CENTENE CORP
Form 10-Q
July 26, 2016

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, DC 20549

FORM 10-Q

(Mark One)

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

For the quarterly period ended June 30, 2016
OR

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

For the transition period from to

Commission file number: 001-31826

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

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

Registrant's telephone number, including area code:

(314) 725-4477

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). x Yes o No

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer", "accelerated filer" and "small reporting company" in Rule 12b-2 of the Exchange Act. Large accelerated filer x Accelerated filer o Non-accelerated filer o (do

not check if a smaller reporting company) Smaller reporting company o

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

As of July 15, 2016, the registrant had 170,736,886 shares of common stock outstanding.

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

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

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

- our ability to accurately predict and effectively manage health benefits and other operating expenses and reserves;
- competition;
- membership and revenue projections;
- timing of regulatory contract approval;
- changes in healthcare practices;
- changes in federal or state laws or regulations, including the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act and any regulations enacted thereunder;
- changes in expected contract start dates;
- changes in expected closing dates, estimated purchase price and accretion for acquisitions;
- inflation;
- foreign currency fluctuations;
- provider and state contract changes;
- new technologies;
- advances in medicine;
- rate cuts or other payment reductions by governmental payors and other risks and uncertainties affecting our Medicare and Medicaid businesses;
- major epidemics;
- disasters and numerous other factors affecting the delivery and cost of healthcare;
- the expiration, cancellation or suspension of our managed care contracts by federal or state governments (including but not limited to Medicaid, Medicare, and TRICARE);
- the outcome of our pending legal and regulatory proceedings;
- availability of debt and equity financing, on terms that are favorable to us;
- our ability to adequately price products on federally facilitated and state based Health Insurance Marketplaces;

- changes in economic, political and market conditions;
- the possibility that the expected synergies and value creation from acquired businesses, including, without limitation, the acquisition of Health Net, Inc., will not be realized, or will not be realized within the expected time period; and
- the risk that acquired businesses will not be integrated successfully.

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

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Non-GAAP Financial Presentation

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

Specifically, the Company believes the presentation of non-GAAP financial information which excludes Health Net acquisition related expenses and amortization of acquired intangible assets allows investors to understand the Company's performance more consistently. The tables below provide a reconciliation of non-GAAP items ($ in millions, except share data):

	Three Months Ended June 30,		Six Months Ended June 30,	
	2016	2015	2016	2015
GAAP general and administrative expenses	$949	$437	$1,671	$833
Health Net acquisition related expenses	25	2	214	2
General and administrative expenses, excluding Health Net acquisition related expenses	$924	$435	$1,457	$831
GAAP net earnings from continuing operations	$170	$88	$154	$152
Health Net acquisition related expenses	25	2	214	2
Amortization of acquired intangible assets	43	5	52	12
Income tax effects of adjustments [1]	(14)	(2)	(101)	(5)
Adjusted net earnings from continuing operations	$224	$93	$319	$161
GAAP diluted earnings per share (EPS)	$0.98	$0.72	$1.02	$1.24
Health Net acquisition related expenses [2]	0.16	0.01	0.89	0.01
Amortization of acquired intangible assets [3]	0.15	0.03	0.20	0.06
Adjusted diluted EPS	$1.29	$0.76	$2.11	$1.31

(1) The income tax effects of adjustments are based on the effective income tax rates applicable to adjusted (non-GAAP) results. The amounts are based on the annual estimated effective income tax rate that would increase or decrease based on the exclusion of these expenses.

(2) The Health Net acquisition related expenses per diluted share presented above are net of the income tax benefit (expense) of $(0.02) and $0.01 for the three months ended June 30, 2016 and 2015, respectively, and $0.53 and zero for the six months ended June 30, 2016 and 2015, respectively.

(3) The amortization of acquired intangible assets per diluted share presented above are net of the income tax benefit of $0.10 and $0.01 for the three months ended June 30, 2016 and 2015, respectively, and $0.14 and $0.04 for the six months ended June 30, 2016 and 2015, respectively.

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PART I
FINANCIAL INFORMATION

