition or cash flows.

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

In March 2017, the FASB issued ASU No. 2017-08, "*Receivables—Nonrefundable Fees and Other Costs (Subtopic 310-20): Premium Amortization on Purchased Callable Debt Securities*". This update shortens the amortization period for the premium on certain purchased callable debt securities to the earliest call date. Currently, entities generally amortize the premium as a yield adjustment over the contractual life of the security. The new guidance does not change the accounting for purchased callable debt securities held at a discount. This guidance is effective for interim and annual periods beginning after December 15, 2018, with early adoption permitted. We adopted this guidance on January 1, 2019 on a modified retrospective basis. We do not anticipate the adoption of this guidance to have a material effect on our consolidated results of operations, financial condition or cash flows.

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

carrying amount exceeds the reporting unit's fair value; however, the loss recognized should not exceed the total amount of goodwill allocated to that reporting unit. We adopted this guidance prospectively on January 1, 2018. The adoption of this guidance did not have a material effect on our consolidated results of operations, financial condition or cash flows.

In January 2017, the FASB issued ASU 2017-01, "*Business Combinations (Topic 805): Clarifying the Definition of a Business*." The amendments in this update provide guidance to assist entities with evaluating when a group of transferred assets and activities (collectively referred to as a "set") is a business. This new guidance provides for a "screen", which requires a determination that when substantially all of the fair value of the gross assets acquired (or disposed of) is concentrated in a single identifiable asset or a group of similar identifiable assets, the set is not a business. If the screen's threshold is not met, a set cannot be considered a business unless it includes an input and a substantive process that together significantly contribute to the ability to create output, eliminating the evaluation of whether a market participant could replace missing elements. This guidance is effective for prospective business combinations for public entities for interim and annual periods beginning after December 15, 2017. We adopted this guidance prospectively on January 1, 2018. The adoption of this guidance did not have a material effect on our consolidated results of operations, financial condition or cash flows.

In November 2016, the FASB issued ASU 2016-18, "*Statement of Cash Flows (Topic 230) Restricted Cash; a consensus of the FASB Emerging Issues Task Force.*" This update requires entities to reconcile, on the statement of cash flows, changes in the total of cash, cash equivalents, and amounts generally described as restricted cash or restricted cash equivalents. This guidance is effective for public entities for interim and annual periods beginning after December 15, 2017, and will be applied retrospectively. We adopted this guidance retrospectively on January 1, 2018. The adoption of this guidance did not have a material effect on our consolidated results of operations, financial condition or cash flows. The following table provides a reconciliation of cash, cash equivalents and restricted cash and cash equivalents as reported within the consolidated balance sheets to the total of the same such amounts shown within the consolidated statements of cash flows:

	As of	
	December 31, 2018	**December 31, 2017**
Cash and cash equivalents	$ 3,653.9	$ 4,198.6
Restricted cash and cash equivalents [(1)]	62.7	64.4
Total cash, cash equivalents, and restricted cash and cash equivalents	$ 3,716.6	$ 4,263.0

(1) Restricted cash and cash equivalents consist of restricted cash and restricted money market funds and are included in Restricted cash, cash equivalents and investments within noncurrent assets of our consolidated balance sheets. Refer to Note 7 - *Restricted Cash, Cash Equivalents and Investments* for further detail.

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

In February 2016, the FASB issued ASU 2016-02, "*Leases (Topic 842)*" ("ASU 2016-02"), which for operating leases, requires a lessee to recognize a right-of-use asset and a lease liability, initially measured at the present value of the lease payments in its balance sheet. This standard also requires a lessee to recognize a single lease cost, calculated so that the cost of the lease is allocated over the lease term, on a generally straight-line basis. Subsequently, in July 2018, the FASB issued ASU 2018-11, "*Leases (Topic 842), Targeted Improvements*" which, among other things, allows companies to elect an optional transition method to apply the new lease standard through a cumulative-effect adjustment, if any, in the period of adoption. We adopted the standard on January 1, 2019 using the optional transition method. We elected the practical expedients permitted under the transition guidance, which, among other things, allows us to carryforward our historical lease classifications. Additionally, we elected the practical expedient to not separate non-lease components from the associated lease component. In preparation for the new requirements, we implemented a new lease accounting system. While we continue to assess the potential effect of ASU 2016-02, based on the operating leases in effect as of January 1, 2019, we expect the adoption of this guidance will result in the recognition of right-of-use assets and lease liabilities of approximately $350.0 million to $425.0 million. We do not anticipate the adoption of this guidance to have a material effect on our consolidated results of operations or cash flows.

In January 2016, the FASB issued ASU 2016-01, "*Financial Instrument - Overall (Subtopic 825-10): Recognition and Measurement of Financial Assets and Financial Liabilities*," which requires entities to measure equity securities that are not

consolidated or accounted for under the equity method at fair value through net income. This amendment also simplifies the impairment test of equity investments without readily determinable fair values. This guidance is effective for public companies for fiscal years beginning after December 15, 2017, including interim periods within those fiscal years. We adopted this guidance prospectively on January 1, 2018. The adoption of this guidance did not have a material effect on our consolidated results of operations, financial condition or cash flows.

In May 2014, the FASB issued ASU 2014-09, "*Revenue from Contracts with Customers (Topic 606).*" ASU 2014-09 superseded existing revenue recognition standards with a single model unless those contracts are within the scope of other standards (e.g., an insurance entity's insurance contracts). The revenue recognition principle in ASU 2014-09 is that an entity should recognize revenue to depict the transfer of goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. In addition, new and enhanced disclosures are required. Companies can adopt the new standard either using the full retrospective approach, a modified retrospective approach with practical expedients, or a cumulative effect upon adoption approach. In August 2015, the FASB issued ASU 2015-14, "*Revenue from Contracts with Customers (Topic 606): Deferral of the Effective Date*", which deferred the effective dates of ASU 2014-09 by one year. We adopted this guidance on January 1, 2018 using the modified retrospective approach. Given that substantially all of our revenues are derived from insurance contracts accounted for in accordance with ASC 944, *Financial Services-Insurance*, which are specifically excluded from the scope of ASU 2014-09, the adoption of this guidance did not have a material effect on our consolidated results of operations, financial condition or cash flows.

Recently Issued Accounting Standards

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

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

Premium Revenue Recognition and Premiums Receivable

We earn premium revenue primarily through our participation in Medicaid, Medicaid-related and Medicare programs. Our Medicaid contracts with state agencies generally are multi-year contracts subject to annual renewal provisions, while our Medicare contracts with CMS renew annually. Our Medicare and Medicaid contracts establish fixed, monthly premium rates per member ("PMPM"), which are generally determined at the beginning of each new contract renewal period; however, premiums may be adjusted by CMS and state agencies throughout the term of the contracts in certain cases. Premium rate changes are recognized in the period the change becomes effective, when the effect of the change in the rate is reasonably estimable and collection is assured.

We recognize premium revenue in the period in which we are obligated to provide services to our members. We are generally paid by CMS and state agencies in the month in which we provide services. On a monthly basis, we bill members for any premiums for which they are responsible according to their respective plan. We record premiums earned but not received as premiums receivable and record premiums received in advance of the period of service as unearned premiums in the consolidated balance sheets. Unearned premiums are recognized as revenue when we provide the related services. Member premiums are recognized as revenue in the period of service. We estimate, on an on-going basis, the amount of members' billings that may not be collectible based on our evaluation of historical trends. An allowance is established for the estimated amount that may not be collectible. In addition, we routinely monitor the collectability of specific premiums receivable from CMS and state agencies, including Medicaid receivables for obstetric deliveries and newborns, and net receivables for member

retroactivity. We reduce revenue and premiums receivable by the amount we estimate may not be collectible. We reported premiums receivable net of an allowance for uncollectible premiums receivable of $26.6 million and $16.3 million at December 31, 2018 and 2017, respectively. Historically, the provision for uncollectible premiums for member premiums receivable has not been material relative to consolidated premium revenue.

Premium payments are based upon eligibility lists produced by CMS and state agencies. We verify these lists to determine whether we have been paid for the correct premium category and program. From time to time, CMS and state agencies require us to reimburse them for premiums that we received for individuals who were subsequently determined to be ineligible for any government-sponsored program or belong to a plan other than ours. Additionally, the verification of membership may result in additional premiums due to us from CMS and state agencies for individuals who were subsequently determined to belong to our plan for periods in which we received no premium for those members. We estimate the amount of outstanding retroactivity adjustments and adjust premium revenue based on historical trends, premiums billed, the volume of member and contract renewal activity and other information. We record amounts receivable in premiums receivable, net and amounts payable in accounts payable and accrued expenses in the consolidated balance sheets.

Supplemental Medicaid Premiums

We earn supplemental premium payments for eligible obstetric deliveries and/or newborns for our Medicaid members in several of our states. We also earn supplemental Medicaid premium payments in some states for high cost drugs and other eligible services. Each state Medicaid contract specifies how and when these supplemental payments are earned and paid. We recognize supplemental premium revenue in the period we provide related services to our members. For the years ended December 31, 2018, 2017, and 2016 we recognized approximately $385.2 million, $478.9 million and $238.7 million, respectively, of supplemental Medicaid premium revenue.

Medicaid ACA Industry Fee Reimbursement

The ACA imposed certain new taxes and fees, including an annual premium-based health insurance industry assessment (the "ACA industry fee") on health insurers, which began in 2014. We received amendments, written agreements or other documentation from all of our state Medicaid customers that commit them to reimburse us for the portion of the ACA industry fee attributable to our Medicaid plans, including its non-deductibility for income tax purposes. In December 2016, President Obama signed the Consolidated Appropriations Act, 2016 which, among other provisions, included a one-year moratorium on the ACA industry fee for 2017. As a result, the associated Medicaid ACA industry fee reimbursements from our state government partners were eliminated for 2017. Accordingly, we recognized $302.2 million and $244.9 million of Medicaid ACA industry fee reimbursement revenue for the years ended December 31, 2018 and 2016, respectively. We did not recognize any Medicaid ACA industry fee reimbursement revenue for the year ended December 31, 2017.

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

Medicaid Risk-Adjusted Premiums and Retroactive Rate Changes

As previously discussed, Medicaid premium rate changes are recognized in the period the change becomes effective, when the effect of the change in the rate is reasonably estimable and collection is assured. In some instances, our Medicaid premiums are subject to risk score adjustments based on the health profile of our membership. Generally, the risk score is determined by the state agency's analysis of encounter submissions of processed claims data to determine the acuity of our membership relative to the entire state's Medicaid membership. The frequency of when states adjust premiums varies, but is usually done quarterly, semi-annual or annual on a retrospective basis. We recognize periodic changes to risk-adjusted premiums as revenue when the amounts are determinable and collection is reasonably assured. As of December 31, 2018, our consolidated balance sheet includes a net receivable from our Medicaid state partners of $54.4 million related to retroactive rate changes and risk score adjustments, compared with a net payable to our Medicaid state partners of $50.7 million as of December 31, 2017. Historically, we have not experienced significant differences between our estimates and amounts ultimately paid or received.

Medicare Risk-Adjusted Premiums

CMS provides risk-adjusted payments for MA Plans and PDPs based on the demographics and health severity of enrollees. The risk-adjusted premiums we receive are based on claims and encounter data that we submit to CMS within prescribed deadlines. We develop our estimates for risk-adjusted premiums utilizing historical experience, or other data, and predictive models as sufficient member risk score data becomes available over the course of each CMS plan year. We recognize periodic changes to risk-adjusted premiums as revenue when the amounts are determinable and collection is reasonably assured, which

is possible as additional diagnosis code information is reported to CMS, when the ultimate adjustment settlements are received from CMS, or we receive notification of such settlement amounts. CMS adjusts premiums on two separate occasions on a retrospective basis. The first retrospective adjustment for a given plan year generally occurs during the third quarter of that year. This initial settlement represents the update of risk scores for the current plan year based on the severity of claims incurred in the prior plan year. CMS then issues a final retrospective risk adjusted premium settlement for that plan year in the following year. Historically, we have not experienced significant differences between our estimates and amounts ultimately received. The data provided to CMS to determine members' risk scores is subject to audit by CMS even after the annual settlements occur. An audit may result in the refund of premiums to CMS. While our experience to date has not resulted in a material refund, future refunds could materially reduce premium revenue in the year in which CMS determines a refund is required and could be material to our results of operations, financial position and cash flows. Premiums receivable in the accompanying consolidated balance sheets include risk-adjusted premiums receivable of $252.4 million and $190.3 million as of December 31, 2018 and 2017, respectively.

Minimum Medical Expense and Risk Corridor Provisions

We may be required to refund certain premium revenue to state agencies and CMS under various contractual and plan arrangements. We estimate the effect of the following arrangements on a monthly basis and reflect any adjustments to premium revenues in current operations. We report the estimated net amounts due to state agencies and CMS in other payables to government partners in the consolidated balance sheets.

Certain of our Medicaid contracts require us to expend a minimum percentage of premiums on eligible medical benefits expense. To the extent that we expend less than the minimum percentage of the premiums on eligible medical benefits, we are required to refund to the state all or some portion of the difference between the minimum and our actual allowable medical benefits expense. Additionally, certain of our Medicaid contracts include other types of risk sharing arrangements (e.g., profit sharing arrangements) that require return of revenue to the state or receipt of revenue from the state, based on certain pre-tax earnings, net earnings or other results of operations -based calculations. In all arrangements, we estimate the amounts due from or to the state agencies based on the terms of our contracts with the applicable state agency and record the amounts as a change in premium. Historically, we have not experienced material differences between our recorded estimates and the subsequent state agencies settlement amounts.

Our MA and PDP premiums are subject to risk sharing through the CMS Medicare Part D risk corridor provisions. The risk corridor calculation compares our actual experience to the target amount of prescription drug costs, limited to costs under the standard coverage as defined by CMS, less rebates included in our submitted plan year bid. We receive additional premium from CMS if our actual experience is more than 5% above the target amount. We refund premiums to CMS if our actual experience is more than 5% below the target amount. Based on the risk corridor provision and PDP activity-to-date, an estimated risk-sharing receivable or payable is recorded as an adjustment to premium revenue. After the close of the annual plan year, CMS performs the risk corridor calculation and any differences are settled between CMS and our plans. Historically, we have not experienced material differences between the subsequent CMS settlement amount and our recorded estimates.

Beginning in 2014, the ACA required the establishment of a minimum medical loss ratio (“MLR”) for MA plans and Part D plans, requiring them to spend not less than 85% of premiums on medical benefits. The rules implementing the minimum MLR impose financial and other penalties for failing to achieve the minimum MLR, including requirements to refund to CMS shortfalls in amounts spent on medical benefits and termination of a plan’s MA contract for prolonged failure to achieve the minimum MLR. MLR is determined by adding a plan’s spending for clinical services, prescription drugs and other direct patient benefits, plus its total spending on quality improvement activities and dividing the total by earned premiums (after subtracting specific identified taxes and other fees). These provisions did not have a material effect on our results of operations in 2018, 2017 and 2016.

A summary of other net payables to government partners is as follows (in millions):

	As of December 31,	
	2018	2017
Liability to states under Medicaid risk sharing provisions	$ (178.5)	$ (142.5)
Liability to CMS under risk corridor and other provisions	(232.0)	(179.1)
Liability to CMS under MA/PDP minimum MLR provisions of the ACA	(19.9)	(1.2)
Net payables to government partners[(1)]	$ (430.4)	$ (322.8)

(1) The components of net payables to government partners are classified in the consolidated balance sheets as $28.5 million and $458.9 million in current assets and current liabilities, respectively, as of December 31, 2018, and $44.2 million and $367.0 million in current assets and current liabilities, respectively, as of December 31, 2017.

Medicare Part D Subsidies

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 MA and PDP members as a fixed monthly per member amount, based on the estimated costs of providing prescription drug benefits over the plan year, as reflected in our bids. 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. The subsidy components under Part D are described below.

Low-Income Cost Sharing Subsidy ("LICS")-For qualifying low income members, CMS reimburses us for all or a portion of the low income member's deductible, coinsurance and co-payment amounts above the out-of-pocket threshold.

Catastrophic Reinsurance Subsidy-CMS reimburses plans for 80% of the drug costs after a member reaches his or her out-of-pocket catastrophic threshold through a catastrophic reinsurance subsidy.

Coverage Gap Discount Subsidy ("CGDS")-CMS provides monthly prospective payments for pharmaceutical manufacturer discounts made available to members.

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

CGDS advance payments are recorded within Funds receivable/payable for the benefit of members in the consolidated balance sheets. Receivables are set up for manufacturer-invoiced amounts. Manufacturer payments reduce the receivable as payments are received. After the end of the contract year, during the Medicare Part D Payment reconciliation process for the CGDS, CMS will perform a cost-based reconciliation to ensure the Medicare Part D sponsor is paid for gap discounts advanced at the point of sale, based on accepted prescription drug event data.

Funds payable for the benefit of members, net consisted of the following (in millions):

	As of December 31,	
	2018	2017
Low-income cost sharing subsidy	$ 97.7	$ (47.7)
Catastrophic reinsurance subsidy	(583.2)	(987.1)
Coverage gap discount subsidy	(20.5)	(13.6)
Funds payable for the benefit of members, net[1]	$ (506.0)	$ (1,048.4)

(1) The components of net funds payable for the benefit of members, net are classified in the consolidated balance sheets as $187.3 million and $693.3 million in current assets and current liabilities, respectively, as of December 31, 2018, and as $27.5 million and $1,075.9 million in current assets and current liabilities, respectively, as of December 31, 2017.

Based on our historical experience and trends, our 2018 PDP and MA bids reflected higher estimates for cash outflows for the government's responsibility of the Part D benefit plan design as compared with our 2017 bids, particularly for the catastrophic reinsurance subsidy; however, the level of subsidy payments we made on behalf of CMS compared with the level of subsidies we received in 2018 were significantly lower than our 2018 bids due to the composition of the 2018 PDP membership. As a result, the net funds payable for the benefit of members decreased from $1.0 billion as of December 31, 2017 to $506.0 million as of December 31, 2018. Additionally, as of December 31, 2018, our consolidated balance sheet included a $274.6 million net payable for the 2016 Part D plan year, primarily relating to certain contracts terminated effective January 1, 2017. This net payable is expected to be settled within the next 18 to 24 months.

Medical Benefits Expense and Medical Benefits Payable

We recognize the cost of medical benefits in the period in which services are provided, including an estimate of the cost of medical benefits incurred but not reported ("IBNR"). Medical benefits expense includes direct medical expenses and certain medically-related administrative costs.

Direct medical expenses include amounts paid or payable to hospitals, physicians, pharmacy benefit managers and providers of ancillary services. Recorded direct medical expenses are reduced by the amount of pharmacy rebates earned, which are estimated based on historical utilization of specific pharmaceuticals, current utilization and contract terms. Pharmacy rebates earned but not yet received from pharmaceutical manufacturers are included in pharmacy rebates receivable in the accompanying consolidated balance sheets. Direct medical expenses may also include reserves for estimated referral claims related to health care providers under contract with us who are financially troubled or insolvent and who may not be able to honor their obligations for the costs of medical services provided by other providers. In these instances, we may be required to honor these obligations for legal or business reasons. Based on our current assessment of providers under contract with us, such losses have not been and are not expected to be significant. Also included in direct medical expense are our estimates for provider settlements due to clarification of contract terms, out-of-network reimbursement, claims payment differences and amounts due to contracted providers under risk-sharing and/or value-based arrangements.

Consistent with the criteria specified and defined in guidance issued by the Department of Health and Human Services ("HHS") for costs that qualify to be reported as medical benefits under the minimum MLR provision of the ACA, we record certain medically related administrative costs such as preventive health and wellness, care management, and other quality improvement costs, as medical benefits expense. All other medically related administrative costs, such as utilization review services, network and provider credentialing and claims handling costs, are recorded in selling, general, and administrative expense.