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

	June 30, 2016 (Unaudited)	December 31, 2015
ASSETS		
Current assets:		
Cash and cash equivalents	$ 2,710	$ 1,760
Premium and related receivables	3,488	1,279
Short term investments	443	176
Other current assets	1,212	390
Total current assets	7,853	3,605
Long term investments	4,230	1,927
Restricted deposits	137	115
Property, software and equipment, net	626	518
Goodwill	4,707	842
Intangible assets, net	1,609	155
Other long term assets	334	177
Total assets	$ 19,496	$ 7,339
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims liability	$ 3,950	$ 2,298
Accounts payable and accrued expenses	3,218	976
Return of premium payable	589	207
Unearned revenue	212	143
Current portion of long term debt	845	5
Total current liabilities	8,814	3,629
Long term debt	3,649	1,216
Other long term liabilities	1,346	170
Total liabilities	13,809	5,015
Commitments and contingencies		
Redeemable noncontrolling interests	147	156
Stockholders' equity:		
Preferred stock, $0.001 par value; authorized 10,000,000 shares; no shares issued or outstanding at June 30, 2016 and December 31, 2015	—	—
Common stock, $0.001 par value; authorized 400,000,000 shares; 176,231,905 issued and 170,653,478 outstanding at June 30, 2016, and 126,855,477 issued and 120,342,981 outstanding at December 31, 2015	—	—
Additional paid-in capital	4,119	956
Accumulated other comprehensive earnings (loss)	43	(10)
Retained earnings	1,510	1,358
Treasury stock, at cost (5,578,427 and 6,512,496 shares, respectively)	(143)	(147)
Total Centene stockholders' equity	5,529	2,157

Noncontrolling interest	11	11
Total stockholders' equity	5,540	2,168
Total liabilities and stockholders' equity	$ 19,496	$ 7,339

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

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2016	2015	2016	2015
Revenues:				
Premium	$9,688	$ 4,692	$15,674	$ 8,991
Service	588	492	1,013	954
Premium and service revenues	10,276	5,184	16,687	9,945
Premium tax and health insurer fee	621	322	1,163	692
Total revenues	10,897	5,506	17,850	10,637
Expenses:				
Medical costs	8,385	4,181	13,696	8,042
Cost of services	515	419	882	821
General and administrative expenses	949	437	1,671	833
Amortization of acquired intangible assets	43	5	52	12
Premium tax expense	498	239	948	520
Health insurer fee expense	130	52	204	107
Total operating expenses	10,520	5,333	17,453	10,335
Earnings from operations	377	173	397	302
Other income (expense):				
Investment and other income	32	10	47	19
Interest expense	(52)	(11)	(85)	(21)
Earnings from continuing operations, before income tax expense	357	172	359	300
Income tax expense	188	84	205	147
Earnings from continuing operations, net of income tax expense	169	88	154	153
Discontinued operations, net of income tax benefit	(1)	—	(2)	(1)
Net earnings	168	88	152	152
(Earnings) loss attributable to noncontrolling interests	1	—	—	(1)
Net earnings attributable to Centene Corporation	$169	$ 88	$152	$ 151
Amounts attributable to Centene Corporation common shareholders:				
Earnings from continuing operations, net of income tax expense	$170	$ 88	$154	$ 152
Discontinued operations, net of income tax benefit	(1)	—	(2)	(1)
Net earnings	$169	$ 88	$152	$ 151
Net earnings (loss) per common share attributable to Centene Corporation:				
Basic:				
Continuing operations	$1.00	$ 0.74	$1.04	$ 1.28
Discontinued operations	(0.01)	—	(0.01)	(0.01)
Basic earnings per common share	$0.99	$ 0.74	$1.03	$ 1.27
Diluted:				
Continuing operations	$0.98	$ 0.72	$1.02	$ 1.24
Discontinued operations	(0.01)	—	(0.01)	(0.01)
Diluted earnings per common share	$0.97	$ 0.72	$1.01	$ 1.23

Weighted average number of common shares outstanding:				
Basic	170,558,778	179,003,569	148,050,927	178,894,269
Diluted	173,778,532	182,965,011	151,147,640	182,785,459

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

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2016	2015	2016	2015
Net earnings	$168	$88	$152	$152
Reclassification adjustment, net of tax	—	—	1	—
Change in unrealized gain on investments, net of tax	34	(4)	52	1
Foreign currency translation adjustments	(1)	1	—	(4)
Other comprehensive earnings	33	(3)	53	(3)
Comprehensive earnings	201	85	205	149
Comprehensive (earnings) loss attributable to noncontrolling interests	1	—	—	(1)
Comprehensive earnings attributable to Centene Corporation	$202	$85	$205	$148

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

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

Six Months Ended June 30, 2016

	Centene Stockholders' Equity								
	Common Stock					Treasury Stock			
	$.001 Par Value Shares	Amt	Additional Paid-in Capital	Accumulated Other Comprehensive Earnings (Loss)	Retained Earnings	$.001 Par Value Shares	Amt	Non controlling Interest	Total
Balance, December 31, 2015	126,855,477	$ —	$ 956	$ (10)	$ 1,358	6,512,496	$ (147)	$ 11	$ 2,168
Comprehensive Earnings:									
Net earnings	—	—	—	—	152	—	—	—	152
Other comprehensive earnings, net of $21 tax	—	—	—	53	—	—	—	—	53
Common stock issued for acquisitions	48,218,310	—	3,074	—	—	(1,375,596)	31	—	3,105
Common stock issued for employee benefit plans	1,158,118	—	3	—	—	—	—	—	3
Common stock repurchases	—	—	—	—	—	441,527	(27)	—	(27)
Stock compensation expense	—	—	83	—	—	—	—	—	83
Excess tax benefits from stock compensation	—	—	3	—	—	—	—	—	3
Balance, June 30, 2016	176,231,905	$ —	$ 4,119	$ 43	$ 1,510	5,578,427	$ (143)	$ 11	$ 5,540