Medical benefits payable represents amounts for claims fully adjudicated but not yet paid and estimates for IBNR. Our estimate of IBNR is the most significant estimate included in our consolidated financial statements. We determine our best estimate of the base liability for IBNR utilizing consistent standard actuarial methodologies based upon key assumptions, which vary by business segment. Our assumptions include current payment experience, trend factors, and completion factors. Trend factors in our standard actuarial methodologies include contractual requirements, historic utilization trends, the interval between the date services are rendered and the date claims are paid, denied claims activity, disputed claims activity, benefit changes, expected health care cost inflation, seasonality patterns, maturity of lines of business, changes in membership and other factors.

After determining an estimate of the base liability for IBNR, we make an additional estimate, also using standard actuarial techniques, to account for adverse conditions that may cause actual claims to be higher than the estimated base reserve. We refer to this additional liability as the provision for moderately adverse conditions. Our estimate of the provision for moderately adverse conditions captures the potential adverse development from factors such as:

- our entry into new geographical markets;
- our provision of services to new populations such as the aged, blind and disabled;
- variations in utilization of benefits and increasing medical costs, including higher drug costs;
- changes in provider reimbursement arrangements;
- variations in claims processing speed and patterns, claims payment and the severity of claims; and
- health epidemics or outbreaks of disease such as the flu or enterovirus.

We evaluate our estimates of medical benefits payable as we obtain more complete claims information and medical expense trend data over time. We record differences between actual experience and estimates used to establish the liability, which we refer to as favorable and unfavorable prior year reserve developments, as increases or decreases to medical benefits expense in the period we identify the differences.

Premium Deficiency Reserves

We evaluate our contracts to determine if it is probable that a loss will be incurred. We establish a premium deficiency reserve ("PDR") when it is probable that expected future medical benefits and administrative expenses will exceed future premiums and reinsurance recoveries for the remainder of a contract period. For purposes of determining a PDR, we do not consider investment income and contracts are grouped in a manner consistent with our method of acquiring, servicing and measuring the profitability of such contracts. A PDR is recorded as medical benefits expense and in medical benefits payable. Once established, a PDR is reduced over the contract period as an offset to actual losses. We re-evaluate our PDR estimates each reporting period and, if estimated future losses differ from those in the current PDR estimate, we adjust the liability through medical benefits expense, as necessary.

Our medical benefits payable balance includes premium deficiency reserves for our Illinois Medicaid programs ("Illinois PDR") of $16.1 million and $45.6 million as of December 31, 2018 and 2017, respectively, in connection with our Medicaid managed care contract with the Illinois Department of Health Care and Family Services ("HFS") that was effective on January 1, 2018 (the "Illinois PDR"). The Illinois PDR reflects the premium rate structure, estimated medical benefits and other costs expected to be incurred during the initial four-year contractual term of the contract.

ACA Industry Fee

Beginning in 2014, the ACA industry fee was levied on certain health insurers that provide insurance in the assessment year and is allocated to health insurers based on each health insurer's share of net premiums for all U.S health insurers in the year preceding the assessment. The initial estimated liability for each year is accrued as of January 1, with a corresponding deferred expense asset that is amortized over 12 months to expense on a straight line basis. The fee is payable by September 30 of each year. The ACA industry fee is not deductible for income tax purposes, which significantly increased our effective income tax rate during 2018 and 2016 compared to prior periods.

As previously discussed, the Consolidated Appropriations Act, 2016, included a one-year moratorium on the ACA industry fee for 2017, among other provisions. Accordingly, we did not incur ACA industry fee expense for the year ended December 31, 2017, compared with $344.1 million and $228.4 million incurred in 2018 and 2016, respectively.

There is a one-year moratorium for the ACA industry fee in 2019.

Equity-Based Employee Compensation

Certain of our employees, including executive officers, are eligible for long-term incentive awards ("LTI Program"), consisting of equity awards granted pursuant to the WellCare Health Plans, Inc. 2013 Incentive Compensation Plan (the "2013 Plan"). We designed the LTI Program to motivate and promote the achievement of our long-term financial and operating goals and improve retention. Under the LTI Program, we grant multi-year performance period awards that are not realized by employees and officers until subsequent years. We base award amounts on each participant's pre-established long-term incentive target and allocate the awards to various types of equity and performance-based cash awards, depending on job level.

The Compensation Committee of our board of directors (the "Compensation Committee") has sole discretion of the ultimate funding and payout of certain performance awards under the LTI program.

The Compensation Committee awards certain equity-based compensation under our stock plans, including stock options, restricted stock units ("RSUs"), performance stock units ("PSUs") and market stock units ("MSUs"), each of which is described below:

RSUs - For each RSU granted, employees receive one share of common stock, net of taxes withheld at the statutory minimum, at the end of the vesting period. RSUs typically vest one to three years from the date of grant. We estimate compensation cost for RSUs based on the grant date fair value, which is based on the closing price of our common stock on the date of grant, and recognize the expense ratably over the vesting period of the award.

PSUs - The actual number of common stock shares earned upon vesting will range from zero shares up to 200% of the target award, depending on the award date, the target award amounts for the PSU awards and our achievement of certain financial, market-based and quality-based performance goals set by the Compensation Committee at its sole discretion. PSUs generally cliff-vest 3 years from the grant date based on the achievement of the performance goals and conditioned on the employee's continued service through the vesting date. The number of shares earned by the participant are generally paid net of taxes withheld at the statutory minimum.

The Compensation Committee has awarded two variations of PSUs, including:

- Financial and Quality Performance Goals: Certain of our PSUs are subject to variable accounting as they do not have a grant date fair value for accounting purposes due to the subjective nature of the terms of the PSUs, which precludes a mutual understanding of the key terms and conditions. We recognize expense for PSUs ultimately expected to vest over the requisite service period based on our estimates of progress made towards the achievement of the predetermined performance measures and changes in the market price of our common stock. In March 2016, we issued certain PSUs whereby a mutual understanding of key terms and conditions exist; therefore, for these awards we estimate compensation cost based on the grant date fair value, as well as our estimate of the performance outcome, and recognize the expense ratably over the vesting period of the award with cumulative changes in expense recognized in periods in which performance conditions change or are ultimately met.

- Market Based Goals: Beginning in 2016, we issued certain PSUs, which are subject to a market condition (total shareholder return relative to industry peer companies or prescribed stock price growth) and we estimate compensation cost based on the grant date fair value and recognize the expense ratably over the vesting period of the award. For these PSUs, the grant date fair value is measured using a Monte Carlo simulation approach, which estimates the fair value of awards based on randomly generated simulated stock-price paths through a lattice-type structure. PSUs expected to vest are recognized as expense either on a straight-line or accelerated basis, depending on the award structure, over the vesting period.

MSUs - The number of shares of common stock earned upon vesting is determined based on the ratio of our average common stock price during the last 30 days market trading days of the calendar year immediately preceding the vesting date to the comparable average common stock price in the year immediately preceding the grant date, applied to the base units granted. The performance ratio is capped at 200%. If our common stock price declines by more than 50% over the performance period, no shares are earned by the recipient. The number of shares earned by the participant are generally paid net of taxes withheld at the statutory minimum. For MSUs, the grant date fair value is measured using a Monte Carlo simulation approach, which estimates the fair value of awards based on randomly generated simulated stock-price paths through a lattice-type structure. MSUs expected to vest are recognized as expense on a straight-line basis over the vesting period, which is generally three years. The last of our MSU awards vested in March 2018.

We estimate equity-based compensation expense based on awards ultimately expected to vest. We make assumptions of forfeiture rates at the time of grant and continuously reassess our assumptions based on actual forfeiture experience.

Medicaid Premium Taxes

Premiums related to our Medicaid contracts in certain states are subject to an assessment or tax on Medicaid premiums. The premium revenues we receive from these states include a reimbursement for this premium assessment. We have reported premium taxes on a gross basis, as premium revenue and as premium tax expense in the consolidated statements of income. We

recognize the premium tax assessment as expense in the period we earn the related premium revenue and remit the taxes back to the state agencies on a periodic basis. We incurred Medicaid premium taxes of $126.8 million, $119.8 million and $110.0 million for the years ended December 31, 2018, 2017 and 2016, respectively.

Income Tax Expense

We record income tax expense as incurred based on enacted tax rates, estimates of book-to-tax differences in income, and projections of income that will be earned in each taxing jurisdiction. We recognize deferred tax assets and liabilities for the estimated future tax consequences of differences between the carrying amounts of existing assets and liabilities and their respective tax basis. We measure deferred tax assets and liabilities using tax rates, as enacted by law and applicable to taxable income in the years in which we expect to recover or settle those temporary differences. We record a valuation allowance on deferred taxes if we determine it is more likely than not that we will not fully realize the future benefit of deferred tax assets. We file tax returns after the close of our fiscal year end and adjust our estimated tax receivable or liability to the actual tax receivable or due per the filed state and federal tax returns. Historically, we have not experienced significant differences between our estimates of income tax expense and actual amounts incurred.

State and federal taxing authorities may challenge the positions we take on our filed tax returns. We evaluate our tax positions and only recognize a tax benefit if it is more likely than not that a tax audit will sustain our conclusion. Based on our evaluation of tax positions, we believe that potential tax exposures have been recorded appropriately. State and federal taxing authorities may propose additional tax assessments based on periodic audits of our tax returns. We believe our tax positions comply with applicable tax law in all material aspects and we will vigorously defend our positions on audit. The ultimate resolution of these audits may materially affect our financial position, results of operations or cash flows. We have not experienced material adjustments to our consolidated financial statements as a result of these audits.

Cash and Cash Equivalents

We classify unrestricted cash and short-term investments with original maturities of three months or less as cash and cash equivalents in the consolidated balance sheets. We record cash and cash equivalents at cost, which approximates fair value.

Investments

We classify our fixed maturity securities, including short-term, long-term, and restricted investments, as available-for-sale and report them at fair value. We generally record unrealized gains and losses on securities, net of deferred income taxes, as a separate component of accumulated other comprehensive loss in the consolidated balance sheets. We record investment income when earned and classify investment income earned but not received in prepaid expenses and other current assets in the consolidated balance sheets. We may purchase fixed maturity securities at a premium or discount. We amortize these premiums and discounts as adjustments to investment income over the estimated remaining term of the securities. We determine realized gains and losses on sales of securities on a specific identification basis.

We determine the fair value of fixed maturity securities based on quoted prices in active markets or market prices provided by a third-party pricing service. The third-party pricing service determines market prices using inputs such as reported trades, benchmark yields, issuer spreads, bids, offers, estimated cash flows and prepayment spreads. Based on the typical trading volumes and the lack of quoted market prices for fixed maturities, third party pricing services will normally derive the security prices through recent reported trades for identical or similar securities making adjustments through the reporting date based upon available market observable information. If there are no recent reported trades, the pricing services may use matrix or model processes to develop a security price using future cash flow expectations based upon collateral performance and discount this at an estimated market rate.

We regularly compare the fair value of our investments to the amortized cost of those investments. The evaluation of impairment is a quantitative and qualitative process, which is subject to risk and uncertainties. Our fixed maturity investments are exposed to four primary sources of investment risk: credit, interest rate, liquidity and market valuation. The financial statement risks are those associated with the recognition of impairments and income, as well as the determination of fair values.

We perform a case-by-case evaluation of the underlying reasons for the decline in fair value and consider a wide range of factors about the security issuer, including assumptions and estimates about the operations of the issuer and its future earnings potential. We use our best judgment in evaluating the cause of the decline in the estimated fair value of the security and in assessing the prospects for near-term recovery. Our evaluation of impairment includes, but is not limited to:

- the length of time and the extent to which the market value has been below cost;
- the potential for impairments of securities when the issuer is experiencing significant financial difficulties;
- the potential for impairments in an entire industry sector or sub-sector;
- the potential for impairments in certain economically depressed geographic locations;
- the potential for impairments of securities where the issuer, series of issuers or industry has suffered a catastrophic type of loss or has exhausted natural resources;
- unfavorable changes in forecasted cash flows on asset-backed securities; and
- other subjective factors, including concentrations and information obtained from regulators and rating agencies.

We recognize impairments of securities when we consider a decline in fair value below the amortized cost basis to be other-than-temporary. If we intend to sell a security, or it is more likely than not that we will be required to sell the security before recovery of its amortized cost basis, we recognize an other-than-temporary impairment ("OTTI") in earnings equal to the entire difference between the security's amortized cost basis and its fair value. If we do not intend to sell the security and it is more likely than not that we will not be required to sell the security before recovery of its amortized cost basis, but the present value of the cash flows expected to be collected is less than the amortized cost basis of the security (referred to as the credit loss), we conclude an OTTI has occurred. In this instance, we bifurcate the total OTTI into the amount related to the credit loss, which we recognize in earnings as investment income, net, with the remaining amount of the total OTTI attributed to other factors (referred to as the noncredit portion) recognized as a separate component in other comprehensive income. After the recognition of an OTTI, we account for the security as if it had been purchased on the measurement date of the OTTI, with an amortized cost basis equal to the previous amortized cost basis less than the OTTI recognized in earnings. We did not realize any OTTI for the years ended December 31, 2018, 2017 or 2016.

Restricted Cash, Cash Equivalents and Investments

As a condition for licensure, we are required to maintain certain funds on deposit or pledged to various state agencies. Certain of our state contracts require the issuance of surety bonds. We record our restricted cash, cash equivalents, and other short-term investments, at fair value. We classify restricted cash, cash equivalents and investments as long-term regardless of the contractual maturity date of the securities held, due to the nature of the states' requirements.

Prepaid Expenses and Other Current Assets

Prepaid expenses and other current assets, net, are comprised of receivables relating to advances to providers, prepaid premium taxes, pharmaceutical coverage gap discounts receivable and other prepaid expenses and current assets. The balance also includes utilization performance guarantee program receivables from our new pharmacy benefit manager.

Property, Equipment and Capitalized Software, net

Property, equipment and capitalized software are stated at historical cost, net of accumulated depreciation. We capitalize 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. We expense other software development costs, such as training and data conversion costs, as incurred. We capitalize the costs of improvements that extend the useful lives of the related assets.

We record depreciation expense using the straight-line method over the estimated useful lives of the related assets, which ranges from three to ten years for leasehold improvements, five years for furniture and equipment, and three to seven years for computer equipment and software. We record maintenance and repair costs as selling, general and administrative expense when incurred.

On an ongoing basis, we review events or changes in circumstances that may indicate that the carrying value of an asset may not be recoverable. If the carrying value of an asset exceeds the sum of estimated undiscounted future cash flows, we recognize an impairment loss in the current period for the difference between estimated fair value and carrying value. If assets are determined to be recoverable but the useful lives are shorter than we originally estimated, we depreciate the remaining net book value of the asset over the newly determined remaining useful lives.

Goodwill and Other Intangible Assets

Our acquisitions typically result in goodwill, which represents the excess of the acquisition cost over the fair value of net assets acquired. Goodwill is assigned to reporting units, which we determined to be the same as our operating segments. Goodwill recorded at December 31, 2018 was $2.2 billion compared with $660.7 million at December 31, 2017. Goodwill

attributable to our Medicaid reporting unit was $274.7 million at December 31, 2018 and 2017. Goodwill attributable to our MA reporting unit was $392.3 million and $386.0 million at December 31, 2018 and 2017, respectively. Additionally, we recorded $1.6 billion attributed to the Meridian acquisition that has not been assigned to a reporting unit as of December 31, 2018. The increases in consolidated goodwill from December 31, 2017 primarily resulted from our acquisition Meridian during 2018. Refer to Note 3 - *Acquisitions*, included in the consolidated financial statements in this 2018 Form 10-K for additional discussion.

We test goodwill for impairment at the reporting unit level at least annually, or more frequently if events or circumstances indicate that it would be more likely than not that the fair value of a reporting unit is below its carrying value. Such events or circumstances could include a significant adverse change in business climate, an adverse action or assessment by a regulator, unanticipated competition and the testing for recoverability of a significant asset group within a reporting unit, among others. To determine whether goodwill is impaired, we compare an estimate of the fair value of the applicable reporting unit to its carrying value, including goodwill. If the carrying value exceeds the estimated fair value, we compare the implied fair value of the applicable goodwill to its carrying value to measure the amount of goodwill impairment, if any. We perform our annual goodwill impairment test based on our financial position and results of operations as of June 30 of each year, which generally coincides with the finalization of federal and state contract negotiations and our initial budgeting and planning process. The annual impairment tests are based on an evaluation of estimated future discounted cash flows. The estimated discounted cash flows are based on the best information available to us at the time, including supportable assumptions and projections we believe are reasonable. Our discounted cash flow estimates use discount rates that correspond to a weighted-average cost of capital consistent with a market-participant view. The discount rates are consistent with those used for investment decisions and take into account the operating plans and strategies of our operating segments. Certain other key assumptions utilized, including changes in membership, premium, health care costs, operating expenses, fees, assessments and taxes and effective tax rates, are based on estimates consistent with those utilized in our annual budgeting and planning process that we believe are reasonable. However, if we do not achieve the results reflected in the assumptions and estimates, our goodwill impairment evaluations could be adversely affected, and we may impair a portion of our goodwill, which would adversely affect our operating results in the period of impairment. Impairments, if any, would be classified as an operating expense. Based on the results of our annual impairment testing in 2018, we determined that the fair value of each reporting unit substantially exceeded its carrying value and no further goodwill impairment assessment was necessary.

Other intangible assets resulting from our acquisitions generally include provider networks, broker networks, trademarks, state contracts, non-compete agreements, licenses and permits. We amortize other intangible assets over their estimated useful lives ranging from approximately one to 15 years. These assets are allocated to reporting units for impairment testing purposes. We review our other intangible assets for impairment when events or changes in circumstances occur, which may potentially affect the estimated useful life or recoverability of the remaining balances of our intangible assets. Such events and changes in circumstances would include significant changes in membership, state funding, federal and state government contracts and provider networks. Upon such an occurrence, recoverability of assets to be held and used is measured by comparing the carrying amount of an asset to current forecasts of undiscounted future net cash flows expected to be generated by the assets. Identifiable cash flows are measured at the lowest level for which they are largely independent of the cash flows of other groups of assets and liabilities. If these assets are determined to be impaired, the amount of impairment recognized is measured by the amount by which the carrying amount of the assets exceeds their fair value. During 2018, 2017, and 2016, no events or circumstances have occurred, which may potentially affect the estimated useful life or recoverability of the remaining balances of our other intangible assets. Accordingly, there were no impairment losses recognized during these periods.

Accounts Payable and Accrued Expenses

Accounts payable and accrued expenses are primarily comprised of liabilities relating to pharmacy benefit administration, accrued salaries and incentive compensation, consulting contract obligations, and other miscellaneous current liabilities.

3. ACQUISITIONS

Aetna Medicare Part D Acquisition

On November 30, 2018, we completed the purchase of Aetna Inc.'s ("Aetna") entire standalone Medicare Part D prescription drug plan membership ("Aetna Part D membership"), which Aetna divested as part of CVS Health Corporation's acquisition of Aetna, for total cash consideration of $107.2 million, which is subject to certain true-up provisions. These membership assets are recorded within other intangible assets, net in the consolidated balance sheets as of December 31, 2018 and have a weighted-average useful life of 8 years beginning in 2020. Per the terms of the agreement, Aetna will provide

administrative services to, and retain financial risk of, the Aetna Part D membership through 2019. Therefore, the Aetna Part D membership will be excluded from our membership and results of operations until January 1, 2020.

Business Acquisitions

Fair value determination of intangible assets acquired

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

Meridian Acquisition

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

As a result of the Meridian acquisition, we expanded our Medicaid portfolio through the addition of Michigan, where Meridian has the leading market position; expanded our Medicaid presence in Illinois; and acquired an integrated PBM platform. Meridian also serves MA members in Illinois, Indiana, Michigan, and Ohio, as well as Health Insurance Marketplace members in Michigan.

The following table summarizes the estimated fair values of major classes of assets acquired and liabilities assumed at the Effective Date, based on our valuation assumptions, reconciled to the total consideration transferred.