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

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

	Six Months Ended June 30,	
	2016	2015
Cash flows from operating activities:		
Net earnings	$152	$152
Adjustments to reconcile net earnings to net cash (used in) provided by operating activities		
Depreciation and amortization	111	53
Stock compensation expense	83	33
Deferred income taxes	(13)	(13)
Gain on contingent consideration	(1)	(10)
Changes in assets and liabilities		
Premium and related receivables	(1,121)	(341)
Other current assets	(26)	(28)
Medical claims liabilities	188	366
Unearned revenue	(50)	(102)
Accounts payable and accrued expenses	(8)	166
Other long term liabilities	463	144
Other operating activities, net	(3)	(25)
Net cash (used in) provided by operating activities	(225)	395
Cash flows from investing activities:		
Capital expenditures	(94)	(58)
Purchases of investments	(956)	(513)
Sales and maturities of investments	593	276
Investments in acquisitions, net of cash acquired	(862)	(11)
Other investing activities, net	—	7
Net cash used in investing activities	(1,319)	(299)
Cash flows from financing activities:		
Proceeds from borrowings	5,711	750
Payment of long term debt	(3,124)	(479)
Common stock repurchases	(27)	(7)
Purchase of noncontrolling interest	(14)	—
Debt issue costs	(59)	(4)
Other financing activities, net	7	1
Net cash provided by financing activities	2,494	261
Net increase in cash and cash equivalents	950	357
Cash and cash equivalents, beginning of period	1,760	1,610
Cash and cash equivalents, end of period	$2,710	$1,967
Supplemental disclosures of cash flow information:		
Interest paid	$36	$27
Income taxes paid	$222	$145
Equity issued in connection with acquisitions	$3,105	$13

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

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

1. Basis of Presentation

Basis of Presentation

The accompanying interim financial statements have been prepared under the presumption that users of the interim financial information have either read or have access to the audited financial statements included in the Form 10-K for the fiscal year ended December 31, 2015. The unaudited interim financial statements herein have been prepared pursuant to the rules and regulations of the Securities and Exchange Commission. Accordingly, footnote disclosures which would substantially duplicate the disclosures contained in the December 31, 2015 audited financial statements have been omitted from these interim financial statements where appropriate. In the opinion of management, these financial statements reflect all adjustments, consisting only of normal recurring adjustments, which are necessary for a fair presentation of the results of the interim periods presented.

Certain 2015 amounts in the notes to the consolidated financial statements have been reclassified to conform to the 2016 presentation. These reclassifications have no effect on net earnings or stockholders' equity as previously reported.

On March 24, 2016, the Company completed the acquisition of Health Net, Inc. (Health Net) for approximately $6.0 billion, including the assumption of debt. The acquisition was accounted for as a business combination, which requires that assets acquired and liabilities assumed be recognized at their fair values as of the acquisition date. Those estimated amounts are reflected in the accompanying financial statements.

As a result of the completion of the Health Net acquisition, the Company's results of operations for the three and six months ended June 30, 2016 include the results of operations of Health Net from March 24, 2016 to June 30, 2016. The Health Net segment previously known as the Western Region Operations, with the exception of certain operations of its pharmaceutical services and behavioral health subsidiaries, is included in the Company's Managed Care segment. The portions of Health Net's Western Region Operations segment included in the Managed Care segment consist of the following Health Net operations: commercial, Medicare, Medicaid and dual eligible health plans, primarily in Arizona, California, Oregon, and Washington.

The Company's Specialty Services segment includes the Health Net segment previously known as Government Contracts as well as certain operations of its pharmaceutical services and behavioral health subsidiaries, primarily in Arizona, California, Oregon and Washington (which Health Net previously included in its Western Region Operations segment). Health Net's Government Contracts segment included its federal government-sponsored managed care support contract with the U.S. Department of Defense (DoD) under the TRICARE program in the North Region, its Military and Family Life Counseling (MFLC) contract with the DoD and other health care related government contracts, including the Veterans Choice and Patient Centered Community Care program (PC3/Choice) with the U.S. Department of Veterans Affairs (VA).

Recent Accounting Pronouncements

In February 2016, the Financial Accounting Standards Board (FASB) issued an Accounting Standards Update (ASU) which introduces a lessee model that brings most leases on to the balance sheet. The new standard also aligns many of the underlying principles of the new lessor model with those in Accounting Standards Codification 606, the FASB's new revenue recognition standard, and addresses other concerns related to the current lessee model. The standard also

requires lessors to increase the transparency of their exposure to changes in value of their residual assets and how they manage that exposure. It is effective for annual and interim periods beginning after December 15, 2018. Early adoption is permitted. The Company is currently evaluating the effect of the new lease guidance.

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In March 2016, the FASB issued an ASU which simplifies several aspects of the accounting for employee share-based payment transactions, including the accounting for income taxes, forfeitures, and statutory tax withholding requirements, as well as classification in the statement of cash flows. Under the new guidance, an entity recognizes all excess tax benefits and tax deficiencies as income tax expense or benefit in the income statement. The ASU also allows an entity to elect as an accounting policy either to continue to estimate the total number of awards for which the requisite service period will not be rendered, as currently required, or to account for forfeitures when they occur. Finally, the ASU modifies the current exception to liability classification of an award when an employer uses a net-settlement feature to withhold shares to meet the employee's minimum statutory tax withholding requirement. The new standard is effective for annual periods beginning after December 15, 2016, including interim periods within those annual reporting periods. Early adoption is permitted. The Company is currently evaluating the effect of the employee share-based payment guidance.

2. Summary of Significant Accounting Policies

A summary of the Company’s significant accounting policies is included in Note 2 entitled “Summary of Significant Accounting Policies” to the company’s Annual Report on Form 10-K for the year ended December 31, 2015. As a result of the Health Net acquisition, material changes to the Company's significant accounting policies during the three and six months ended June 30, 2016 are described below:

Business Combinations

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

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

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

Revenue Recognition

The Company's health plans generate revenues primarily from premiums received from the states in which it operates health plans. The Company receives a fixed premium per member per month pursuant to its state contracts. The Company generally receives premium payments during the month it provides services and recognizes premium revenue during the period in which it is obligated to provide services to its members. In some instances, the Company's base premiums are subject to an adjustment, or risk score, based on the acuity of its membership. Generally, the risk score is determined by the State analyzing submissions of processed claims data to determine the acuity of the Company's membership relative to the entire state's Medicaid membership. Some states enact premium taxes, similar assessments and provider pass-through payments, collectively premium taxes, and these taxes are

recorded as a separate component of both revenues and operating expenses. Some contracts allow for additional premiums related to certain supplemental services provided such as maternity deliveries.

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

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

The Company's specialty services generate revenues under contracts with state and federal programs, healthcare organizations, and other commercial organizations, as well as from our own subsidiaries. Revenues are recognized when the related services are provided or as ratably earned over the covered period of services. The Company recognizes revenue related to administrative services under the T-3 TRICARE government-sponsored managed care support contract in the North Region for the DoD's TRICARE program (T-3 contract) on a straight-line basis over the option period, when the fees become fixed and determinable. The T-3 contract includes various performance-based incentives and penalties. For each of the incentives or penalties, the Company adjusts revenue accordingly based on the amount that it has earned or incurred at each interim date and are legally entitled to in the event of a contract termination.

Premium and Related Receivables and Unearned Revenue

Premium and service revenues collected in advance are recorded as unearned revenue. For performance-based contracts the Company does not recognize revenue subject to refund until data is sufficient to measure performance. Premiums and service revenues due to the Company are recorded as premium and related receivables and are recorded net of an allowance based on historical trends and management's judgment on the collectibility of these accounts. As the Company generally receives payments during the month in which services are provided, the allowance is typically not significant in comparison to total revenues and does not have a material impact on the presentation of the financial condition or results of operations.

Amounts receivable under government contracts are comprised primarily of contractually defined billings, accrued contract incentives under the terms of the contract and amounts related to change orders for services not originally specified in the contract. Pursuant to the Company's T-3 contract, the government has the right to unilaterally modify the contract in certain respects by issuing change orders directing it to implement terms or services that were not originally included in the contract. Following receipt of a change order, the Company has a contractual right to negotiate an equitable adjustment to the contract terms to account for the impact of the change order. The Company starts to perform under such change orders and begins to incur associated costs after it receives the government's unilateral modification, but before it has negotiated the final scope and/or value of the change order. In these situations, costs are expensed as incurred, and the Company estimates and records revenue when it has met all applicable revenue recognition criteria. These criteria include the requirements that change order amounts are determinable, that the Company has performed under the change orders, and that collectability of amounts payable to the Company is reasonably assured.