Assets	(in millions)	
Cash, cash equivalents and restricted cash	$	484.4
Investments, including restricted investments		180.4
Premiums receivable, net		379.6
Other current assets		145.1
Property, equipment and capitalized software, net		49.3
Goodwill		1,560.7
Other intangible assets, net		594.0
Fair value of total assets acquired	$	3,393.5
Liabilities		
Medical benefits payable	$	534.3
ACA Fee liability		66.5
Other liabilities		272.6
Fair value of liabilities assumed		873.4
Fair value of net assets acquired	$	2,520.1

The fair value results from judgments about future events, which reflect certain uncertainties and rely on estimates and assumptions. The judgments used to determine the fair value assigned to each class of assets acquired and liabilities assumed, as well as intangible asset lives, can materially affect our operating results. As of the Effective Date, the expected fair value of

all current assets and liabilities approximated their historical cost. We have not yet completed our evaluation and determination of certain assets acquired and liabilities assumed, primarily (i) the final valuation of intangible assets acquired (discussed below) related to memberships and trade names, (ii) the final assessment and valuation of certain other assets acquired and liabilities assumed, including premiums receivable, property, equipment and capitalized software, medical benefits payable and other liabilities and (iii) the final assessment and valuation of certain income tax amounts. Therefore, the final fair values of the assets acquired and liabilities assumed may vary significantly from our preliminary estimates.

Identifiable intangible assets acquired

Under the Hart-Scott-Rodino Antitrust Improvements Act and other relevant laws and regulations, there were significant limitations on our ability to obtain specific information about Meridian's intangible assets prior to completion of the acquisition in September 2018. As of December 31, 2018, certain of the more significant assumptions inherent in the development of intangible asset fair values, including the following, are preliminary.

- final membership attrition rates;
- final discount rates selected to measure the risks inherent in the future cash flows;
- key assumptions in the valuation of the acquired technology, including, but not limited to, estimated costs associated with developers' salaries, external direct costs of materials and services; and the estimated time to replace the acquired software applications; and
- working capital adjustments and the assessment of the assets' life cycle, among other key assumptions.

The following table summarizes the preliminary fair values and weighted average useful lives for identifiable intangible assets acquired in the Meridian acquisition as of the Effective Date of the acquisition.

	Gross Fair Value (in millions)	Weighted Average Useful Life (in years)
Membership	$ 378.6	8.9
Tradenames	110.4	4.9
Provider network	8.3	15.0
Technology and other	96.7	7.1
Total	$ 594.0	8.0

During the fourth quarter of 2018, we recorded customary measurement period adjustments, which resulted in an increase to goodwill of $474.2 million, and corresponding decreases to identified intangible assets and tangible net assets of $406.0 million and $68.2 million, respectively. These adjustments resulted from updated assumptions and information obtained about the facts and circumstances that existed as of the Effective Date, including the initial intangible asset valuation results based on updated preliminary assumptions (as discussed above in the determination of the intangible asset fair values), as well as the fair value of certain premium receivables and other current assets. These preliminary estimates of fair value and weighted-average useful life may be different from the final acquisition accounting, and the difference could have a material impact on the consolidated financial statements.

Goodwill

We recorded $1.6 billion for the valuation of goodwill for the excess of the purchase price over the estimated fair value of the net assets acquired. The assignment of goodwill to our respective segments has not been completed at this time. The recorded goodwill related to the acquisition is deductible for tax purposes.

Deferred taxes

The Meridian acquisition included taxable and nontaxable components resulting in differences in amounts recognized for GAAP and tax purposes. In both taxable and nontaxable business combinations, the amounts assigned to the individual assets acquired and liabilities assumed for financial statement purposes are often different from the amounts assigned or carried forward for tax purposes. We recorded a $46.5 million deferred tax liability based on the estimated bases differences.

Consolidated Statements of Comprehensive Income

We included the results of Meridian's operations since the Effective Date in our consolidated financial statements. The amount of total revenues attributable to Meridian included in our consolidated statement of comprehensive income for the year ended December 31, 2018 was $1.7 billion. Total pre-tax net losses in our consolidated statement of comprehensive income for the year ended December 31, 2018 was $34.1 million, excluding transaction and integration-related costs discussed below.

We incurred transaction and integration-related costs of $25.4 million during the year ended December 31, 2018, respectively, related to the acquisition of Meridian. These costs include severance payments to former executives, advisory, legal and other professional fees that are reflected in selling, general and administrative ("SG&A") expense in our consolidated statement of comprehensive income.

Universal American Acquisition

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

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

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

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

The fair value of the Convertible Notes was determined based on quoted market prices; therefore, have been classified within Level 1 of the fair value hierarchy.

(b) Upon acquisition, we redeemed an aggregate of $40.0 million of Universal American's Preferred Shares, which became redeemable by the holders on April 28, 2017 due to certain change in control provisions for the Preferred Shares. We redeemed the Preferred Shares for $41.0 million, which includes the $40.0 million par value of the Preferred Shares and $1.0 million of accrued dividends.

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

The following table summarizes the final fair values of major classes of assets acquired and liabilities assumed as of April 28, 2017, based on our valuation assumptions, reconciled to the total consideration transferred.

Assets	(in millions)
Cash and cash equivalents	$ 66.4
Investments, including restricted investments	254.4
Premiums receivable, net	90.7
Pharmacy rebates receivable, net, and other current assets	52.9
Property, equipment and capitalized software, net	7.5
Goodwill	282.0
Other intangible assets, net	298.2
Assets of discontinued operations	219.6
Estimated fair value of total assets acquired	$ 1,271.7
Liabilities	
Medical benefits payable	$ 128.1
Deferred tax liabilities, net	67.1
Other liabilities	87.8
Liabilities of discontinued operations	218.7
Estimated fair value of liabilities assumed	501.7
Estimated fair value of net assets acquired	$ 770.0

The fair value results from judgments about future events, which reflect certain uncertainties and relies on estimates and assumptions. The judgments used to determine the fair value assigned to each class of assets acquired and liabilities assumed, as well as intangible asset lives, can materially affect our operating results.

As of April 28, 2017, the fair value of all current assets and liabilities, as well as assets and liabilities of discontinued operations (refer to Note 17 - *Discontinued Operations* for further discussion), approximated their historical cost. For certain noncurrent assets and liabilities, we have made fair value adjustments based on information reviewed through April 2018, the end of the measurement period.

Identifiable intangible assets acquired

The following table summarizes the final fair values and weighted average useful lives for identifiable intangible assets acquired in the Universal American acquisition as of the effective date of the acquisition.

	Gross Fair Value (in millions)	Weighted Average Useful Life (in years)
Membership	$ 240.0	10.0
Tradenames	36.0	13.9
Provider network	9.5	15.0
Technology and other	12.7	6.2
Total	$ 298.2	10.5

Deferred taxes

The purchase price allocation includes net deferred tax liabilities of $67.1 million, primarily relating to deferred tax liabilities established on the identifiable acquired intangible assets, partially offset by deferred tax assets acquired in the Universal American transaction.

Goodwill

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

Consolidated Statement of Comprehensive Income

We included the results of Universal American's operations after the acquisition in our consolidated financial statements. The amount of premium revenue attributable to Universal American included in our consolidated statement of comprehensive income for the years ended December 31, 2018 and 2017 was $1.5 billion and $936.5 million, respectively. Additionally, our consolidated statement of comprehensive income for the years ended December 31, 2018 and 2017 included a pretax net income of $36.7 million and $24.6 million, respectively, attributable to Universal American's operations, which includes transaction and integration-related costs of $6.1 million and $37.5 million for the years ended December 31, 2018 and 2017, respectively, related to the transaction. These costs include severance payments to former executives, advisory, legal and other professional fees that are reflected in selling, general and administrative ("SG&A") expense in our consolidated statement of comprehensive income.

Unaudited Pro Forma Financial Information

The results of operations and financial condition for our 2018 and 2017 acquisitions have been included in our consolidated financial statements since the respective acquisition dates. The unaudited pro forma financial information presented below reflects our 2018 acquisition of Meridian as though the business had been acquired as of January 1, 2017 and our 2017 business acquisitions, including Universal American, as though the businesses had been acquired as of January 1, 2016.

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

	For the years ended December 31,		
(in millions, except per share data)	**2018**	**2017**	**2016**
Total revenues	$ 23,408.6	$ 20,598.2	$ 16,211.4
Net income	$ 420.8	$ 376.1	$ 239.0
Earnings per common share:			
Basic	$ 8.47	$ 7.57	$ 5.40
Diluted	$ 8.16	$ 7.50	$ 5.36

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

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

4. SEGMENT REPORTING

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

We allocate premium revenue, medical benefits expense, Medicaid premium taxes, the ACA industry fee incurred in 2018 and 2016, and goodwill to our reportable segments. We do not allocate to our reportable segments any other assets and liabilities, investment and other income, selling, general and administrative expenses, depreciation and amortization, or interest expense. The Company's decision makers primarily use premium revenue, medical benefits expense and gross margin to evaluate the performance of our reportable segments.

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

Medicaid Health Plans

Our Medicaid Health Plans segment includes plans for beneficiaries of Temporary Assistance for Needy Families ("TANF"), Supplemental Security Income ("SSI"), Aged Blind and Disabled ("ABD") and other state-based programs that are not part of the Medicaid program, such as Children's Health Insurance Program ("CHIP") and Long-Term Services and Supports ("LTSS"). TANF generally provides assistance to low-income families with children. ABD and SSI generally provide assistance to low-income aged, blind or disabled individuals. CHIP provides assistance to qualifying families who are not eligible for Medicaid because their income exceeds the applicable income thresholds. The LTSS program is designed to help people with chronic illnesses or who have disabilities and need health and long-term care services, such as home care or adult day care, to enable them to stay in their homes and communities as long as possible.

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

	For the Years Ended December 31,		
	2018	**2017**	**2016**
Kentucky	14%	15%	18%
Florida	12%	15%	18%
Georgia	*	*	11%

* Effective July 1, 2017, we commenced services under a new Medicaid contract with the State of Georgia serving TANF and CHIP beneficiaries. As a result of the decline in membership and overall growth in the Medicaid Health Plans segment, premium revenue attributable to our Georgia Medicaid health plan accounted for less than 10% of our consolidated premium revenue for the years ended December 31, 2018 and 2017.

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

Medicare Health Plans

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

Medicare PDPs

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

Summary of Financial Information

An operating segment engages in business activities from which it may earn revenue and incur expenses, has discrete financial information and whose results are regularly reviewed by the chief operating decision makers for performance assessment and resource allocation decisions. Factors used to determine our reportable segments include the nature of operating activities, economic characteristics, existence of separate senior management teams and the type of information used by our chief operating decision makers. Reportable segments with similar economic characteristics, products and services, customers, distribution methods and operational processes that operate in a similar regulatory environment are combined. Accordingly, we have three reportable segments: Medicaid Health Plans, Medicare Health Plans and Medicare PDPs. A summary of financial information for our reportable segments through the gross margin level and a reconciliation to income from operations is presented in the tables below.

	Medicaid Health Plan	Medicare Health Plan	Medicare PDP	Corporate & Other	Consolidated
For the Year Ended December 31, 2018			**(in millions)**		
Premium	$ 12,992.8	$ 6,313.8	$ 835.0	$ 4.7	$ 20,146.3
Products and services	—	—	—	154.1	154.1
Total premium and products and services revenues	12,992.8	6,313.8	835.0	158.8	20,300.4
Medical benefits	11,171.3	5,347.8	604.8	4.2	17,128.1
Costs of products and services	—	—	—	148.6	148.6
ACA industry fee	216.3	109.4	18.3	0.1	344.1
Medicaid premium taxes	126.8	—	—	—	126.8
Total gross margin expenses	11,514.4	5,457.2	623.1	152.9	17,747.6
Gross margin [1]	1,478.4	856.6	211.9	5.9	2,552.8
Investment and other income	—	—	—	113.7	113.7
Other expenses [2]	—	—	—	(1,968.2)	(1,968.2)
Income from operations	$ 1,478.4	$ 856.6	$ 211.9	$ (1,848.6)	$ 698.3
For the Year Ended December 31, 2017					
Premium	$ 10,726.3	$ 5,320.2	$ 913.8	$ —	$ 16,960.3
Products and services	—	—	—	—	—
Total premium and products and services revenues	10,726.3	5,320.2	913.8	—	16,960.3
Medical benefits	9,414.1	4,577.3	753.4	—	14,744.8
Costs of products and services	—	—	—	—	—
ACA industry fee	—	—	—	—	—
Medicaid premium taxes	119.8	—	—	—	119.8
Total gross margin expenses	9,533.9	4,577.3	753.4	—	14,864.6
Gross margin [1]	1,192.4	742.9	160.4	—	2,095.7
Investment and other income	—	—	—	46.9	46.9
Other expenses [2]	—	—	—	(1,673.6)	(1,673.6)
Income from operations	$ 1,192.4	$ 742.9	$ 160.4	$ (1,626.7)	$ 469.0

For the Year Ended December 31, 2016	Medicaid Health Plan	Medicare Health Plan	Medicare PDP	Corporate & Other	Consolidated
			(in millions)		
Premium	$ 9,499.3	$ 3,876.6	$ 845.0	$ —	$ 14,220.9
Products and services	—	—	—	—	—
Total premium and products and services revenues	9,499.3	3,876.6	845.0	—	14,220.9
Medical benefits	8,188.5	3,278.5	622.4	—	12,089.4
Costs of products and services	—	—	—	—	—
ACA industry fee	148.0	64.2	16.2	—	228.4
Medicaid premium taxes	110.0	—	—	—	110.0
Total gross margin expenses	8,446.5	3,342.7	638.6	—	12,427.8
Gross margin (1)	1,052.8	533.9	206.4	—	1,793.1
Investment and other income	—	—	—	16.2	16.2
Other expenses (2)	—	—	—	(1,279.8)	(1,279.8)
Income from operations	$ 1,052.8	$ 533.9	$ 206.4	$ (1,263.6)	$ 529.5

(1) Effective January 1, 2018, the Company redefined gross margin as total revenues less investment and other income, medical expenses, cost of products and services, the ACA industry fee expense and Medicaid premium tax expense. Accordingly, results for 2017 and 2016 were adjusted to include Medicaid premium taxes, which decreased gross margin by $119.8 million and $110.0 million, respectively.

(2) Effective January 1, 2018, other expenses includes selling, general and administrative expenses, depreciation, amortization and interest. Accordingly, other expenses for 2017 and 2016 were adjusted to exclude Medicaid premium taxes, which decreased other expenses by $119.8 million and $110.0 million, respectively.

5. EQUITY AND EARNINGS PER COMMON SHARE

Issuance of Common Stock

In August 2018, we completed a public offering of our common stock and issued 5,207,547 shares of our common stock, at an offering price of $265.00 per share. The net proceeds from the offering were approximately $1,342.3 million, after deducting underwriting discounts and offering costs of approximately $37.7 million. We used the net proceeds to fund a portion of the cash consideration for our acquisition of Meridian.

Earnings per Common Share

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

We calculated weighted-average common shares outstanding — diluted as follows:

	For the Years Ended December 31,		
	2018	2017	2016
Weighted-average common shares outstanding — basic	46,767,626	44,474,016	44,248,778
Dilutive effect of outstanding stock-based compensation awards	586,910	493,045	370,811
Weighted-average common shares outstanding — diluted	47,354,536	44,967,061	44,619,589
Anti-dilutive stock-based compensation awards excluded from computation	211,978	76,446	14,867

6. INVESTMENTS

As of December 31, 2018 and 2017, all of our investments were classified as available-for-sale securities. The amortized cost, gross unrealized gains or losses and estimated fair value of short-term and long-term investments by security type are summarized in the following tables.

	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
December 31, 2018				
Asset-backed securities	$ 144.7	$ —	$ (0.5)	$ 144.2
Corporate debt securities	943.0	0.5	(10.1)	933.4
Municipal securities	199.6	0.6	(0.9)	199.3
Residential mortgage-backed securities	7.2	—	(0.2)	7.0
Short-term time deposits	242.2	—	—	242.2
Government and agency obligations	44.9	—	(0.1)	44.8
Other securities	72.5	—	(0.1)	72.4
Total	$ 1,654.1	$ 1.1	$ (11.9)	$ 1,643.3
December 31, 2017				
Asset-backed securities	$ 88.9	$ —	$ (0.2)	$ 88.7
Corporate debt securities	400.6	0.7	(1.2)	400.1
Municipal securities	223.7	1.0	(1.9)	222.8
Residential mortgage-backed securities	11.2	—	—	11.2
Short-term time deposits	300.4	—	—	300.4
Government and agency obligations	148.7	—	(1.2)	147.5
Other securities	65.2	—	(0.2)	65.0
Total	$ 1,238.7	$ 1.7	$ (4.7)	$ 1,235.7

Contractual maturities of our available-for-sale investments at December 31, 2018 are as follows:

	Total	Within 1 Year	1 Through 5 Years	5 Through 10 Years	Thereafter
Asset-backed securities	$ 144.2	$ 70.3	$ 70.1	$ 1.2	$ 2.6
Corporate debt securities	933.4	417.0	429.0	79.3	8.1
Municipal securities	199.3	19.9	115.5	62.5	1.4
Residential mortgage-backed securities	7.0	—	—	—	7.0
Short-term time deposits	242.2	242.2	—	—	—
Government and agency obligations	44.8	30.9	11.9	2.0	—
Other securities	72.4	49.8	5.6	3.0	14.0
Total	$ 1,643.3	$ 830.1	$ 632.1	$ 148.0	$ 33.1

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

During the years ended December 31, 2018, 2017, and 2016, we sold available-for-sale investments totaling $1.1 billion, $348.2 million and $142.2 million, respectively. Realized gains and losses resulting from these sales were not material for any of these years. Additionally, we did not realize any other-than-temporary impairment for any of these years.

7. RESTRICTED CASH, CASH EQUIVALENTS AND INVESTMENTS

The amortized cost, gross unrealized gains, gross unrealized losses and fair value of our restricted cash, cash equivalents and investment securities are as follows:

	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
December 31, 2018				
Cash	$ 11.3	$ —	$ —	$ 11.3
Money market funds	51.4	—	—	51.4
U.S. government securities and other	172.5	—	(0.5)	172.0
Total	$ 235.2	$ —	$ (0.5)	$ 234.7
December 31, 2017				
Cash	$ 5.7	$ —	$ —	$ 5.7
Money market funds	58.7	—	—	58.7
U.S. government securities and other	147.4	—	(0.8)	146.6
Total	$ 211.8	$ —	$ (0.8)	$ 211.0

Realized gains or losses related to sales and redemptions of restricted cash, cash equivalents and investments were not material for the years ended December 31, 2018, 2017, or 2016.

8. PROPERTY, EQUIPMENT AND CAPITALIZED SOFTWARE

Property, equipment and capitalized software and related accumulated depreciation are as follows:

	December 31,	
	2018	2017
Leasehold improvements	$ 75.5	$ 36.9
Computer equipment	173.2	128.3
Capitalized software	671.7	526.2
Furniture and equipment	69.3	39.2
	989.7	730.6
Less accumulated depreciation	(561.5)	(411.1)
Total property and equipment, net	$ 428.2	$ 319.5

We recognized depreciation expense on property, equipment and capitalized software of $107.0 million, $87.7 million, and $77.2 million for the years ended December 31, 2018, 2017, and 2016, respectively, including depreciation expense on capitalized software of $78.8 million, $65.2 million, and $57.6 million for the years ended December 31, 2018, 2017, and 2016, respectively. The increase in expense reflects continued additions to capitalized software and computer equipment resulting from investments in our information technology infrastructure.