3. Health Net

On March 24, 2016, the Company acquired all of the issued and outstanding shares of Health Net, a publicly traded managed care organization that delivers health care services through health plans and government-sponsored managed care plans. The transaction was valued at approximately $5,986 million, including the assumption of $703 million of outstanding debt. The acquisition allows the Company to offer a more comprehensive and scalable portfolio of solutions and provides opportunity for additional growth across the combined company's markets.

The total consideration for the acquisition was $5,283 million, consisting of Centene common shares valued at $3,038 million (based on Centene's stock price of $62.70), $2,243 million in cash, and $2 million related to the fair value adjustment to stock based compensation associated with pre-combination service. Each Health Net share was converted into 0.622 of a validly issued, fully paid, non-assessable share of Centene common stock and $28.25 in cash. In total, 48,449,444 shares of Centene common stock were issued in connection with the transaction. The cash portion of the acquisition consideration was funded through the issuance of long-term debt as further discussed in Note 7. Debt. For the three and six months ended June 30, 2016, the Company also recognized acquisition related expenses of $25 million and $214 million, respectively, that were recorded in general and administrative expense in the statement of operations.

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The acquisition of Health Net has been accounted for as a business combination using the acquisition method of accounting which requires assets acquired and liabilities assumed to be recognized at fair value as of the acquisition date. The valuation of the majority of assets acquired and liabilities assumed has not yet been finalized. As a result, preliminary estimates have been recorded and are subject to change. Any necessary adjustments from our preliminary estimates will be finalized within one year from the date of acquisition. Measurement period adjustments will be recorded in the period in which they are determined, as if they had been completed at the acquisition date.

During the second quarter of 2016, the Company made adjustments to the fair value of certain assets and liabilities acquired, including the medical claims liability, accrued liabilities and deferred taxes, resulting in a net increase of $249 million to goodwill. The Company will continue to revise its preliminary purchase price allocation as additional information becomes available during the remainder of the measurement period. The Company's preliminary allocation of the fair value of assets acquired and liabilities assumed as of the acquisition date of March 24, 2016 is as follows ($ in millions):

Assets Acquired and Liabilities Assumed	
Cash and cash equivalents	$1,368
Premium and related receivables [(a)]	1,086
Short term investments	82
Other current assets	638
Long term investments	1,966
Restricted deposits	36
Property, software and equipment, net	41
Intangible assets [(b)]	1,500
Other long term assets	204
Total assets acquired	6,921
Medical claims liability	1,462
Borrowings under revolving credit facility	285
Accounts payable and accrued expenses [(c)]	2,030
Return of premium payable	375
Unearned revenue	117
Long term deferred tax liabilities [(d)]	349
Long term debt [(e)]	418
Other long term liabilities	452
Total liabilities assumed	5,488
Total identifiable net assets	1,433
Goodwill [(f)]	3,850
Total assets acquired and liabilities assumed	$5,283

The Company has made the following preliminary fair value adjustments based on information reviewed through June 30, 2016. Significant fair value adjustments are noted as follows:

(a) The preliminary fair value of premium and related receivables approximated their historical cost, with the exception of the risk corridor receivable associated with the Health Insurance Marketplace. The fair value of the risk corridor receivable was estimated at $9 million.

(b) The identifiable intangible assets acquired are to be measured at fair value as of the completion of the acquisition. The fair value of intangible assets is determined primarily using variations of the "income approach," which is

based on the present value of the future after tax cash flows attributable to each identified intangible asset. Other valuation methods, including the market approach and cost approach, were also considered in estimating the fair value. The Company has estimated the preliminary fair value of intangibles to be $1.5 billion with a weighted average life of 10 years. The Company expects the identifiable intangible assets to include purchased contract rights, provider contracts, trade names and developed technology. The Company is still in the process of finalizing its intangible valuation.

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(c) Accounts payable and accrued expenses includes approximately $300 million related to premium deficiency reserves based on costs trends existing prior to the acquisition date. The premium deficiency reserves are primarily associated with losses in the individual commercial business, largely in California, unfavorable performance in the Arizona commercial business as well as unfavorable performance in the Medicare business primarily in Oregon and Arizona. The premium deficiency reserve for the individual PPO commercial contracts in California includes future losses associated with substance abuse rehabilitation claims.

(d) The preliminary deferred tax liabilities are presented net of $500 million of deferred tax assets.

(e) Debt is required to be measured at fair value under the acquisition method of accounting. The fair value of Health Net's $400 million Senior Notes assumed in the acquisition was $418 million. The $18 million increase will be amortized as a reduction to interest expense over the remaining life of the debt.

(f) The acquisition resulted in $3.9 billion of goodwill related primarily to buyer specific synergies expected from the acquisition and the assembled workforce of Health Net. This goodwill is not deductible for income tax purposes. The assignment of goodwill to the Company's respective segments has not been completed at this time.

Statement of Operations

From the acquisition date through June 30, 2016, the Company's Consolidated Statements of Operations include total Health Net revenues of $4,269 million and $4,623 million for the three and six months ended June 30, 2016, respectively. It is impracticable to determine the effect on net income resulting from the Health Net acquisition for the three and six months ended June 30, 2016, as the Company immediately integrated Health Net into its ongoing operations.

Unaudited Pro Forma Financial Information

The unaudited pro forma total revenues for the six months ended June 30, 2016 were $21,523 million. The following table presents supplemental pro forma information for the three and six months ended June 30, 2015 ($ in millions, except per share data).

	Three Months Ended June 30, 2015	Six Months Ended June 30, 2015
Total revenues	$9,650	$18,657
Net earnings attributable to Centene Corporation	$91	$130
Diluted earnings per share	$0.53	$0.76

The pro forma results do not reflect any anticipated synergies, efficiencies, or other cost savings of the acquisition. Accordingly, the unaudited pro forma financial information is not indicative of the results if the acquisition had been completed on January 1, 2015 and is not a projection of future results. It is impracticable for the Company to determine the pro forma earnings information for the six months ended June 30, 2016 due to the nature of obtaining that information as the Company immediately integrated Health Net into its ongoing operations.

The unaudited pro forma financial information reflects the historical results of Centene and Health Net adjusted as if the acquisition had occurred on January 1, 2015, primarily for the following:

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Additional interest income associated with adjusting the amortized cost of Health Net's investment portfolio to fair value.

- Elimination of historical Health Net intangible asset amortization expense and addition of amortization expense based on the current preliminary values of identifiable intangible assets.
- Interest expense associated with financing the acquisition and amortization of the fair value adjustment to Health Net's debt.
- Additional stock compensation expense related to the amortization of the fair value increase to Health Net rollover stock awards.
- Increased tax expense due to the assumption that Centene would be subject to the IRS Regulation 162(m)(6) beginning in 2015.
- Elimination of acquisition related costs.

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Restructuring Related Charges

In connection with the Health Net acquisition, the Company undertook a restructuring plan as a result of the integration of Health Net's operations into its business, resulting in a reduction in workforce beginning in 2016 and continuing through early 2017. The restructuring related costs are classified as general and administrative expenses in the Consolidated Statements of Operations. Changes in the restructuring liability for the six months ended June 30, 2016 were as follows ($ in millions):

	June 30, 2016		
	Employee Termination Costs	Stock Based Compensation	Total
Total accrued restructuring costs as of December 31, 2015	$—	$ —	$—
Charges incurred	32	38	70
Paid/settled	(18)	(38)	(56)
Total accrued restructuring costs as of June 30, 2016	$14	$ —	$14

For the three and six months ended June 30, 2016, the Company recorded employee termination costs of $18 million and $32 million and stock based compensation of $7 million and $38 million, respectively, in the Managed Care Segment. The Company expects to record a total of approximately $50 million of employee termination costs and $43 million of stock based compensation in connection with the acquisition, the majority of which is expected to be incurred through 2016 and early 2017.

Commitments

In connection with obtaining regulatory approval of the Health Net acquisition from the California Department of Insurance and the California Department of Managed Health Care, the Company committed to certain undertakings (the Undertakings). The Undertakings included, among other items, operational commitments around premiums, dividend restrictions, minimum Risk Based Capital (RBC) levels, local offices, growth, accreditation, HEDIS scores and other quality measures, network adequacy, certifications, investments and capital expenditures. Specifically, the Company agreed to, among other things:

- invest an additional $30 million through the California Organized Investment Network over the five years following completion of the acquisition;
- build a service center in an economically distressed community in California, investing $200 million over ten years and employing at least 300 people;
- contribute $65 million to improve enrollee health outcomes ($10 million over ten years), support locally-based consumer assistance programs ($5 million over five years) and strengthen the health care delivery system ($50 million over five years), (of which, the present value of $62 million was expensed in the six months ended June 30, 2016 and classified as general and administrative expenses in the Consolidated Statements of Operations); and
- invest $75 million of its investment portfolio in vehicles supporting California’s health care infrastructure.