9. GOODWILL AND OTHER INTANGIBLE ASSETS, NET

A summary of changes in our goodwill by reportable segment is as follows for 2018 and 2017:

	Medicaid Health Plans	Medicare Health Plans	Not Assigned [4]	Total
Balance as of December 31, 2016 [1] [2]	$ 282.1	$ 110.4	$ —	$ 392.5
Acquired goodwill	8.3	275.6	—	283.9
Measurement period adjustments [2]	(15.7)	—	—	(15.7)
Balance as of December 31, 2017 [1]	274.7	386.0		660.7
Acquired goodwill [4]	—	—	1,560.7	1,560.7
Measurement period adjustments [3]	—	6.3	—	6.3
Balance as of December 31, 2018 [1] [4]	$ 274.7	$ 392.3	$ 1,560.7	$ 2,227.7

(1) Cumulative impairment charges relating to goodwill were $78.3 million as of December 31, 2018 and 2017, which related to goodwill assigned to our Medicare Health Plans reporting unit which we impaired during 2008.

(2) Medicaid Health Plans goodwill as of December 31, 2016, includes approximately $102.7 million of goodwill resulting from our acquisition of Care1st Arizona effective on December 31, 2016. During 2017, we reallocated $24.0 million of this goodwill to identifiable intangible assets, net of a $9.0 million corresponding deferred tax liability, based on our valuation of these assets.

(3) Medicare Health Plans goodwill as of December 31, 2017, includes approximately $275.6 million of goodwill resulting from our acquisition of Universal American effective on April 28, 2017. During 2018, we reallocated $6.3 million of this goodwill to identifiable net assets, based on our final fair value assessment of assets acquired and liabilities assumed. Refer to Note 3 – *Acquisitions* for additional discussion of the Universal American acquisition.

(4) Goodwill related to our 2018 acquisition of Meridian is considered preliminary, pending the final allocation of the applicable purchase price. Refer to Note 3 – *Acquisitions* for additional discussion of our 2018 acquisition.

Other intangible assets as of December 31, 2018 and 2017, and the related weighted-average amortization periods as of December 31, 2018, are as follows:

	As of December 31,						
	2018				2017		
	Weighted Average Amortization Period (In Years)	Gross Carrying Amount	Accumulated Amortization	Other Intangibles, Net	Gross Carrying Amount	Accumulated Amortization	Other Intangibles, Net
Membership and state contracts	9.4	$ 830.1	$ (100.7)	$ 729.4	$ 344.4	$ (52.6)	$ 291.8
Trademarks and tradenames	7.6	159.8	(22.6)	137.2	53.3	(12.9)	40.4
Provider networks	15.0	35.6	(7.0)	28.6	27.3	(5.1)	22.2
Licenses and permits	13.7	7.9	$ (4.5)	3.4	7.1	(4.1)	3.0
Technology and other	6.8	110.8	(13.2)	97.6	14.9	(4.4)	10.5
Total other intangible assets	9.1	$ 1,144.2	$ (148.0)	$ 996.2	$ 447.0	$ (79.1)	$ 367.9

We recorded amortization expense of $72.7 million, $32.7 million, and $10.4 million for the years ended December 31, 2018, 2017 and 2016, respectively. The increase is primarily driven by the previously noted 2018 and 2017 acquisitions, discussed in Note 3 – *Acquisitions.*

Amortization expense expected to be recognized during fiscal years subsequent to December 31, 2018 is as follows:

	Expected Amortization Expense
2019	$ 126.3
2020	132.7
2021	131.1
2022	128.2
2023	119.8
2024 and thereafter	358.1
Total	$ 996.2

10. DEBT

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

	December 31, 2018	December 31, 2017
Long-term debt, net:		
5.25% Senior Notes, due April 1, 2025	$ 1,200.0	$ 1,200.0
5.375% Senior Notes, due August 15, 2026	750.0	—
Revolving Credit Facility	200.0	—
Debt issuance costs	(23.6)	(17.6)
Total long-term debt, net	$ 2,126.4	$ 1,182.4

5.375% Senior Notes due 2026

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

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

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

- incur additional indebtedness and issue preferred stock;
- pay dividends or make other distributions;
- make other restricted payments and investments;
- sell assets, including capital stock of restricted subsidiaries;
- create certain liens;

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

In addition, the 2026 Indenture requires that for the Company to merge, consolidate or sell all or substantially all of its assets, (i) either the Company must be the surviving entity, or the surviving entity or purchaser must be a U.S. entity; (ii) the surviving entity or purchaser must assume all the obligations of the Company under the notes and the indenture; (iii) no default or event of default (as defined under the Indenture) exits and (iv) the surviving entity, after giving pro forma effect to the transaction, (x) may incur at least $1.00 of additional indebtedness pursuant to the fixed charge coverage ratio or (y) have a fixed charge coverage ratio that is no worse than the fixed charge coverage ratio of the Company without giving pro forma effect to the transactions.

Ranking and Optional Redemption

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

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

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

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

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

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

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

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

The 2026 Notes are classified as long-term debt in our consolidated balance sheet at December 31, 2018 based on their August 2026 maturity date.

5.25% Senior Notes due 2025

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

is discussed further below. The remaining net proceeds from the offering of the 2025 Notes were used for general corporate purposes, including organic growth and working capital.

The 2025 Notes will mature on April 1, 2025, and bear interest at a rate of 5.25% per annum, payable semi-annually on April 1 and October 1 of each year, commencing on October 1, 2017.

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

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

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

Ranking and Optional Redemption

The 2025 Notes are senior obligations of our company and rank equally in right of payment with all of our other existing and future unsecured and unsubordinated indebtedness. In addition, the 2025 Notes are structurally subordinated to all indebtedness and other liabilities of our subsidiaries (unless our subsidiaries become guarantors of the 2025 Notes).

At any time prior to April 1, 2020, we may, on any one or more occasions, redeem up to 40% of the aggregate principal amount of 2025 Notes at a redemption price equal to 105.250% of the principal amount of the 2025 Notes redeemed, plus accrued and unpaid interest, if any, with the net cash proceeds of an equity offering by the Company; provided that:

(1) at least 60% of the aggregate principal amount of 2025 Notes issued under the Indenture (including any additional Senior Notes, but excluding Senior Notes held by the Company or its subsidiaries) remains outstanding immediately after the occurrence of such redemption; and
(2) the redemption occurs within 90 days of the date of the closing of such equity offering.

At any time prior to April 1, 2020, we may on any one or more occasions redeem all or a part of the 2025 Notes, at a redemption price equal to 100% of the principal amount of the 2025 Notes redeemed, plus the Applicable Premium. The Applicable Premium means the greater of (i) 1.0% of the then outstanding principal amount of the note or (ii) the excess of the present value at such redemption date of the redemption price set forth in the optional redemption table below plus all required interest payments on the notes due through April 1, 2020 over the then outstanding principal amount of the notes, using the yield-to-maturity treasury rate most nearly equal to the period from the redemption date to April 1, 2020, as further set forth in the Indenture.

Except pursuant to the preceding two paragraphs, the 2025 Notes will not be redeemable at our option prior to April 1, 2020.

On or after April 1, 2020, we may on any one or more occasions redeem all or a part of the 2025 Notes, at the redemption prices (expressed as percentages of principal amount) set forth below, plus accrued and unpaid interest, if any, on the 2025 Notes redeemed, to, but not including, the applicable date of redemption, if redeemed during the twelve-month period

beginning on November 15 of the years indicated below, subject to the rights of holders of 2025 Notes on the relevant record date to receive interest due on the relevant interest payment date:

Period	Redemption Price
2020	103.938%
2021	102.625%
2022	101.313%
2023 and thereafter	100.000%

The 2025 Notes are classified as long-term debt in our consolidated balance sheet at December 31, 2017, based on their April 2025 maturity date.

5.75% Senior Notes due 2020

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

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

Revolving Credit Facility

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

On July 23, 2018, we entered into an amended and restated Credit Agreement (“Amended and Restated Credit Agreement”) which increased the aggregate principle amount available under our Revolving Credit Facility from $1.0 billion to $1.3 billion. Additionally, in July 2018, we extended the maturity date under the Revolving Credit Facility from January 2021 to July 2023 and decreased the applicable margins for borrowings under the Revolving Credit Facility to a range of (A) 0.375% to 1.00% per annum for ABR Loans (as defined in the Amended and Restated Credit Agreement) and (B) 1.375% to 2.00% per annum for Eurodollar Loans (as defined in the Amended and Restated Credit Agreement), in each case depending on our ratio of total debt to consolidated EBITDA, as calculated in accordance with the Amended and Restated Credit Agreement. The Amended and Restated Credit Agreement also includes an accordion feature which allows the Company to increase the total commitments under the revolving credit facility by up to an additional $500 million, subject to certain conditions.

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

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

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

In August 2018, $225.0 million was drawn on our Revolving Credit Facility to partially fund the Meridian acquisition, of which $25.0 million was repaid during September 2018. As of December 31, 2018, $200.0 million was outstanding under the Revolving Credit Facility, and was classified as long-term in accordance with the contractual terms of the Amended and Restated Credit Agreement.

As of December 31, 2018, and the date of this filing, we were in compliance with all covenants under the 2026 Notes, the 2025 Notes and the Amended and Restated Credit Agreement.

11. FAIR VALUE MEASUREMENTS

Our consolidated balance sheets include the following financial instruments: cash and cash equivalents, investments, receivables, accounts payable, medical benefits payable, long-term debt and other liabilities. We consider the carrying amounts of cash and cash equivalents, receivables, other current assets and current liabilities to approximate their fair value due to the short period of time between the origination of these instruments and the expected realization or payment.

For other financial instruments, including short- and long-term investments, restricted investments, and long-term debt, fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. Assets and liabilities measured at fair value are classified using the following hierarchy, which is based upon the transparency of inputs to the valuation as of the measurement date.

Level 1—Quoted (unadjusted) prices for identical assets or liabilities in active markets: We include investments in cash, money market funds and U.S. government securities in Level 1. The carrying amounts of money market funds and cash approximate fair value because of the short-term nature of these instruments. We base fair values of the other investments included in Level 1 on unadjusted quoted market prices for identical securities in active markets.

Level 2—Inputs other than quoted prices in active markets: We include in Level 2 investments in certain certificates of deposit, commercial paper, corporate debt, asset-backed and other municipal securities for which fair market valuations are based on quoted prices for identical securities in markets that are not active, quoted prices for similar securities in active markets, broker or dealer quotations, or alternative pricing sources or for which all significant inputs are observable, either directly or indirectly, including interest rates and yield curves observable at commonly quoted intervals, volatilities, prepayment speeds, loss severities, credit risks and default rates.

In addition to using market data, we make assumptions when valuing our assets and liabilities, including assumptions about risks inherent in the inputs to the valuation technique. When there is not an observable market price for an identical or similar asset or liability, we use an income approach reflecting our best assumptions regarding expected cash flows, discounted using a commensurate risk-adjusted discount rate.

Level 3—Unobservable inputs that cannot be corroborated by observable market data: Through June 2018, we held investments in auction rate securities designated as available for sale and reported at fair value. During June 2018, we sold the remaining auction rate securities in our portfolio. The sale resulted in a loss of $1.2 million that was included within investment and other income in the consolidated statements of comprehensive income for year ended December 31, 2018. As these securities were believed to be in an inactive market, we historically estimated the fair value of these securities using a discounted cash flow model, utilizing significant unobservable inputs. These fair values were based on an approach that relied heavily on management assumptions and qualitative observations and therefore fall within Level 3 of the fair value hierarchy. We include our auction rate security investments in Municipal securities below.

We determine transfers between levels at the end of the reporting period. No transfers between levels occurred during the years ended December 31, 2018 and 2017.

Recurring Fair Value Measurements

Assets and liabilities measured at fair value on a recurring basis at December 31, 2018 are as follows:

		Fair Value Measurements Using		
	Carrying Value	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Investments:				
Asset-backed securities	$ 144.2	$ —	$ 144.2	$ —
Corporate debt securities	933.4	—	933.4	—
Municipal securities	199.3	—	199.3	—
Residential mortgage-backed securities	7.0	—	7.0	—
Short-term time deposits	242.2	—	242.2	—
Government and agency obligations	44.8	44.8	—	—
Other securities	72.4	49.8	22.6	—
Total investments	$ 1,643.3	$ 94.6	$ 1,548.7	$ —
Restricted cash, cash equivalents and investments:				
Cash	$ 11.3	$ 11.3	$ —	$ —
Money market funds	51.4	51.4	—	—
U.S. government securities and other	172.0	171.8	0.2	—
Total restricted cash, cash equivalents and investments	$ 234.7	$ 234.5	$ 0.2	$ —

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

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

The following table presents the changes in the fair value of our Level 3 auction rate securities for the years ended December 31, 2018, 2017 and 2016:

	Fair Value Measurements Using Significant Unobservable Inputs (Level 3)		
	December 31,		
	2018	2017	2016
Balance as of January 1	$ 12.3	$ 12.4	$ 31.7
Realized gains (losses) in earnings	(1.2)	—	—
Changes in net unrealized gains and losses in other comprehensive income	1.4	—	0.9
Purchases, sales and redemptions	(12.5)	(0.1)	(20.2)
Net transfers in or (out) of Level 3	—	—	—
Balance as of December 31	$ —	$ 12.3	$ 12.4

Debt

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

		Fair Value Measurements Using		
	Carrying Value	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Long-term debt - December 31, 2018	$ 2,126.4	$ 1,885.2	$ 200.0	
Long-term debt - December 31, 2017	1,182.4	1,274.3	—	—

The fair value of both our 2026 Notes and 2025 Notes was determined based on quoted market prices; therefore, would be classified within Level 1 of the fair value hierarchy. The fair value of obligations outstanding under our Revolving Credit Facility as of December 31, 2018, approximated carrying value and would be classified within Level 2 of the fair value hierarchy. There were no borrowings outstanding under our Revolving Credit Facility as of December 31, 2017

12. MEDICAL BENEFITS PAYABLE

Medical benefits payable consists of:

(in millions)	As of December 31, 2018	% of Total	As of December 31, 2017	% of Total
IBNR	$ 2,029.8	70%	$ 1,412.3	66%
Other medical benefits payable	867.6	30%	734.0	34%
Total medical benefits payable	$ 2,897.4	100%	$ 2,146.3	100%

A reconciliation of the beginning and ending balances of our consolidated medical benefits payable is as follows:

	For the years ended December 31,		
	2018	2017	2016
		(in millions)	
Beginning balance	$ 2,146.3	$ 1,690.5	$ 1,536.0
Acquisitions	534.3	128.1	37.3
Medical benefits incurred related to:			
Current year [1]	17,603.4	15,112.4	12,374.1
Prior years	(475.3)	(367.6)	(284.7)
Total	17,128.1	14,744.8	12,089.4
Medical benefits paid related to:			
Current year	(15,486.3)	(13,355.9)	(10,925.0)
Prior years	(1,425.0)	(1,061.2)	(1,047.2)
Total	(16,911.3)	(14,417.1)	(11,972.2)
Ending balance	$ 2,897.4	$ 2,146.3	$ 1,690.5

(1) The Medicaid Health Plans and Consolidated ending balances for 2018 and 2017 include a premium deficiency reserve for our Illinois Medicaid programs ("Illinois PDR"), which amounted to $16.1 million and $45.6 million at December 31, 2018 and 2017, respectively. Refer to Note 2 – *Summary of Significant Accounting Policies* for additional discussion of our premium deficiency reserves.

Medical benefits payable recorded developed favorably by approximately $475.3 million, $367.6 million, and $284.7 million in 2018, 2017 and 2016, respectively. The release of the provision for moderately adverse conditions included in our prior year estimates was substantially offset by the provision for moderately adverse conditions established for claims incurred in the current year. Accordingly, the favorable development in our estimate of medical benefits payable related to claims incurred in prior years does not directly correspond to a decrease in medical benefits expense recognized during the period in which the favorable development is recognized.

Excluding the prior year development related to the release of the provision for moderately adverse conditions, our estimates of consolidated medical benefits expense recorded developed favorably by approximately $243.8 million, $224.6 million, and $154.3 million in 2018, 2017, and 2016, respectively. Such amounts are net of the development relating to refunds due to government customers in connection with minimum loss ratio provisions. The net favorable development recognized in 2018, 2017 and 2016 was primarily in our Medicaid Health Plans segment and, to a lesser extent, in our Medicare Health Plans segment. The net favorable development resulted primarily due to a number of operational and clinical initiatives planned and executed that contributed to lower than expected pharmacy and medical trends, and actual claim submission time being faster than we originally assumed (i.e. our completion factors were higher than we originally assumed) in establishing our medical benefits payable in the prior years. This development does not directly correspond to an increase in our current year operating results as these reductions were offset by estimated current period medical benefits expense when we established our estimate of the current year medical benefits payable. Both completion factor and medical trend assumptions are influenced by utilization levels, unit costs, mix of business, provider reimbursement levels, processing system conversions and changes, claim inventory levels, claim processing patterns, our ability and practices to manage medical and pharmaceutical costs, claim submission patterns and operational changes resulting from business combinations, among others. Our actual costs were ultimately less than expected.

Our Meridian acquisition in 2018, our Universal American acquisition in 2017 and our Care1st acquisition in 2016 resulted in increases to medical benefits payable as of the effective date of each acquisition. See Note 3 - *Acquisitions*, for additional discussion of our 2017 and 2018 acquisitions.

Incurred and paid claims development

The following is information about incurred and paid claims development, by segment and consolidated, as of December 31, 2018, 2017 and 2016, net of reinsurance, as well as cumulative claim frequency and the total of incurred-but-not-reported liabilities plus expected development on reported claims included within the net incurred claims amounts. The reported cumulative claims below represent billed services rendered to health plan members that are submitted for payment according to industry standards.

Medicaid Health Plans

A reconciliation of the beginning and ending balances of our Medicaid Health Plans medical benefits payable is as follows:

	For the years ended December 31,		
	2018	**2017**	**2016**
		(in millions)	
Beginning balance	$ 1,373.2	$ 1,135.8	$ 1,040.2
Acquisitions	484.0	—	37.3
Medical benefits incurred related to:			
Current year [(1)]	11,454.4	9,612.2	8,404.2
Prior years	(283.1)	(198.1)	(215.7)
Total	11,171.3	9,414.1	8,188.5
Medical benefits paid related to:			
Current year	(10,081.7)	(8,417.4)	(7,431.4)
Prior years	(934.0)	(759.3)	(698.8)
Total	(11,015.7)	(9,176.7)	(8,130.2)
Ending balance	$ 2,012.8	$ 1,373.2	$ 1,135.8

(1) The Medicaid Health Plans and Consolidated ending balances for 2018 and 2017 include a premium deficiency reserve for our Illinois Medicaid programs ("Illinois PDR"), which amounted to $16.1 million and $45.6 million at December 31, 2018 and 2017, respectively.

The following tables provide information about incurred and paid claims development for our Medicaid Health Plans segment as of December 31, 2018, net of reinsurance. Incurred and paid claims development for the years ended December 31, 2017 and 2016 have been retrospectively adjusted for the 2018 acquisition of Meridian.

Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance			As of December 31, 2018	
	Incurred amount			
Incurred Year	2017	2018	Total of IBNR Liabilities Plus Expected Development on Reported Claims	Cumulative Number of Reported Claims
2017[1]	$ 11,814.1	$ 11,608.2	$ 90.8	94.2
2018[1]		13,163.3	1,836.9	101.6
	Total	$ 24,771.5		

(1) Incurred amounts for 2018 and 2017 are net of a $5.8 million reinsurance receivable acquired from Meridian. Refer to Note 3 – *Acquisitions* for additional discussion of the Meridian acquisition.