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4. Short term and Long term Investments, Restricted Deposits

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

	June 30, 2016				December 31, 2015			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$293	$ 3	$ —	$296	$431	$ —	$ (2)	$429
Corporate securities	1,885	28	(1)	1,912	859	2	(8)	853
Restricted certificates of deposit	5	—	—	5	5	—	—	5
Restricted cash equivalents	73	—	—	73	78	—	—	78
Municipal securities	1,520	33	(1)	1,552	496	2	(1)	497
Asset-backed securities	298	2	(1)	299	163	—	(1)	162
Residential mortgage-backed securities	197	3	(1)	199	66	1	—	67
Commercial mortgage-backed securities	320	3	—	323	40	—	—	40
Cost and equity method investments	135	—	—	135	71	—	—	71
Life insurance contracts	16	—	—	16	16	—	—	16
Total	$4,742	$ 72	$ (4)	$4,810	$2,225	$ 5	$ (12)	$2,218

The Company’s investments are classified as available-for-sale with the exception of life insurance contracts and certain cost and equity method investments. The Company’s investment policies are designed to provide liquidity, preserve capital and maximize total return on invested assets with the focus on high credit quality securities. The Company limits the size of investment in any single issuer other than U.S. treasury securities and obligations of U.S. government corporations and agencies. As of June 30, 2016, 95% of the Company’s investments in rated securities carry an investment grade rating by S&P and Moody's. At June 30, 2016, the Company held certificates of deposit, life insurance contracts and cost and equity method investments which did not carry a credit rating.

The Company's residential mortgage-backed securities are primarily issued by the Federal National Mortgage Association, Government National Mortgage Association or Federal Home Loan Mortgage Corporation, which carry implicit or explicit guarantees of the U.S. government. The Company's commercial mortgage-backed securities are primarily senior tranches with a weighted average rating of AA+ and a weighted average duration of 3.3 years at June 30, 2016.

In January 2016, the Company completed a 19% investment in a data analytics business and as a result, issued 1.1 million shares of Centene common stock, valued at $68 million, to the selling stockholders. The investment is being accounted for using the equity method of accounting.

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

	June 30, 2016				December 31, 2015			
	Less Than 12 Months		12 Months or More		Less Than 12 Months		12 Months or More	
	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$—	$2	$—	$—	$(2)	$294	$—	$14
Corporate securities	(1)	228	—	80	(6)	561	(2)	41
Municipal securities	(1)	76	—	30	(1)	208	—	5
Asset-backed securities	(1)	83	—	6	(1)	121	—	8
Residential mortgage-backed securities	(1)	39	—	—	—	30	—	—
Commercial mortgage-backed securities	—	64	—	10	—	34	—	—
Total	$(4)	$492	$—	$126	$(10)	$1,248	$(2)	$68

As of June 30, 2016, the gross unrealized losses were generated from 374 positions out of a total of 2,476 positions. The change in fair value of fixed income securities is primarily a result of movement in interest rates subsequent to the purchase of the security.

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

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

	June 30, 2016				December 31, 2015			
	Investments		Restricted Deposits		Investments		Restricted Deposits	
	Amortized Cost	Fair Value	Amortized Cost	Fair Value	Amortized Cost	Fair Value	Amortized Cost	Fair Value
One year or less	$443	$443	$109	$109	$176	$176	$93	$93
One year through five years	1,912	1,935	28	28	1,662	1,654	22	22
Five years through ten years	944	964	—	—	267	268	—	—
Greater than ten years	491	508	—	—	5	5	—	—
Asset-backed securities	815	823	—	—	—	—	—	—
Total	$4,605	$4,673	$137	$137	$2,110	$2,103	$115	$115

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

The Company continuously monitors investments for other-than-temporary impairment. Certain investments have experienced a decline in fair value due to changes in credit quality, market interest rates and/or general economic

conditions. The Company recognizes an impairment loss for cost and equity method investments when evidence demonstrates that it is other-than-temporarily impaired. Evidence of a loss in value that is other-than-temporary may include the absence of an ability to recover the carrying amount of the investment or the inability of the investee to sustain a level of earnings that would justify the carrying amount of the investment.

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5. Fair Value Measurements

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

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

The following table summarizes fair value measurements by level at June 30, 2016, for assets and liabilities measured at fair value on a recurring basis ($ in millions):

	Level I	Level II	Level III	Total
Assets				
Cash and cash equivalents	$2,710	$—	$ —	$2,710
Investments available for sale:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$215	$22	$ —	$237
Corporate securities	—	1,912	—	1,912
Municipal securities	—	1,552	—	1,552
Asset-backed securities	—	299	—	299
Residential mortgage-backed securities	—	199	—	199
Commercial mortgage-backed securities	—	323	—	323
Total investments	$215	$4,307	$ —	$4,522
Restricted deposits available for sale:				
Cash and cash equivalents	$73	$—	$ —	$73
Certificates of deposit	5	—	—	5
U.S. Treasury securities and obligations of U.S. government corporations and agencies	59	—	—	59
Total restricted deposits	$137	$—	$ —	$137
Other long term assets: Interest rate swap agreements	$—	$42	$ —	$42
Total assets at fair value	$3,062	$4,349	$ —	$7,411
Liabilities				
Other long term liabilities:				
Interest rate swap agreements	$—	$—	$ —	$—
Total liabilities at fair value	$—	$—	$ —	$—