Cumulative Paid Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance		
Incurred Year	2017	2018
2017	$ (10,249.0)	$ (11,517.4)
2018		(11,326.4)
	Total	$ (22,843.8)
	All outstanding liabilities before 2017, net of reinsurance	79.3
	Liabilities for claims and claim adjustment expenses, net of reinsurance	$ 2,007.0

Medicare Health Plans

A reconciliation of the beginning and ending balances of our Medicare Health Plans medical benefits payable is as follows:

	For the years ended December 31,		
	2018	2017	2016
		(in millions)	
Beginning balance	$ 722.5	$ 510.0	$ 473.9
Acquisitions	47.7	128.1	—
Medical benefits incurred related to:			
Current year	5,478.2	4,676.8	3,332.9
Prior years	(130.4)	(99.5)	(54.4)
Total	5,347.8	4,577.3	3,278.5
Medical benefits paid related to:			
Current year	(4,780.9)	(4,164.6)	(2,901.3)
Prior years	(513.6)	(328.3)	(341.1)
Total	(5,294.5)	(4,492.9)	(3,242.4)
Ending balance	$ 823.5	$ 722.5	$ 510.0

The following tables provide information about incurred and paid claims development for our Medicare Health Plans segment as of December 31, 2018, net of reinsurance. Incurred and paid claims development for the years ended December 31, 2017 and 2016 have been retrospectively adjusted for the 2018 acquisition of Meridian and the 2017 acquisition of Universal American.

Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance			As of December 31, 2018	
	Incurred amount		Total of IBNR Liabilities Plus Expected Development on Reported Claims	Cumulative Number of Reported Claims
Incurred Year	2017	2018		
2017	$ 5,583.3	$ 5,457.4	$ 31.3	32.3
2018		5,603.5	742.3	34.0
	Total	$ 11,060.9		

Cumulative Paid Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance		
Incurred Year	2017	2018
2017	$ (4,907.2)	$ (5,426.1)
2018		(4,861.2)
	Total	$ (10,287.3)
	All outstanding liabilities before 2017, net of reinsurance	49.9
	Liabilities for claims and claim adjustment expenses, net of reinsurance	$ 823.5

Medicare PDPs

A reconciliation of the beginning and ending balances of our Medicare PDPs medical benefits payable is as follows:

	For the years ended December 31,		
	2018	2017	2016
		(in millions)	
Beginning balance	$ 50.6	$ 44.7	$ 21.9
Acquisitions	—	—	—
Medical benefits incurred related to:			
Current year	666.6	823.4	637.0
Prior years	(61.9)	(70.0)	(14.6)
Total	604.7	753.4	622.4
Medical benefits paid related to:			
Current year	(618.7)	(773.9)	(592.3)
Prior years	22.5	26.4	(7.3)
Total	(596.2)	(747.5)	(599.6)
Ending balance	$ 59.1	$ 50.6	$ 44.7

The following tables provide information about incurred and paid claims development for our Medicare PDPs segment as of December 31, 2018, net of reinsurance. Incurred and paid claims development for the years ended December 31, 2017 and 2016 have been retrospectively adjusted for the 2018 acquisition of Meridian.

Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance			As of December 31, 2018	
	Incurred amount			
Incurred Year	2017	2018	Total of IBNR Liabilities Plus Expected Development on Reported Claims	Cumulative Number of Reported Claims
2017	$ 823.4	$ 753.2	$ —	51.3
2018		666.6	47.8	47.7
	Total	$ 1,419.8		

Cumulative Paid Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance		
Incurred Year	2017	2018
2017	$ (773.9)	$ (753.2)
2018		(618.8)
	Total	$ (1,372.0)
	All outstanding liabilities before 2017, net of reinsurance	11.3
	Liabilities for claims and claim adjustment expenses, net of reinsurance	$ 59.1

Consolidated

The following tables provide information about the consolidated company incurred and paid claims development as of December 31, 2018, net of reinsurance. The information for 2018 and 2017 has been retrospectively adjusted for our Meridian and Universal American acquisitions.

Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance			As of December 31, 2018	
	Incurred amount			
Incurred Year	2017	2018	Total of IBNR Liabilities Plus Expected Development on Reported Claims	Cumulative Number of Reported Claims
2017[(1)]	$ 18,231.2	$ 17,828.5	$ 122.1	177.9
2018 [(1)]		19,440.6	2,629	183.4
	Total	$ 37,269.1		

(1) Incurred amounts for 2018 and 2017 include the $16.1 million and $45.6 million Illinois PDR, respectively, discussed further in Note 2 - *Summary of Significant Accounting Policies*. Additionally, incurred amounts for 2018 and 2017 are net of a $5.8 million reinsurance recoverable.

Cumulative Paid Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance		
Incurred Year	2017	2018
2017	$ (15,937.9)	$ (17,706.4)
2018		(16,811.6)
	Total	$ (34,518.0)
	All outstanding liabilities before 2017, net of reinsurance	140.5
	Liabilities for claims and claim adjustment expenses, net of reinsurance	$ 2,891.6

The reconciliation of the net incurred and paid claims development tables, by segment, to the liability for claims and claim adjustment expenses in the consolidated balance sheets is as follows.

Reconciliation of the Disclosure of Incurred and Paid Claims Development to the Liability for Unpaid Claims and Claim Adjustment Expenses		
		December 31, 2018
Net Outstanding Liabilities		
Medicaid Health Plans	$	2,007.0
Medicare Health Plans		823.5
Medicare PDPs		59.1
Corporate and other [1]	$	2.0
Liabilities for unpaid claims and claim adjustment expenses, net of reinsurance	$	2,891.6
Reinsurance Recoverable		5.8
Total gross liability for unpaid claims and claim adjustment expense	$	2,897.4

[1] The Corporate and other category, which includes operating segments that are not individually reportable because they do not meet the quantitative thresholds required by generally accepted accounting principles, has an insignificant amount of medical claims liability and, therefore, disclosures related to medical claims liabilities have been aggregated within the consolidated results.

13. COMMITMENTS AND CONTINGENCIES

Indemnification Obligations

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

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

in the specific case that the indemnitee has satisfied any standards of conduct required as a condition to indemnification under Section 145 of the Delaware General Corporation Law.

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

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

In April 2017, the Commission and Mr. Farha entered into a consent judgment to pay $12.5 million to the Commission and $7.5 million to us. In April 2017, the Commission and Mr. Behrens also entered into a consent judgment to pay $4.5 million to the Commission and $1.5 million to us. In May 2018, the Commission and Mr. Bereday entered into a consent judgment to pay $4.5 million to the Commission and the case was closed.

In addition, we have advanced a portion of the legal fees and related expenses to Mr. Farha in connection with lawsuits he filed in Delaware and Florida state court to have certain restrictions lifted on WellCare stock purportedly awarded to him during his employment with us. The Delaware and Florida state court matters have been dismissed.

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

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

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

In connection with these matters, we have advanced to the five individuals, cumulative legal fees and related expenses of approximately $237.1 million from the inception of the investigations through December 31, 2018. We incurred $0.9 million, $6.4 million and $18.7 million of these legal fees and related expenses during the years ended December 31, 2018, 2017 and 2016, respectively. These fees are not inclusive of the amounts recovered from Mr. Farha and Mr. Behrens discussed above. We expense these costs as incurred and classify the costs as selling, general and administrative expense incurred in connection with the investigations and related matters.

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

Other Lawsuits and Claims

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

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

Operating Leases

We recorded rental expense of $43.7 million, $35.1 million and $30.7 million for the years ended December 31, 2018, 2017 and 2016, respectively, related to our operating leases for office space. Future minimum lease payments under non-cancelable operating leases with initial or remaining lease terms in excess of one year at December 31, 2018 are as follows:

	Minimum Lease Payments
2019	$ 42.4
2020	44.4
2021	45.5
2022	41.9
2023	38.7
2024 and thereafter	151.4
Total	$ 364.3

14. INCOME TAXES

The Company and subsidiaries file a consolidated federal income tax return, combined state income tax returns, and separate state franchise, income and premium tax returns, as applicable. The following table provides components of income tax expense (benefit):

	For the Years Ended December 31,		
	2018	2017	2016
Current:			
Federal	$ 203.8	$ 120.8	$ 251.6
State	48.1	14.2	24.2
	251.9	135.0	275.8
Deferred:			
Federal	(0.3)	(48.3)	12.8
State	1.4	1.2	(1.2)
	1.1	(47.1)	11.6
Total income tax expense	$ 253.0	$ 87.9	$ 287.4

A reconciliation of income tax at the statutory federal rate (currently 21% for the 2018 tax year and 35% for the 2017 and 2016 tax years) to income tax at the effective rate is as follows:

	For the Years Ended December 31,		
	2018	2017	2016
Income tax expense at statutory federal rate	$ 145.5	$ 161.6	$ 185.3
Adjustments resulting from:			
State income tax, net of federal benefit	36.6	11.7	14.4
Unrecognized tax benefits	2.5	(23.5)	9.5
Tax rate change	3.1	(56.1)	—
Non-deductible ACA industry fees	72.3	—	79.9
Other, net	(7.0)	(5.8)	(1.7)
Total income tax expense	$ 253.0	$ 87.9	$ 287.4

Our effective income tax rate on pre-tax income was 36.5% for the year ended December 31, 2018, compared with 19.0% and 54.3% for the years ended December 31, 2017 and 2016, respectively. The rate increase during 2018 was primarily driven by the tax rate change resulting from the enactment of the *Tax Cuts and Jobs Act of 2017* (the "TCJA") during 2017 (discussed below); the one-year moratorium on the non-deductible ACA industry fee for 2017 and the favorable effect of the recognition of certain previously unrecognized tax benefits during 2017. The rate increase was partially offset by the reduction in the federal income tax rate.

The TCJA was enacted on December 22, 2017. The TCJA, in part, reduced the U.S. federal statutory corporate income tax rate from 35% to 21% effective January 1, 2018. Staff Accounting Bulletin No. 118 allows filers one year subsequent to the end of the tax year to finalize the valuation of deferred tax assets and liabilities. We have completed our accounting for the tax effects resulting from enactment of TCJA with respect to valuation of our deferred tax assets and liabilities, as well as other aspects of the new law, and recognized non-cash decreases to income tax expense of $1.0 million and $56.1 million for the years ended December 31, 2018 and December 31, 2017, respectively.

Significant components of our deferred tax assets and liabilities are:

	As of December 31,	
Deferred tax assets:	**2018**	**2017**
Net operating losses	$ 31.6	$ 24.7
Foreign tax credits	17.1	22.0
Medical and other benefits discounting	17.9	18.7
Allowance for doubtful accounts	30.4	14.8
Stock-based compensation	17.2	14.1
Unearned premium discounting	0.1	3.1
Capital losses	7.1	9.9
Premium deficiency reserve	3.9	10.7
Accrued expenses and other	19.4	5.6
Total deferred tax assets	144.7	123.6
Valuation allowance	(39.7)	(48.5)
Net deferred tax assets	105.0	75.1
Deferred tax liabilities:		
Goodwill and other intangible assets	(150.5)	(101.1)
Software development costs and property and equipment	(77.2)	(56.7)
Prepaid assets	(11.5)	(10.7)
Total deferred tax liabilities	(239.2)	(168.5)
Net deferred tax liability	$ (134.2)	$ (93.4)

Valuation allowances are provided when it is considered more-likely-than-not that deferred tax assets will not be realized. The valuation allowances relate to future benefits on certain state net operating loss carryforwards, capital loss carryforwards, and foreign tax credits which expire beginning with the 2019 tax year through 2038.

A reconciliation of the beginning and ending amount of unrecognized tax benefits (excluding interest and penalties) is as follows:

	Years Ended December 31,	
	2018	**2017**
Unrecognized tax benefits, beginning of period	$ 3.5	$ 23.5
Increases:		
Prior year tax positions	2.6	—
Current year tax positions	1.7	3.5
Decreases:		
Prior year tax positions	—	(23.5)
Unrecognized tax benefits, end of period	$ 7.8	$ 3.5

The Company includes interest and penalties related to unrecognized tax benefits within the provision for income taxes which were immaterial for the periods ending December 31, 2018 and December 31, 2017.

We believe it is reasonably possible that our liability for unrecognized tax benefits will decrease in the next 12 months as a result of audit settlements.

We file our income tax returns in the U.S. federal jurisdiction and various states and localities. We currently participate in the Compliance Assurance Program ("CAP") with the IRS, excluding the 2017 tax year. Under CAP, the IRS undertakes audit procedures during the tax year and as the return is prepared for filing. The IRS has concluded its CAP review of our 2016 tax

return as well as all the prior years. We are no longer subject to state and local tax examinations prior to 2015. As of December 31, 2018, we are not aware of any material proposed adjustments.

15. STOCK-BASED COMPENSATION

We recorded stock-based compensation expense of $70.8 million, $59.8 million and $35.5 million for the years ended December 31, 2018, 2017, and 2016, respectively. The increase in 2018 was primarily driven by the increase in our closing stock price from $201.11 as of December 31, 2017 to $236.09 as of December 31, 2018, which had the effect of increasing cumulative compensation expense recognized for our PSUs subject to variable accounting.

As of December 31, 2018, we expect $75.2 million of unrecognized compensation cost related to non-vested stock-based compensation arrangements, net of estimated forfeitures, to be recognized over a weighted-average period of 1.7 years. The unrecognized compensation cost for our PSUs subject to variable accounting was determined based on the closing common stock price as of December 31, 2018 and amounted to approximately $20.9 million of the total unrecognized compensation cost. Due to the nature of the accounting for these awards, future compensation cost will fluctuate based on changes in our common stock price.

The weighted-average grant-date fair values of shares granted during the years ended December 31, 2018, 2017 and 2016 were $199.92, $139.49 and $100.07, respectively. The total fair value of all shares vested during the year ended December 31, 2018 was $76.2 million. We generally repurchase vested shares from our employees to satisfy our tax withholding requirements at the statutory minimum, and then retire the repurchased shares.

Restricted Stock Units

A summary of the activity for our RSU awards for the year ended December 31, 2018 is presented in the table below.

	RSUs		Weighted Average Grant-Date Fair Value
Outstanding as of January 1, 2018	274,643	$	120.73
Granted	129,520		205.47
Vested	(130,736)		114.18
Forfeited	(20,192)		153.09
Outstanding as of December 31, 2018	253,235	$	164.88

Performance Stock Units

A summary of the activity for our PSU awards for the year ended December 31, 2018 is presented in the table below. For our PSUs, shares attained over target upon vesting are reflected as awards granted during the period, while shares canceled due to vesting below target are reflected as awards forfeited during the period.

	PSUs		Weighted Average Award-Issuance Fair Value
Outstanding as of January 1, 2018	552,618	$	118.64
Granted	256,679		199.26
Vested	(154,055)		91.32
Forfeited and expired	(48,534)		150.13
Outstanding as of December 31, 2018	606,708	$	149.16

Market Stock Units

A summary of the activity for our MSU awards for the year ended December 31, 2018 is presented in the table below. For our MSUs, shares attained over target upon vesting are reflected as awards granted during the period, while shares canceled due to vesting below target are reflected as awards forfeited during the period.

	MSUs	Weighted Average Grant-Date Fair Value
Outstanding as of January 1, 2018	45,230	$ 130.01
Granted	45,075	130.01
Vested	(90,150)	130.01
Forfeited and expired	(155)	130.38
Outstanding as of December 31, 2018	—	$ —

16. REGULATORY CAPITAL AND DIVIDEND RESTRICTIONS

Each of our health maintenance organizations ("HMO") and insurance subsidiaries must maintain a minimum amount of statutory capital determined by statute or regulation. The minimum statutory capital requirements differ by state and are generally based on a percentage of annualized premium revenue, a percentage of annualized health care costs, a percentage of certain liabilities, a statutory minimum, risk-based capital ("RBC") requirements or other financial ratios. Failure to maintain these requirements would trigger regulatory action by the state. Such statues, regulations and capital requirements also restrict the timing, payment and amount of dividends and other distributions that may be paid to us as the sole stockholder. Based upon current statutes and regulations, the minimum capital and surplus requirement, or net assets, for these subsidiaries that may not be transferable to us in the form of loans, advances or cash dividends was approximately $1.6 billion at December 31, 2018 and $1.2 billion at December 31, 2017. The combined statutory capital and surplus of our HMO and insurance subsidiaries was $2.7 billion and $2.0 billion at December 31, 2018 and 2017, respectively, which was in compliance with the minimum capital requirements as of those dates. These increases resulted from the Meridian acquisition in 2018 and the Universal American acquisition in 2017. Our HMO and insurance subsidiaries were in compliance with and in excess of the minimum capital requirements as of both December 31, 2018 and 2017.

Dividend restrictions vary by state, but the maximum amount of dividends which can be paid without prior approval from the applicable state is subject to restrictions relating to statutory capital, surplus and net income for the previous year. Some states require prior approval of all dividends, regardless of amount. States may disapprove any dividend that, together with other dividends paid by a subsidiary in the prior 12 months, exceeds the regulatory maximum as computed for the subsidiary based on its statutory surplus and net income. We received $335.6 million, $335.0 million and $241.0 million in dividends from our regulated subsidiaries during the years ended December 31, 2018, 2017 and 2016, respectively. The 2018 amount included $65.6 million not requiring prior regulatory approval, and $270.0 million paid after obtaining prior regulatory approval. Under applicable regulatory requirements at December 31, 2018, the amount of dividends that may be paid through the end of 2019 by our HMO and insurance subsidiaries without prior approval by regulatory authorities is approximately $420.7 million in the aggregate.

17. DISCONTINUED OPERATIONS

On August 3, 2016, our subsidiary, Universal American, completed the sale of its Traditional Insurance business prior to our acquisition of Universal American. This was accomplished by selling two life insurance subsidiaries, while retaining ownership of a third life insurance subsidiary, American Progressive Life & Health Insurance Company of New York ("Progressive"). The sale of the Traditional Insurance business underwritten by Progressive was accomplished through a 100% quota-share reinsurance treaty with a wholly-owned subsidiary of Nassau Re, that, when considered in combination with other reinsurance transactions previously entered into, resulted in the reinsurance of all of the Traditional Insurance policies that were underwritten by Progressive. Accordingly, the discontinued Traditional Insurance business did not materially affect our consolidated statements of comprehensive income for the year ended December 31, 2018 and 2017.

In accordance with ASC 360-10, *Property, Plant and Equipment and ASC 205-20, Presentation of Financial Statements—Discontinued Operations*, the Traditional Insurance business has been reported in discontinued operations in this 2018 Form 10-K.

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

	December 31, 2018	December 31, 2017
	(in millions)	
Assets		
Cash and cash equivalents	$ 0.1	$ 1.3
Investments	42.8	46.5
Reinsurance recoverables	170.2	166.9
Other assets	0.5	0.5
Total Assets	$ 213.6	$ 215.2
Liabilities		
Reserves and other policy liabilities	$ 166.9	$ 148.6
Other liabilities	46.7	66.6
Total liabilities	$ 213.6	$ 215.2

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

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

18. QUARTERLY FINANCIAL INFORMATION

Selected unaudited quarterly financial data is as follows (in millions, except membership and per share data):

	For the Three Month Periods Ended			
	March 31, 2018	June 30, 2018	September 30, 2018	December 31, 2018
Total revenues	$ 4,646.2	$ 4,639.0	$ 5,058.1	$ 6,070.8
Gross margin [1]	550.7	637.0	676.9	688.2
Income from operations	161.2	233.9	208.6	94.6
Income before income taxes	158.5	229.9	215.2	89.2
Net income	101.7	151.6	130.6	55.9
Net income per share - basic [2]	$ 2.28	$ 3.39	$ 2.74	$ 1.12
Net income per share - diluted [2]	2.25	3.35	2.70	1.11
Period end membership	4,284,000	4,384,000	5,508,000	5,538,000

	For the Three Month Periods Ended			
	March 31, 2017	June 30, 2017	September 30, 2017	December 31, 2017
Total revenues	$ 3,954.2	$ 4,305.0	$ 4,402.9	$ 4,345.1
Gross margin [1]	438.5	543.4	620.7	493.1
Income (loss) from operations	103.2	141.9	211.9	12.0

Income (loss) before income taxes	103.2	114.7	235.1	8.6
Net (loss) income	67.3	74.1	171.6	60.7
Net income per share - basic [2]	$ 1.52	$ 1.67	$ 3.86	$ 1.36
Net income per share - diluted [2]	1.50	1.65	3.82	1.34
Period end membership	4,078,000	4,428,000	4,349,000	4,371,000

(1) Effective July 1, 2018, the Company redefined gross margin as total revenues less investment and other income, medical expenses, cost of products and services, the ACA industry fee expense, and Medicaid premium tax expense. Accordingly, results for 2017 and the three months ended March 31, 2018 and June 30, 2018 were adjusted to include Medicaid premium taxes. Gross margin decreased by $32.1 million, $30.6 million, $29.9 million, $31.2 million, $29.5 million and $29.2 million for the three months ended March 31, 2018, June 30, 2018, March 31, 2017, June 30, 2017, September 30, 2017 and December 31, 2017, respectively.
(2) The calculation of net income per share is based on weighted average shares outstanding during each quarter and, accordingly, the sum may not equal the total for the year.

19. SUBSEQUENT EVENTS

In February 2019, we received notice from the North Carolina Department of Health and Human Services (“DHHS”) that we were awarded a contract to administer the state’s Medicaid Prepaid Health Plans, which is subject to a protest process. DHHS has selected four health plans, including us, to serve North Carolina's Medicaid beneficiaries on a statewide basis. One additional health plan led by providers was selected to operate health plans in certain regions. The state is expected to implement the new managed care program, in two phases, for its 1.6 million Medicaid beneficiaries beginning November 1, 2019.

Schedule I

CONDENSED FINANCIAL INFORMATION OF REGISTRANT
WELLCARE HEALTH PLANS, INC. (Parent Company Only)
STATEMENTS OF COMPREHENSIVE INCOME
(In millions)

	For the Years Ended December 31,		
	2018	**2017**	**2016**
Revenues:			
Investment and other income	$ 2.1	$ 0.3	$ 0.1
Total revenues	2.1	0.3	0.1
Expenses:			
Selling, general and administrative	82.6	63.4	37.5
Interest expense	87.5	68.5	59.1
Total expenses	170.1	131.9	96.6
Loss from operations	(168.0)	(131.6)	(96.5)
Loss on extinguishment of debt	—	26.1	—
Loss before income taxes	(168.0)	(157.7)	(96.5)
Income tax benefit	28.4	69.7	30.8
Loss before equity in subsidiaries	(139.6)	(88.0)	(65.7)
Equity in earnings of subsidiaries	579.4	461.7	307.8
Net income	439.8	373.7	242.1
Other comprehensive (loss) income, before tax:			
Change in net unrealized gains and losses on available-for-sale securities	(9.1)	(2.2)	1.8
Income tax (benefit) expense related to other comprehensive income	(2.9)	(0.5)	0.6
Other comprehensive (loss) income, net of tax	(6.2)	(1.7)	1.2
Comprehensive income	$ 433.6	$ 372.0	$ 243.3

See notes to condensed financial statements.

CONDENSED FINANCIAL INFORMATION OF REGISTRANT
WELLCARE HEALTH PLANS, INC. (Parent Company Only)
BALANCE SHEETS
(In millions, except share data)

	As of December 31,	
	2018	**2017**
Assets		
Current assets:		
Cash and cash equivalents	$ 27.9	$ 31.8
Short-term investments	—	2.1
Taxes receivable	—	16.4
Affiliate receivables and other current assets	3,273.7	1,050.3
Total current assets	3,301.6	1,100.6
Other asset	9.6	5.4
Investment in subsidiaries	3,089.5	2,509.6
Total Assets	$ 6,400.7	$ 3,615.6
Liabilities and Stockholders' Equity		
Current liabilities:		
Accrued expenses and other current liabilities	$ 34.3	$ 16.5
Total current liabilities	34.3	16.5
Long-term debt	2,126.4	1,182.4
Other liabilities	—	—
Total liabilities	2,160.7	1,198.9
Commitments and contingencies (see Note 13)	—	—
Stockholders' Equity:		
Preferred stock, $0.01 par value (20,000,000 authorized, no shares issued or outstanding)	—	—
Common stock, $0.01 par value (100,000,000 authorized, 49,993,219 and 44,522,988 shares issued and outstanding at December 31, 2018 and December 31, 2017, respectively)	0.5	0.4
Paid-in capital	1,981.1	591.5
Retained earnings	2,267.3	1,827.5
Accumulated other comprehensive loss	(8.9)	(2.7)
Total stockholders' equity	4,240.0	2,416.7
Total Liabilities and Stockholders' Equity	$ 6,400.7	$ 3,615.6

See notes to condensed financial statements.

CONDENSED FINANCIAL INFORMATION OF REGISTRANT
WELLCARE HEALTH PLANS, INC. (Parent Company Only)
STATEMENTS OF CASH FLOWS
(In millions)

	For the Years Ended December 31,		
	2018	**2017**	**2016**
Net cash (used in) provided by operating activities	$ (30.1)	$ (9.6)	$ 155.8
Cash used in investing activities:			
Net proceeds (payments) from purchases and sales and maturities of investments	(4.1)	(1.6)	1.2
Payments to subsidiaries, net	(2,223.9)	(99.7)	(53.7)
Net cash used in investing activities	(2,228.0)	(101.3)	(52.5)
Cash provided by financing activities:			
Proceeds from issuance of common stock, net of issuance fees paid	1,342.3	—	—
Proceeds from debt, net of financing costs paid	739.0	1,182.2	196.9
Borrowings on Revolving Credit Facility, net of financing costs paid	221.3	—	—
Payments on debt	(25.0)	(1,026.1)	(400.0)
Repurchase and retirement of shares to satisfy tax withholding requirements	(23.4)	(15.2)	(7.0)
Net cash provided by (used in) financing activities	2,254.2	140.9	(210.1)
Cash and cash equivalents:			
(Decrease) increase in cash and cash equivalents	(3.9)	30.0	(106.8)
Balance at beginning of period	31.8	1.8	108.6
Balance at end of period	$ 27.9	$ 31.8	$ 1.8

See notes to condensed financial statements.

CONDENSED FINANCIAL INFORMATION OF REGISTRANT
WELLCARE HEALTH PLANS, INC. (Parent Company Only)
NOTES TO CONDENSED FINANCIAL STATEMENTS

1. BASIS OF PRESENTATION

The financial statements reflect financial information for WellCare Health Plans, Inc.'s parent company, which has been derived from its consolidated financial statements and should be read in conjunction with the consolidated financial statements included in this 2018 Form 10-K.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

The accounting policies for the registrant are the same as those described in Note 2 - *Summary of Significant Accounting Policies* of Notes to the Consolidated Financial Statements included in Part IV, Item 15, “Exhibits, Financial Statement Schedules.”

3. LONG-TERM DEBT

Discussion of long-term debt, including the issuance of our 5.375% unsecured senior notes due 2026 in the aggregate principal amount of $750.0 million in August 2018, can be found in Note 10 - *Debt* of Notes to the Consolidated Financial Statements included in Part IV, Item 15, “Exhibits, Financial Statement Schedules.”

4. STOCKHOLDERS' EQUITY

Discussion of stockholders' equity, including the issuance of common shares in August 2018, can be found in Note 5 - *Equity and Earnings per Common Share* of Notes to the Consolidated Financial Statements included in Part IV, Item 15, “Exhibits, Financial Statement Schedules.”

5. COMMITMENTS AND CONTINGENCIES

For a summary of commitments and contingencies, see Note 13 - *Commitments and Contingencies* of Notes to the Consolidated Financial Statements included in Part IV, Item 15, “Exhibits, Financial Statement Schedules.”

Exhibit Index

Exhibit Number	Description	INCORPORATED BY REFERENCE		
		Form	Filing Date with SEC	Exhibit Number
2.1	Transaction Agreement dated May 28, 2018 by and among Caidan Management Company, LLC, MeridianRx, LLC, Caidan Holding Company, Caidan Enterprises, Inc. and The WellCare Management Group, Inc.	10-Q	July 31, 2018	2.1
3.1	Amended and Restated Certificate of Incorporation of the Registrant (conformed and restated for SEC filing purposes only)	10-K	February 12, 2016	3.1
3.2	Third Amended and Restated Bylaws of the Registrant	8-K	November 2, 2010	3.2
4.1	Specimen common stock certificate	10-Q	November 4, 2010	4.1
4.2	Base Indenture, dated March 22, 2017 between WellCare Health Plans, Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee	8-K	March 23, 2017	4.1
	a. First Supplemental Indenture, dated March 22, 2017 between WellCare Health Plans, Inc. and The Bank of New York Mellon Trust Company, N.A., as trustee (including the form of 5.25% Senior Note due 2025)	8-K	March 23, 2017	4.2

4.3	Indenture, dated August 13, 2018 between WellCare Health Plans, Inc. and the Bank of New York Mellon Trust Company, N.A. as trustee (including the form of 5.375% Senior Note due 2026)	8-K	August 14, 2018	4.1
MATERIAL AGREEMENTS RELATING TO COMPENSATION AND INDEMNIFICATION				
2013 Incentive Compensation Plan and Forms Adopted Thereunder				
10.1	**Registrant's 2013 Incentive Compensation Plan***	DEF 14A	April 10, 2013	A
10.2	**Forms of Agreement under Registrant's 2013 Incentive Compensation Plan**			
	a. Form of Performance Stock Unit Award Notice and Agreement*	8-K	May 22, 2013	10.1
	b. Form of Performance Stock Unit Award Agreement*	8-K	May 22, 2013	10.2
	c. Form of Performance Stock Unit Award Notice and Agreement (for grants dated September 2, 2014) *	8-K	September 4, 2014	10.1
	d. Form of Performance Stock Unit Award Notice and Agreement (adopted March 28, 2016) *	8-K	March 31, 2016	10.1
	e. Form of Performance Stock Unit Award Notice and Agreement (for grants dated September 29, 2016) *	10-Q	November 1, 2016	10.1
	f. Form of Market Stock Unit Award Notice and Agreement*	8-K	May 22, 2013	10.5
	g. Form of Market Stock Unit Award Agreement*	8-K	May 22, 2013	10.6
	h. Form of Restricted Stock Unit Award Notice and Agreement (employee version)*	8-K	May 22, 2013	10.9
	i. Form of Restricted Stock Unit Award Agreement (employee version)*	8-K	May 22, 2013	10.10
	j. Form of Restricted Stock Unit Award Notice and Agreement (adopted March 28, 2016)*	8-K	March 28, 2016	10.2
	k. Form of Stock Unit Award Agreement (adopted March 28, 2016)*	8-K	March 28, 2016	10.3
	l. Form of Restricted Stock Unit Award Notice and Agreement (director version)*	8-K	May 22, 2013	10.13
	m. Form of Restricted Stock Unit Award Agreement (director version)*	8-K	May 22, 2013	10.14
	n. Form of Restricted Stock Unit Award Notice and Agreement with deferral provisions (director version)*	8-K	May 22, 2013	10.15
	o. Form of Restricted Stock Unit Award Agreement with deferral provisions (director version)*	8-K	May 22, 2013	10.16
Other Compensation and Indemnification Plans and Forms of Agreement				
10.3	**WellCare Health Plans, Inc. Executive Severance Plan**			
	a. As amended and restated as of September 28, 2017*	8-K	October 2, 2017	10.1
	b. As amended and restated as of September 26, 2018*	10-Q	October 31, 2018	10.1
	c. As amended and restated as of December 22, 2018*†			

10.4	**Non-Employee Director Compensation Policy**			
	a. Non-Employee Director Compensation Policy (as amended and restated effective May 24, 2017)*	10-K	February 13, 2018	10.4.b
	b. Non-Employee Director Compensation Policy (as amended and restated effective February 23, 2018)*	10-Q	May 1, 2018	10.1
10.5	**Forms of Indemnification Agreement**			
	a. Adopted May 16, 2003*	S-1/A	June 8, 2004	10.24
	b. Adopted May 8, 2009*	8-K	May 14, 2009	10.1
	c. Adopted August 5, 2010*	10-Q	August 9, 2010	10.8
Agreements with Individual Officers and Directors				
10.6	Offer Letter, by and between Comprehensive Health Management, Inc. and Kenneth Burdick, dated January 7, 2014*	8-K	January 27, 2014	10.1
10.7	Offer Letter by and between Comprehensive Health Management, Inc. and Andrew Asher, dated August 12, 2014*	8-K	November 5, 2014	10.1
MATERIAL OPERATIONAL AGREEMENTS				
10.8	Credit Agreement, dated January 8, 2016, among WellCare Health Plans, Inc., the lenders party thereto, JPMorgan Chase Bank, N.A., as administrative agent, Bank of America, N.A., MUFG Union Bank, N.A., SunTrust Bank and Wells Fargo Bank, National Association, as co-syndication agents, Goldman Sachs Bank USA and U.S. Bank National Association as Co-Documentation Agents and J.P. Morgan Securities LLC, Merrill Lynch, Pierce, Fenner & Smith Incorporated, MUFG Union Bank, N.A., SunTrust Robinson Humphrey, Inc. and Wells Fargo Securities, LLC as joint bookrunners and joint lead arrangers	8-K	January 12, 2016	10.1
	a. Increasing Lender Supplement dated March 22, 2017 to the Credit Agreement dated January 8, 2016 among WellCare Health Plans, Inc. and the parties thereto	8-K	March 23, 2017	10.1
10.9	Amended and Restated Credit Agreement, dated as of July 23, 2018 by and among WellCare Health Plans, Inc., JPMorgan Chase Bank, N.A., as administrative agent, and the other lenders party thereto	8-K	July 24, 2018	10.1
21.1	List of subsidiaries †			
23.1	Consent of Deloitte & Touche LLP †			
31.1	Certification of Chief Executive Officer pursuant to Section 302 of Sarbanes-Oxley Act of 2002 †			
31.2	Certification of Chief Financial Officer pursuant to Section 302 of Sarbanes-Oxley Act of 2002 †			
32.1	Certification of Chief Executive Officer pursuant to Section 906 of Sarbanes-Oxley Act of 2002 †			
32.2	Certification of Chief Financial Officer pursuant to Section 906 of Sarbanes-Oxley Act of 2002 †			
101.INS	XBRL Instance Document ††			

101.SCH	XBRL Taxonomy Extension Schema Document ††
101.CAL	XBRL Taxonomy Calculation Linkbase Document ††
101.DEF	XBRL Taxonomy Definition Linkbase Document ††
101.LAB	XBRL Taxonomy Labels Linkbase Document ††
101.PRE	XBRL Taxonomy Presentation Linkbase Document ††

_____

* Denotes a management contract or compensatory plan, contract or arrangement

† Filed herewith

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

SIGNATURES

Pursuant to the requirements of 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.

WellCare Health Plans, Inc.

By: /s/ Kenneth A. Burdick

Kenneth A. Burdick

Chief Executive Officer

Date: February 12, 2019

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons in the capacities and on the dates indicated:

Signatures	Title	Date
/s/Kenneth A. Burdick **Kenneth A. Burdick**	Chief Executive Officer (Principal Executive Officer and Director)	February 12, 2019
/s/Andrew L. Asher **Andrew L. Asher**	Executive Vice President and Chief Financial Officer (Principal Financial Officer)	February 12, 2019
/s/Michael Troy Meyer **Michael Troy Meyer**	Vice President and Chief Accounting Officer	February 12, 2019
/s/Christian P. Michalik **Christian P. Michalik**	Chairman of the Board	February 12, 2019
/s/Richard C. Breon **Richard C. Breon**	Director	February 12, 2019
/s/Amy Compton-Phillips **Amy Compton-Phillips**	Director	February 12, 2019
/s/H. James Dallas **H. James Dallas**	Director	February 12, 2019
/s/Kevin F. Hickey **Kevin F. Hickey**	Director	February 12, 2019
/s/Piyush "Bobby" Jindal **Piyush "Bobby" Jindal**	Director	February 12, 2019
/s/Glenn D. Steele, Jr. **Glenn D. Steele, Jr.**	Director	February 12, 2019
/s/William L. Trubeck **William L. Trubeck**	Director	February 12, 2019
/s/Kathleen E. Walsh **Kathleen E. Walsh**	Director	February 12, 2019
/s/Paul E. Weaver **Paul E. Weaver**	Director	February 12, 2019

(Back To Top)

Section 2: EX-10.3C (AMENDED AND RESTATED EXECUTIVE SEVERANCE PLAN)

Exhibit 10.3.c.

AMENDED AND RESTATED WELLCARE HEALTH PLANS, INC.
EXECUTIVE SEVERANCE PLAN

1. Purpose of the Plan

The Board believes that it is in the best interests of the Company to encourage the continued employment and dedication of certain officers by providing economic security to such individuals in the event of certain terminations of employment, and the Plan has been established for this purpose. The Plan is intended to be a "welfare plan" under ERISA providing benefits to a select group of management or highly compensated employees as described in DOL Regulation section 2520.104-24. The Plan is separate from the WellCare Health Plans, Inc. Severance Plan, as amended from time to time. Capitalized terms used in the Plan are defined in Section 10, except as otherwise specified.

2. Effective Date

The Plan, as amended and restated effective December 13, 2018, shall be effective only with respect to a termination of employment covered by the Plan that occurs on or after December 13, 2018 (the "Effective Date").

3. Administration

(a) The Committee shall act as the plan administrator and the "named fiduciary" of the Plan for purposes of ERISA. Before a Change in Control, the Committee has sole and absolute discretion and authority to administer the Plan, including the sole and absolute discretion and authority to:

(i) adopt such rules as it deems advisable in connection with the administration of the Plan, and to construe, interpret, apply and enforce the Plan and any such rules and to remedy ambiguities, errors or omissions in the Plan;

(ii) determine questions of eligibility and entitlement to benefits and any other terms of the Plan applicable to the Participants; the Committee's determinations are conclusive and binding on all parties affected by its determinations;

(iii) act under the Plan on a case-by-case basis; the Committee's decisions under the Plan need not be uniform with respect to similarly situated Participants; and

(iv) delegate its authority under the Plan to any director, officer, employee, or group of directors, officers and/or employees of the Company.

(b) If any person with administrative authority becomes eligible or makes a claim for Plan benefits, that person will have no authority with respect to any matter specifically affecting his/her individual interest under the Plan, and the Committee will designate another person to exercise such authority.

(c) Notwithstanding anything in the Plan to the contrary, after a Change in Control, neither the Committee nor the Board nor any other person or entity shall have discretionary authority in the administration of the Plan, and any court or tribunal that adjudicates any dispute, controversy or claim in connection with any severance benefits under this Plan will apply a *de novo* standard of review to any determinations made by the Committee or Board following such Change in Control. Such *de novo* standard shall apply notwithstanding the grant of full discretion hereunder to the Committee, the Board, or any person or entity or characterization of any decision by the Committee, the Board, or by such person or entity as final, binding or conclusive on any party.

4. Participation

(a) *Eligibility.* Eligibility under the Plan is limited to Company employees designated by the Board as "executive officers" of WellCare within the meaning of Rule 3b-7 of the Exchange Act. If the Board revokes such designation, the employee will cease being eligible for benefits under the Plan and cease being a Participant on the one year anniversary of such revocation; provided, however, that an employee who is a Participant immediately prior to a Change in Control shall continue being eligible for benefits under the Plan following a Change in Control subject to Section 9(a). If a Participant is covered by any plan, program, policy or agreement with the Company that provides severance benefits upon termination of employment, then he or she will not be a Participant in this Plan. To become a Participant, the employee must also become a party to a restrictive covenants agreement in the form provided by the Company.

(b) *Tier Designation.* The Board or the Committee shall designate a Participant as a Tier I Participant, Tier II Participant or Tier III Participant for purposes of participation in the Plan and may change such Tier designation. If the Board or the Committee changes a Participant's Tier designation in a manner that reduces the Participant's Tier designation, that reduction shall not become effective until the first anniversary of the date on which the Board or the Committee approved such reduction; provided, however, if a Change in Control occurs prior to such first anniversary, such reduction shall not become effective.

5. Severance Benefits

(a) *Before a Change in Control*. If a Participant's employment with the Company is terminated after the Effective Date and before a Change in Control either (i) by the Company for reasons other than Cause, death, or Disability, or (ii) by the Participant for Good Reason, then the Participant shall receive: (x) payment of the Accrued Obligations, (y) the Cash Severance benefit described in this Section 5(a) based on the Participant's Tier as in effect on the date Participant's employment with the Company is terminated, and (z) Health Benefit Continuation described in this Section 5(a) based on the Participant's Tier as in effect on the date Participant's employment with the Company is terminated.

Tier as of Termination Date	Cash Severance	Health Benefit Continuation
Tier I Participant	1.5 x Base Salary *plus* 1.5 x Bonus	18 months
Tier II Participant	1 x Base Salary *plus* 1 x Bonus	12 months
Tier III Participant	1 x Base Salary *plus* 1 x Bonus	12 months

The Company shall pay the Base Salary portion of Participant's Cash Severance as determined in accordance with this Section 5(a) in installments in accordance with the Company's normal payroll schedule over 12 months beginning no later than the first regular payroll period following the expiration of any period during which a Participant may revoke the waiver and release of claims executed pursuant to Section 6(a), so long as that waiver and release is signed by the Participant and returned to the Company no later than 30 days after the Participant's termination of employment and the Participant does not revoke such waiver and release of claims. The Company shall pay the Bonus portion of Participant's Cash Severance as determined in accordance with this Section 5(a) on the first anniversary of the Participant's termination of employment, so long as the waiver and release has become effective and irrevocable as described above. If a Change in Control occurs while payments of the Cash Severance as determined in accordance with this Section 5(a) are being made, the payments will continue to be paid as scheduled.

(b) In Contemplation of a Change in Control. If a Participant's employment with the Company is terminated after the Effective Date and before a Change in Control by the Company for reasons other than Cause, death, or Disability, the Participant begins to receive severance in accordance with Section 5(a), a Change in Control occurs, and the Participant provides clear and convincing evidence to the Committee within 30 days after the Change in Control to support a claim that the Participant was terminated In Contemplation of a Change in Control, then within 70 days after the Change in Control, the Participant shall receive: (i) a single lump sum cash payment equal to the Cash Severance determined in accordance with Section 5(c) less the amount of Cash Severance already paid to the Participant under Section 5(a), and (ii) Health Benefit Continuation for the duration described in Section 5(c) based on the Participant's Tier less the months of Health Benefit Continuation already provided under Section 5(a).

(c) After a Change in Control. If a Participant's employment with the Company is terminated within 24 months after a Change in Control either (i) by the Company for reasons other than Cause, death, or Disability, or (ii) by the Participant for Good Reason, then the Participant shall receive: (x) payment of the Accrued Obligations, (y) the Cash Severance benefit described in this Section 5(c) based on the Participant's Tier as in effect on the date of the Change in Control, and (z) Health Benefit Continuation described in this Section 5(c) based on the Participant's Tier as in effect on the date of the Change in Control.

Tier as of Termination Date	Cash Severance	Health Benefit Continuation
Tier I Participant	3 x Base Salary *plus* 3 x Bonus *plus* 1x Prorated Bonus	36 months
Tier II Participant	2 x Base Salary *plus* 2 x Bonus *plus* 1x Prorated Bonus	24 months
Tier III Participant	1.5 x Base Salary *plus* 1.5 x Bonus *plus* 1x Prorated Bonus	18 months

The Company shall pay the Participant's Cash Severance as determined in accordance with this Section 5(c) in a single lump sum cash payment no later than the first regular payroll period following the expiration of any period during which a Participant may revoke the waiver and release of claims executed pursuant to Section 6(a), so long as that waiver and release is signed

by the Participant and returned to the Company no later than 30 days after the Participant's termination of employment and the Participant does not revoke such waiver and release of claims.

(d) *Form of Severance under Existing Agreement*. Participants who are covered by an existing employment or severance agreement with the Company agree that their existing rights under that agreement are terminated and replaced with the provisions of this Plan; provided, however, that for the duration of the original remaining term of the employment or severance agreement only, the timing and form of severance (i.e., lump sum or installments) in the employment or severance agreement shall supersede the timing and form of payment provisions in this Section 5 and control the timing and form of payment of the Cash Severance.

(e) *Employment with Successor*. Notwithstanding anything to the contrary under the Plan, no severance benefits shall be paid to a Participant who is offered comparable employment by an entity that purchases a unit or asset of the Company or, following a Change in Control, by a successor to the Company. "Comparable employment" is determined based on the facts and circumstances in each case, but means employment with duties, responsibilities, Base Salary, annual short-term incentive opportunity, annual long-term incentive opportunity and location that are substantially similar in the aggregate to the Participant's prior employment with the Company. A Participant who accepts comparable employment with a successor to the Company following a Change in Control remains entitled to receive severance benefits if the Participant's employment is terminated as specified under Section 5(c).

(f) *Release of Claims and Restrictive Covenants*. Payment of Cash Severance and Health Benefit Continuation is subject to and contingent on the Participant's satisfaction of the requirements of Section 6(a) (regarding waiver and release of claims) and Section 6(b) (regarding restrictive covenants). If the period during which a Participant has discretion to execute or revoke the waiver and release of claims straddles two taxable years of the Participant, then the Company shall begin making the payment of Cash Severance in the second of such taxable years, regardless of which taxable year the Participant actually delivers the executed waiver and release to the Company.

(g) *Code Section 280G Cutback*. A Participant shall bear all expense of, and be solely responsible for, all federal, state, local or foreign taxes due with respect to any payment received under the Plan, including, without limitation, any excise tax imposed by Code section 4999. Notwithstanding anything to the contrary in the Plan, in the event that any payment or benefit received or to be received by a Participant pursuant to the terms of the Plan (the "Plan Payments") or in connection with the Participant's termination of employment or contingent upon a Change in Control pursuant to any plan or arrangement or other agreement with the Company (together with the Plan Payments, the "Payments") would be subject to the excise tax imposed by Code section 4999, as determined by the Committee, then the Plan Payments shall be reduced to the extent necessary to prevent any portion of the Payments from becoming nondeductible by the Participant's employer under Code section 280G or subject to the excise tax imposed under Code section 4999, but only if, by reason of that reduction, the net after-tax benefit received by the Participant exceeds the net after-tax benefit the Participant would receive if no reduction was made. For this purpose, "net after-tax benefit" means (i) the total of all Payments that would constitute "excess parachute payments" within the meaning of Code section 280G, less (ii) the amount of all federal, state, and local income taxes payable with respect to the Payments calculated at the maximum marginal income tax rate for each year in which the Payments shall be paid to the Participant (based on the rate in effect for that year as set forth in the Code as in effect at the time

of the first payment of the Payments), less (iii) the amount of excise taxes imposed on the Payments described in clause (i) above by Code section 4999. If, pursuant to this Section, Payments are to be reduced, Payments will be reduced in this order: (1) Cash Severance, (2) Health Benefit Continuation, and (3) equity acceleration (to the extent applicable).

6. Other Terms and Conditions of Eligibility

(a) *Waiver and Release of Claims*. As a condition to receiving severance benefits under the Plan, each Participant shall be required to sign and deliver to the Company, and may not revoke or violate the terms of, a general release of all claims against the Company, and the directors, officers, and employees of each of them, in the form attached as Exhibit A or such other form reasonably satisfactory to the Committee. In no case will payments be made or begin before the end of any revocation period required by applicable law or regulation in connection with any release or waiver that the Participant is asked to sign.

(b) *Restrictive Covenants*. Any severance benefits specified under the Plan are provided, if at all, as consideration for, and are contingent upon, the Participant agreeing to, and abiding by, the restrictive covenants in the Participant's restrictive covenants agreement with the Company.

(c) *At-Will Employment*. Each Participant is employed by the Company on an "at will" basis and nothing in this Plan shall give any Participant any right to continue in the employ of the Company. A Participant shall have no rights under the Plan if the Participant's employment is terminated by the Company, or any successor, with Cause or by the Participant without Good Reason, or due to the Participant's death or Disability.

(d) *Nonduplication; No Impact on Benefits*.

(i) Payments to a Participant under the Plan shall be in lieu of any severance or similar payments that otherwise might be payable under any Company plan, program, policy or agreement with the Company that provides severance benefits upon termination of employment.

(ii) Benefits payable under the Plan, whether paid in a lump sum or in periodic payments, will not increase or decrease the benefits otherwise available to a Participant under any company-sponsored retirement plan, welfare plan or any other employee benefit plan or program, unless otherwise expressly provided for in any particular plan or program.

(iii) Any severance benefits specified under the Plan shall be reduced by the amount of any payment required by the Company to the Participant (A) because of insufficient advance notice of employment loss as may be required by law; or (B) under applicable law because of the termination of employment.

7. Benefit Claims

(a) *Initial Claim*. Any claims concerning eligibility, participation, benefits or other aspects of the Plan must be submitted in writing and directed to the Committee, within 30 days after the communication of the determination that is the basis of the claim. Within 30 days after receiving

a claim, the Committee will (i) either accept or deny the claim completely or partially and (ii) notify the Participant of acceptance or denial of the claim. If a claim is partially or wholly denied, the Committee will provide a written denial to the Participant no later than 30 days after receipt of the initial claim request. The written denial shall include specific reasons for the denial, specific references to the Plan provisions upon which the denial was based, a description of any additional material or information necessary for the Participant to perfect the claim, an explanation of why such material is necessary, and instructions on the Plan's claim review procedure. If the Committee requires additional time to process a claim because of special circumstances, the Committee, in its sole discretion, may extend the period 30 additional days. The Committee must notify the Participant of any such extension prior to the expiration of the 30-day period commencing from the date the Committee first received written submission of the claim.

(b) *Appeals*. The Participant may request in writing to the Board a review of a denied claim within 30 days after receipt of such denial. Such written request must contain an explanation as to why the Participant is seeking a review. For purposes of the review, the Participant has the right to: (i) submit written comments, documents, records and other information relating to the claim for benefits; (ii) request, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits; and (iii) a review that takes into account all comments, documents, records, and other information the Participant submitted relating to the claim, regardless of whether the information was submitted or considered in the initial decision. A decision on such review will be rendered in writing within 30 days of the Board's receipt of a request for review, unless special circumstances require an extension of time for processing, in which case a decision will be rendered as soon as possible but no later than 60 days after receipt of the request for review provided that written notice is provided to the Participant or the Participant's authorized representative before the extension commences. A written notice affirming the denial of a claim will set forth the specific reasons for the decision and make specific reference to Plan provisions upon which the decision or appeal is based. In preparation for filing such a request for review, the Participant or the Participant's authorized representative may review pertinent plan documents, and as part of the written request for review, may submit issues and comments concerning the claim. No claim may be brought before or submitted to a court of law or other governmental entity unless and until the claims process under this Section 7 has been exhausted.

8. Recoupment

(a) *Right of Recoupment*. If, at any time, the Board or the Committee, as the case may be, in its sole discretion determines that any action or omission by the Participant constituted (i) wrongdoing that contributed to (A) any material misstatement in or omission from any report or statement filed by the Company with the U.S. Securities and Exchange Commission or (B) a statement, certification, cost report, claim for payment or other filing made under Medicare or Medicaid that was false, fraudulent or for an item or service not provided as claimed; (ii) intentional or gross misconduct; (iii) a breach of a fiduciary duty to the Company; (iv) fraud; (v) a violation of the restrictive covenants; or (vi) non-compliance with the Company's Code of Conduct and Business Ethics ("Code of Conduct"), policies or procedures to the material detriment of the Company, then in each such case, the Participant's participation in the Plan shall be immediately terminated and the Participant shall repay to the Company, upon notice to the Participant by the Company, up to 100% of the pre-tax amount paid to the Participant pursuant to this Plan. The Board or the Committee, as the case may be, shall determine in its sole discretion the date of occurrence of such action or omission and the percentage of the pre-tax amount received pursuant to this Plan that must be repaid to the Company.

(b) *Method of Recoupment*. To the extent permitted by applicable law, the Company may enforce the recoupment of any or all amounts due under this Section 8 by withholding future payment of any severance benefits, seeking reimbursement of previously paid severance benefits, demanding direct cash payment, reducing any amount of compensation owed by the Company to the Participant, and/or such other means determined by the Board or Committee.

(c) *Nonexclusive Remedy*. The Company's right of recoupment under this Section 8 is in addition to any remedy available to the Company with respect to any Participant, including, but not limited to, the initiation of civil or criminal proceedings and any right to repayment under the Sarbanes-Oxley Act of 2002, Dodd-Frank Wall Street Reform and Consumer Protection Act, and any other applicable law.

9. General

(a) *Amendment and Termination of the Plan*. The Board or the Committee may amend or terminate the Plan in any respect; provided, however, if such amendment or termination (including any change to the severance benefits) shall be detrimental to a Participant, such amendment or termination shall be effective only with one year notice to such Participant; provided, further, that (i) any amendment or termination will not be effective if there is a Change in Control during the one year notice period, and (ii) the Plan cannot be amended or terminated during the 24 month period after a Change in Control. A Participant ceasing to be eligible for a benefit under the Plan or a reduction in Tier designation before a Change in Control, as described in Section 4, is not an amendment or termination of the Plan.

(b) *Funding*. Benefits payable under the Plan will be paid only from the general assets of the Company. The Plan does not create any right to, or interest in, any specific assets of the Company.

(c) *No Mitigation*. The Participant shall not be obligated to seek other employment in mitigation of the amounts payable under any provision of the Plan, and the obtaining of such other employment shall not effect any reduction of the Company's obligations to pay the severance benefits provided under the Plan (unless in violation of the restrictive covenants specified under Section 6(b)).

(d) *Withholding*. The Company may withhold from any payments made under the Plan all federal, state, local or other taxes required pursuant to any law or governmental regulation or ruling.

(e) *Right to Offset*. To the extent permitted by law, the Company may offset against any obligation to pay any portion of the severance benefit under the Plan any outstanding amount of whatever nature that the Participant then owes to the Company in the capacity as an employee. However, no amount of "deferred compensation" (as defined under Treasury Regulation section 1.409A-1(b)(1), after giving effect to the exemptions in Treasury Regulation sections 1.409A-1 (b)(3) through (b)(12)) that is payable to a Participant under the Plan may be used to offset any amount that the Participant then owes to the Company.

(f) *Successors*. All rights under the Plan are personal to the Participant and without the prior written consent of the Committee shall not be assignable by the Participant. The Plan shall inure to the benefit of and be enforceable by the Participant's legal representative. The Plan shall inure to the benefit of, and be binding upon, the Company and its successors and assigns. Any successor (whether direct or indirect, by purchase, merger, consolidation or otherwise) to all or substantially all of the business and/or assets of WellCare shall be required to assume expressly and agree to perform the obligations set forth in the Plan in the same manner and to the same extent as the Company would be required to do so.

(g) *Governing Law*. The Plan and all determinations made and actions taken pursuant to the Plan shall be governed by the substantive laws, but not the choice of law rules, of the State of Florida or by United States federal law.

(h) *Dispute Resolution*. Any proceeding relating to this Plan or any Participant's benefits hereunder, or for the recognition and enforcement of any judgment in respect thereof (a "Proceeding"), is subject to the exclusive jurisdiction of the courts of the State of Florida, the court of the United States of America for the District of Florida, and appellate courts having jurisdiction of appeals from any of the foregoing, and agrees that all claims in respect of any such Proceeding shall be heard and determined in such Florida State court or, to the extent permitted by law, in such federal court. By participating in this Plan, each Participant hereby (a) consents that any such Proceeding may and shall be brought in such courts and waives any objection that the Participant or the Company may now or thereafter have to the venue or jurisdiction of any such Proceeding in any such court or that such Proceeding was brought in an inconvenient court and agrees not to plead or claim the same, (b) waives all right to trial by jury in any Proceeding (whether based on contract, tort or otherwise) arising out of or relating to this Plan or the Participant's employment by the Company or any affiliate of the Company, or the Participant's or the Company's performance under, or the enforcement of, this Plan, (c) agrees that service of process in any such Proceeding may be effected by mailing a copy of such process by registered or certified mail (or any substantially similar form of mail), postage prepaid, to such party at the Participant's or the Company's address on record with the Company and (d) agrees that nothing in this Plan shall affect the right to effect service of process in any other manner permitted by the laws of the State of Florida. In addition to all other amounts payable under the Plan, the Company will pay all legal fees and expenses incurred by the Participant in connection with any dispute arising out of or relating to the Plan following or in contemplation of a Change in Control or the interpretation thereof (including, without limitation, all such fees and expenses, if any, incurred in seeking to obtain or enforce any right or benefit provided by the Plan), provided that, the Participant prevails on any material issue raised in any such Proceeding.

(i) *Severability*. If any provision of the Plan is declared illegal, invalid or otherwise unenforceable by a court of competent jurisdiction, the provision shall be reformed, if possible, to the extent necessary to render it legal, valid and enforceable, or otherwise deleted, and the remainder of the terms of the Plan shall not be affected except to the extent necessary to reform or delete such illegal, invalid or unenforceable provision.

(j) *Notices*. Notices and all other communications provided for under the Plan shall be in writing and shall be deemed to have been duly given when personally delivered or when mailed by United States certified mail, return receipt requested, or by overnight courier, postage prepaid, to the Company's corporate headquarters address, to the attention of the Committee, or

to the Participant at the home address most recently communicated by the Participant to the Company in writing.

(k) *409A Compliance*.

(i) The Plan is intended to comply with, or otherwise be exempt from, Code section 409A. The preceding provision, however, shall not be construed as a guarantee by the Company of any particular tax effect to a Participant under the Plan. The Company shall not be liable to a Participant for any payment made under the Plan, at the direction or with the consent of the Participant, which is determined to result in an additional tax, penalty or interest under Code section 409A, nor for reporting in good faith any payment made under the Plan as an amount includible in gross income under Code section 409A.

(ii) "Termination of employment," or words of similar import, as used in this Plan means, for purposes of any payments under this Plan that are payments of deferred compensation subject to Code section 409A, the Participant's "separation from service" as defined in Code section 409A. For purposes of Code section 409A, the right to a series of installment payments under this Plan shall be treated as a right to a series of separate payments.

(iii) With respect to any reimbursement of expenses of, or any provision of in-kind benefits to, a Participant, as specified under this Plan: (A) the expenses eligible for reimbursement or the amount of in-kind benefits provided in one taxable year shall not affect the expenses eligible for reimbursement or the amount of in-kind benefits provided in any other taxable year, except for any medical reimbursement arrangement providing for the reimbursement of expenses referred to in Code section 105(b); (B) the reimbursement of an eligible expense shall be made no later than the end of the year after the year in which such expense was incurred; and (C) the right to reimbursement or in-kind benefits shall not be subject to liquidation or exchange for another benefit.

(iv) If a payment obligation under the Plan arises on account of a Participant's termination of employment while a "specified employee" (as defined under Code section 409A and the regulations thereunder and determined in good faith by the Committee), any payment of "deferred compensation" (as defined under Treasury Regulation section 1.409A-1(b)(1), after giving effect to the exemptions in Treasury Regulation sections 1.409A-1(b)(3) through (b)(12)) shall be made within 15 days after the end of the six-month period beginning on the date of such termination of employment or, if earlier, within 15 days after appointment of the personal representative or executor of the Participant's estate following the death of the Participant.

10. Definitions

The following definitions apply to the Plan:

"Accrued Obligations" means (i) the Participant's Base Salary through the date of termination of employment, (ii) any accrued but unused paid time off and floating holiday pay, and (iii) unreimbursed business expenses. The Company will pay the Accrued Obligations to the

Participant in a single lump sum cash payment within 10 days after the Participant's termination of employment with the Company.

"Affiliate" means Comprehensive Health Management, Inc. and any other entity, whether now or hereafter existing, which controls, is controlled by, or is under common control with, WellCare (including, but not limited to, joint ventures, limited liability companies, and partnerships).

"Base Salary" means the annual rate of base salary in effect as of the date of termination of employment, determined without regard to any reduction thereof that constitutes Good Reason.

"Board" means the Board of Directors of WellCare.

"Bonus" means, (i) with respect to any Participant who has been employed by the Company for a period of time in which he or she participated in the two (2) most recently completed annual short-term incentive bonus cycles that ended before his or her date of termination of employment, the average of the two (2) annual short-term incentive bonuses, if any, paid by the Company to the Participant with respect to those annual short-term incentive bonus cycles, provided that, if the first annual short-term incentive bonus included in the calculation was pro-rated to reflect the portion of the performance period in which the Participant was employed with the Company, then the amount of that first annual short-term incentive bonus shall be annualized solely for the calculation of the Bonus hereunder (such amount, the "Average Bonus"), or (ii) with respect to any Participant who has not been employed by the Company for a period of time in which he or she participated in the two (2) most recently completed annual short-term incentive bonus cycles that ended before his or her date of termination, the Participant's annual short-term incentive bonus target amount in effect on the Participant's date of termination of employment.

"Cash Severance" means the sum of Base Salary, Bonus and, as applicable, Prorated Bonus as described in Section 5.

"Cause" means the occurrence of any one or more of the following events or conditions:

(i) any willful act or willful omission, other than as a result of the Participant's Disability, that constitutes a breach of any agreement to which the Company is a party or the Participant's non-compliance with the Company's Code of Conduct, policies or procedures to the material detriment of the Company;

(ii) bad faith by the Participant in the performance of his duties, consisting of willful acts or willful omissions, other than as a result of the Participant's Disability, to the material detriment of the Company;

(iii) the Participant's repeated failure to follow the reasonable and lawful directions of the Board (or committee of the Board) or Chief Executive Officer which is not cured within fifteen (15) days after written notice to the Participant; or

(iv) the Participant's commission of a crime that constitutes a felony involving fraud, conversion, misappropriation, or embezzlement under the laws of the United States or any political subdivision thereof.

It shall be a condition precedent to the Company's right to terminate the Participant's employment for Cause as defined in (i) or (ii) that (x) the Company shall have first given the Participant written notice stating with reasonable specificity the breach on which such termination is premised within ninety (90) days after the Company becomes aware of such breach, and (y) if such breach is susceptible of cure or remedy, such breach has not been cured or remedied within fifteen (15) days after the Participant's receipt of such notice.

"Change in Control" means the effective date of the occurrence of any of the following events:

(i) any Person or Group is or becomes the Beneficial Owner, directly or indirectly, of securities of WellCare representing more than 50% of either (A) the then fair market value of the then outstanding securities of WellCare or (B) the combined voting power of the then outstanding securities of WellCare;

(ii) the direct or indirect sale or transfer by WellCare of all or substantially all of its assets in a single transaction or a series of related transactions;

(iii) the merger, consolidation or reorganization of WellCare with or into another corporation or other entity, in which the shareholders of more than 50% of the voting power of WellCare's voting securities immediately before such merger, consolidation or reorganization do not own more than 50% of the voting power of the voting securities of the surviving corporation or other entity immediately after such merger, consolidation or reorganization; or

(iv) during any consecutive 12-month period, individuals who at the beginning of such period constitute the Board (together with any new directors whose election by the Board or nomination for election by the stockholders of WellCare was approved by a vote of a majority of the directors on the Board then still in office who were either directors at the beginning of such period or whose election or nomination for election was previously so approved) cease for any reason to constitute a majority of the members of the Board then in office.

Notwithstanding the terms of this Section, none of the foregoing events shall constitute a Change in Control if such event is not a "Change in Control Event" under Treasury regulation section 1.409A-3(i)(5) or successor guidance of the Internal Revenue Service.

For purposes of determining whether a Change in Control has occurred, a Person or Group shall not be deemed to be "unrelated" if: (A) such Person or Group directly or indirectly has Beneficial Ownership of more than 50% of the issued and outstanding voting power of WellCare's voting securities immediately before the transaction in question, (B) WellCare has Beneficial Ownership of more than 50% of the voting power of the issued and outstanding voting securities of such Person or Group, or (C) more than 50% of the voting power of the issued and outstanding voting securities of such Person or Group are owned, directly or indirectly, by Beneficial Owners of more than 50% of the issued and outstanding voting power of WellCare voting securities immediately before the transaction in question.

The terms "Person," "Group," "Beneficial Owner," and "Beneficial Ownership" shall have the meanings used in the Exchange Act. Notwithstanding the foregoing, (A) Persons will not be considered to be acting as a "Group" solely because they purchase or own stock of WellCare at the same time, or as a result of purchases in the same public offering, (B) Persons will be considered to be acting as a "Group" if they are owners of a corporation that enters into a merger, consolidation, reorganization, purchase or acquisition of stock, or similar business transaction, with WellCare, and (C) if a Person, including an entity, owns stock both in WellCare and in a corporation that enters into a merger, consolidation, reorganization, purchase or acquisition of stock, or similar transaction, with WellCare, such Person shall be considered to be acting as a Group with other shareholders only with respect to the ownership in such corporation prior to the transaction.

"Code" means the Internal Revenue Code of 1986, as amended, and the regulations and Treasury guidance promulgated under it.

"Committee" means the Compensation Committee of the Board. The Committee may delegate some or all of its authority under the Plan to any person, persons or subcommittee, in which event, the term "Committee" includes such person, persons or subcommittee to the extent of such delegation.

"Company" means WellCare and any Affiliate.

"Disability" means the Participant is unable to engage in any substantial gainful business activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or that has rendered the Participant unable effectively to carry out his/her duties and obligations to the Company or unable to participate effectively and actively in the management of the Company for a period of 90 consecutive days or for shorter periods aggregating to 120 days (whether or not consecutive) during any consecutive 12 months.

"Effective Date" has the meaning specified in Section 2.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended, and the regulations and guidance promulgated under it.

"Exchange Act" means the Securities Exchange Act of 1934, as amended, and the rules and guidance promulgated under it.

"Good Reason" means, without the Participant's consent:

(i) the occurrence of either of the following conditions which occurs prior to a Change in Control: (A) a material diminution in the Participant's Base Salary, annual short-term incentive opportunity or annual long-term incentive opportunity, except as applicable generally to other similarly situated senior executives of the Company; or (B) the Company requiring the Participant to be based at any office or location outside of fifty miles from the Participant's current employment location, except for travel reasonably required in the performance of the Participant's responsibilities; or

(ii) the occurrence of any of the following conditions which occurs following a Change in Control: (A) any diminution in the Participant's Base Salary, annual short-term

incentive opportunity or annual long-term incentive opportunity; (B) the Company requiring the Participant to be based at any office or location outside of fifty miles from the Participant's current employment location, except for travel reasonably required in the performance of the Participant's responsibilities; (C) a material diminution in the Participant's authority, duties or responsibilities, which, for the Chief Executive Officer, Chief Financial Officer and/or General Counsel, will be deemed to occur (without limitation) if such Participant's duties and responsibilities are in respect of an entity that is not the most senior entity following the Change in Control.

It shall be a condition precedent to the Participant's right to terminate Participant's employment for Good Reason (before or after a Change in Control) that (A) the Participant shall have first given the Company written notice stating with reasonable specificity the breach on which such termination is premised within ninety (90) days after the Participant becomes aware or should have become aware of such breach, and (B) if such breach is susceptible of cure or remedy, such breach has not been cured or remedied within forty-five (45) days after receipt of such notice.

"Health Benefit Continuation" means subsidy by the Company of the portion of the Participant's COBRA premium that exceeds the amount of the premium paid by active employees for the same coverage for the period following the Participant's termination of employment with the Company designated in Section 5. The Company will include the subsidy in the Participant's taxable income and no gross-up will be provided.

"In Contemplation of a Change in Control" means the termination of the Participant's employment by the Company for reasons other than Cause, death, or Disability within the 6 months prior to a Change in Control if the Participant demonstrates by clear and convincing evidence that the termination (i) was at the request of a third party who had taken steps reasonably calculated or intended to effect a Change in Control, or (ii) otherwise arose in contemplation or in anticipation of a Change in Control.

"Participant" means a person who has become a participant pursuant to Section 4 of the Plan.

"Plan" means this WellCare Health Plans, Inc. Executive Severance Plan.

"Prorated Bonus" means an amount equal to (A) the Average Bonus multiplied by (B) a fraction, the numerator of which is the number of days in the performance period that have elapsed through the date of termination of employment and the denominator of which is the number of days in such year.

"WellCare" means WellCare Health Plans, Inc., a Delaware corporation.

Amended and Restated by the Compensation Committee: *December 13, 2018*

(Back To Top)

Section 3: EX-21.1 (LIST OF SUBSIDIARIES)

Exhibit 21.1

LIST OF SUBSIDIARIES OF WELLCARE HEALTH PLANS, INC.
As of February 11, 2019

Entity Name	Jurisdiction of Organization
Accountable Care Coalition of Arizona, LLC	Arizona
Accountable Care Coalition of Central Georgia, LLC	Georgia
Accountable Care Coalition of Chesapeake, LLC	Maryland
Accountable Care Coalition of Coastal Georgia, LLC	Georgia
Accountable Care Coalition of Community Health Centers II, LLC	Texas

Accountable Care Coalition of Community Health Centers, LLC	Texas
Accountable Care Coalition of DeKalb, LLC	Georgia
Accountable Care Coalition of Georgia, LLC	Georgia
Accountable Care Coalition of Hawaii LLC	Hawaii
Accountable Care Coalition of Maryland Primary Care, LLC	Maryland
Accountable Care Coalition of Maryland, LLC	Maryland
Accountable Care Coalition of Mississippi, LLC	Mississippi
Accountable Care Coalition of Mount Kisco, LLC	New York
Accountable Care Coalition of New Jersey LLC	New Jersey
Accountable Care Coalition of North Texas, LLC	Texas
Accountable Care Coalition of Northeast Georgia, LLC	Georgia
Accountable Care Coalition of Northeast Partners, LLC	Pennsylvania
Accountable Care Coalition of Northwest Florida, LLC	Florida
Accountable Care Coalition of South Carolina, LLC	South Carolina
Accountable Care Coalition of Southeast Partners, LLC	Georgia
Accountable Care Coalition of Southeast Texas, Inc.	Texas
Accountable Care Coalition of Southeast Wisconsin, LLC	Wisconsin
Accountable Care Coalition of Syracuse, LLC	New York
Accountable Care Coalition of Tennessee, LLC	Tennessee
Accountable Care Coalition of Texas, Inc.	Texas
Accountable Care Coalition of the North West Region, LLC	Oregon
Accountable Care Coalition of the Northwest Region II, LLC	Oregon
Accountable Care Coalition of the Tri-Counties, LLC	South Carolina
Accountable Care Coalition of Western Georgia, LLC	Georgia
American Progressive Life and Health Insurance Company of New York	New York
America's 1st Choice California Holdings, LLC	Florida
APS Healthcare Holdings, Inc.	Delaware
APS Healthcare, Inc.	Delaware
APS Parent, Inc.	Delaware
AWC of Syracuse, Inc.	New York

Entity Name	Jurisdiction of Organization
Caidan Holding Company	Michigan
Caidan Management Company, LLC	Michigan
Caidan Network Services, LLC	Michigan
Care 1st Health Plan Arizona, Inc.	Arizona
Care1st Health Plan Administrative Services, Inc.	Arizona
Chrysalis Medical Services, LLC	New Jersey
Collaborative Health Systems of Maryland, LLC	Maryland
Collaborative Health Systems of Virginia, LLC	Virginia
Collaborative Health Systems, LLC	New York
Comprehensive Health Management, Inc. (also does business as Comprehensive Health Management Inc. of Florida, Comprehensive Health Management of Florida, Inc., Florida Comprehensive Health Management, Inc., Comprehensive Health Management of Pennsylvania, Inc., and WellCare Innovation Institute)	Florida
Comprehensive Reinsurance, Ltd.	Cayman Islands
Easy Choice Health Plan, Inc.	California
Essential Care Partners, LLC	Texas
Exactus Pharmacy Solutions, Inc. (f/k/a WellCare Specialty Pharmacy, Inc.)	Delaware
Harmony Behavioral Health IPA, Inc.	New York
Harmony Behavioral Health, Inc.	Florida
Harmony Health Management, Inc.	New Jersey
Harmony Health Plan, Inc. (f/k/a Harmony Health Plan of Illinois, Inc.)	Illinois
Harmony Health Systems, Inc.	New Jersey
Heritage Health Systems of Texas, Inc.	Texas
Heritage Health Systems, Inc.	Texas
HHS Texas Management, Inc.	Georgia
HHS Texas Management, L.P.	Georgia
Hudson Accountable Care, LLC	New York
Maine Community Accountable Care Organization, LLC	Maine
Maine Primary Care Holdings, LLC	Maine
Maryland Collaborative Care Transformation Organization, Inc.	Delaware
Maryland Collaborative Care, LLC	Maryland
Meridian Health Plan of Illinois, Inc.	Illinois
Meridian Health Plan of Michigan, Inc.	Michigan
MeridianRx IPA, LLC	New York
MeridianRx, LLC	Michigan
Mid-Atlantic Collaborative Care, LLC	Maryland
Missouri Care, Incorporated (also does business as Missouri Care and Missouri Care Health Plan)	Missouri
Northern Maryland Collaborative Care, LLC	Maryland
Ohana Health Plan, Inc.	Hawaii
One Care by Care1st Health Plan of Arizona, Inc.	Arizona

Entity Name	Jurisdiction of Organization
Penn Marketing America, LLC	Delaware
Premier Marketing Group, LLC	Delaware
Quincy Coverage Corporation	New York
SelectCare Health Plans, Inc.	Texas
SelectCare of Texas, Inc.	Texas
The WellCare Management Group, Inc.	New York
UAM Agent Services Corp.	Iowa
UAM/APS Holding Corp.	Delaware
Universal American Corp.	Delaware
Universal American Financial Services, Inc.	Delaware
Universal American Holdings, LLC	Delaware
Virginia Collaborative Care, LLC	Virginia
WCG Health Management, Inc.	Delaware
WellCare Associate Assistance Fund, Inc.	Florida
WellCare Health Insurance Company of America	Arkansas
WellCare Health Insurance Company of Kentucky, Inc. (f/k/a WellCare Health Insurance of Illinois, Inc.; also does business as WellCare of Kentucky, Inc.)	Kentucky
WellCare Health Insurance Company of Louisiana, Inc.	Louisiana
WellCare Health Insurance Company of New Hampshire, Inc.	New Hampshire
WellCare Health Insurance Company of Washington, Inc.	Washington
WellCare Health Insurance Company of Wisconsin, Inc.	Wisconsin
WellCare Health Insurance of Arizona, Inc. (also does business as ‘Ohana Health Plan, Inc.)	Arizona
WellCare Health Insurance of Connecticut, Inc.	Connecticut
WellCare Health Insurance of New York, Inc.	New York
WellCare Health Insurance of North Carolina, Inc.	North Carolina
WellCare Health Insurance of Tennessee, Inc.	Tennessee
WellCare Health Plans New Jersey Voluntary Employee PAC Inc.	New Jersey
WellCare Health Plans of Arizona, Inc.	Arizona
WellCare Health Plans of California, Inc.	California
WellCare Health Plans of Kentucky, Inc.	Kentucky
WellCare Health Plans of New Jersey, Inc.	New Jersey
WellCare Health Plans of Tennessee, Inc.	Tennessee
WellCare Health Plans of Vermont, Inc.	Vermont
WellCare Health Plans of Wisconsin, Inc.	Wisconsin
WellCare Health Plans, Inc.	Delaware
WellCare National Health Insurance Company	Texas
WellCare of Alabama, Inc.	Alabama
WellCare of Arkansas, Inc.	Arkansas
WellCare of Connecticut, Inc.	Connecticut

Entity Name	Jurisdiction of Organization
WellCare of Florida, Inc. (also does business as Staywell Health Plan of Florida and HealthEase)	Florida
WellCare of Georgia, Inc.	Georgia
WellCare of Indiana, Inc.	Indiana
WellCare of Kansas, Inc.	Kansas
WellCare of Maine, Inc.	Maine
WellCare of Mississippi, Inc.	Mississippi
WellCare of Missouri Health Insurance Company, Inc.	Missouri
WellCare of Nebraska, Inc.	Nebraska
WellCare of New Hampshire, Inc.	New Hampshire
WellCare of New York, Inc.	New York
WellCare of North Carolina, Inc.	North Carolina
WellCare of Ohio, Inc.	Ohio
WellCare of Oklahoma, Inc.	Oklahoma
WellCare of Pennsylvania, Inc.	Pennsylvania
WellCare of Puerto Rico, Inc.	Puerto Rico
WellCare of South Carolina, Inc.	South Carolina
WellCare of Texas, Inc. (also does business as WellCare of Arizona)	Texas
WellCare of Virginia, Inc.	Virginia
WellCare of Washington, Inc.	Washington
WellCare Pharmacy Benefits Management, Inc.	Delaware
WellCare Prescription Insurance, Inc.	Florida
Windsor Health Group, Inc.	Tennessee
Worlco Management Services, Inc.	New York

Other affiliates:

The WellCare Community Foundation, a Delaware not-for-profit corporation
Golden Triangle Physician Alliance, a Texas not-for-profit corporation
Heritage Physician Networks, a Texas not-for-profit corporation

(Back To Top)

Section 4: EX-23.1 (CONSENT OF DELOITTE & TOUCHE LLP)

Exhibit 23.1

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We consent to the incorporation by reference in Registration Statement No. 333-228180 on Form S-3 and Registration Statement Nos. 333-188798, 333-160275, 333-166640, 333-140753, 333-131908, and 333-120257 on Form S-8 of our reports dated February 12, 2019 relating to the consolidated financial statements and financial statement schedules of WellCare Health Plans, Inc. and subsidiaries, and the effectiveness of WellCare Health Plans, Inc. and subsidiaries' internal control over financial reporting, appearing in this Annual Report on Form 10-K of WellCare Health Plans, Inc. and subsidiaries for the year ended December 31, 2018.

/s/ Deloitte and Touche LLP

Tampa, Florida
February 12, 2019

(Back To Top)

Section 5: EX-31.1 (302 CERTIFICATION OF CEO)

EXHIBIT 31.1

CERTIFICATION

I, Kenneth A. Burdick, certify that:

1. I have reviewed this Annual Report on Form 10-K of WellCare Health Plans, Inc.;

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.

Date: February 12, 2019

/s/ Kenneth A. Burdick

Kenneth A. Burdick
Chief Executive Officer
(Principal Executive Officer)

(Back To Top)

Section 6: EX-31.2 (302 CERTIFICATION OF CFO)

EXHIBIT 31.2

CERTIFICATION

I, Andrew L. Asher, certify that:

1. I have reviewed this Annual Report on Form 10-K of WellCare Health Plans, Inc.;

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.

Date: February 12, 2019

/s/ Andrew L. Asher

Andrew L. Asher
Executive Vice President and Chief Financial Officer
(Principal Financial Officer)

(Back To Top)

Section 7: EX-32.1 (906 CERTIFICATION OF CEO)

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 WellCare Health Plans, Inc. (the "Company") for the year ended December 31, 2018 as filed with the Securities and Exchange Commission on the date hereof (the "Form 10-K"), I, Kenneth A. Burdick, Chief Executive Officer of the Company, hereby certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Form 10-K 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 Form 10-K fairly presents, in all material respects, the financial condition and results of operations of the Company.

Date: February 12, 2019

/s/ Kenneth A. Burdick
Kenneth A. Burdick
Chief Executive Officer
(Principal Executive Officer)

(Back To Top)

Section 8: EX-32.2 (906 CERTIFICATION OF CFO)

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 WellCare Health Plans, Inc. (the "Company") for the year ended December 31, 2018 as filed with the Securities and Exchange Commission on the date hereof (the "Form 10-K"), I, Andrew L. Asher, Executive Vice President and Chief Financial Officer of the Company, hereby certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Form 10-K 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 Form 10-K fairly presents, in all material respects, the financial condition and results of operations of the Company.

Date: February 12, 2019

/s/ Andrew L. Asher
Andrew L. Asher
Executive Vice President and Chief Financial Officer
(Principal Financial Officer)

(Back To Top)