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The following table summarizes fair value measurements by level at December 31, 2015, for assets and liabilities measured at fair value on a recurring basis ($ in millions):

	Level I	Level II	Level III	Total
Assets				
Cash and cash equivalents	$1,760	$—	$ —	$1,760
Investments available for sale:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$325	$72	$ —	$397
Corporate securities	—	853	—	853
Municipal securities	—	497	—	497
Asset-backed securities	—	162	—	162
Residential mortgage-backed securities	—	67	—	67
Commercial mortgage-backed securities	—	40	—	40
Total investments	$325	$1,691	$ —	$2,016
Restricted deposits available for sale:				
Cash and cash equivalents	$78	$—	$ —	$78
Certificates of deposit	5	—	—	5
U.S. Treasury securities and obligations of U.S. government corporations and agencies	32	—	—	32
Total restricted deposits	$115	$—	$ —	$115
Other long term assets:				
Interest rate swap agreements	$—	$11	$ —	$11
Total assets at fair value	$2,200	$1,702	$ —	$3,902
Liabilities				
Other long term liabilities:				
Interest rate swap agreements	$—	$2	$ —	$2
Total liabilities at fair value	$—	$2	$ —	$2

The Company periodically transfers U.S. Treasury securities and obligations of U.S. government corporations and agencies between Level I and Level II fair value measurements dependent upon the level of trading activity for the specific securities at the measurement date. The Company's policy regarding the timing of transfers between Level I and Level II is to measure and record the transfers at the end of the reporting period. At June 30, 2016, there were no transfers from Level I to Level II and $38 million of transfers from Level II to Level I. The Company utilizes matrix pricing services to estimate fair value for securities which are not actively traded on the measurement date. The Company designates these securities as Level II fair value measurements. The aggregate carrying amount of the Company's life insurance contracts and other non-majority owned investments, which approximates fair value, was $151 million and $87 million as of June 30, 2016 and December 31, 2015, respectively.

6. Affordable Care Act

The Affordable Care Act (ACA) established risk spreading premium stabilization programs effective January 1, 2014. These programs, commonly referred to as the "three Rs," include a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridor program. Additionally, the ACA established a minimum annual medical loss ratio. Each of the three R programs are taken into consideration to determine if the Company's estimated annual medical costs are less than the minimum loss ratio and require an adjustment to Premium revenue to meet the minimum medical loss ratio.

During the second quarter of 2016, the Company recognized a $70 million net pre-tax benefit related to the reconciliation of 2015 risk adjustment and reinsurance programs.

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

	June 30, 2016	December 31, 2015
Risk adjustment	$ (424)	$ (108)
Reinsurance	217	24
Risk corridor	2	(4)
Minimum medical loss ratio	(16)	(15)

7. Debt

Debt consists of the following ($ in millions):

	June 30, 2016	December 31, 2015
$425 million 5.75% Senior notes, due June 1, 2017	$427	$ 428
$400 million 6.375% Senior notes, due June 1, 2017	414	—
$1,400 million 5.625% Senior notes, due February 15, 2021	1,400	—
$1,000 million 4.75% Senior notes, due May 15, 2022	1,008	500
$1,000 million 6.125% Senior notes, due February 15, 2024	1,000	—
Fair value of interest rate swap agreements	42	9
Total senior notes	4,291	937
Revolving credit agreement	185	225
Mortgage notes payable	66	67
Capital leases and other	19	6
Debt issuance costs	(67)	(14)
Total debt	4,494	1,221
Less current portion	(845)	(5)
Long term debt	$3,649	$ 1,216

Senior Notes

In February 2016, a wholly owned unrestricted subsidiary of the Company (Escrow Issuer) issued $1,400 million in aggregate principal amount of 5.625% Senior Notes ($1,400 Million Notes) at par due 2021 and $1,000 million in aggregate principal amount of 6.125% Senior Notes ($1,000 Million Notes) at par due 2024. In July 2016, the Company completed an exchange offer, whereby it offered to exchange all of the outstanding $1,400 Million Notes and the $1,000 Million Notes for identical securities that have been registered under the Securities Act of 1933. The Company used the net proceeds of the offering, together with borrowings under the Company's new $1,000 million revolving credit facility and cash on hand, primarily to fund the cash consideration for the Health Net acquisition, and to pay acquisition and offering related fees and expenses.

In connection with the February 2016 issuance, the Company entered into interest rate swap agreements for notional amounts of $600 million and $1,000 million, at floating rates of interest based on the three month LIBOR plus 4.22% and the three month LIBOR plus 4.44%, respectively. Gains and losses due to changes in the fair value of the interest rate swaps completely offset changes in the fair value of the hedged portion of the underlying debt and are recorded as an adjustment to the $1,400 Million Notes and $1,000 Million Notes.

In connection with the closing of the Health Net acquisition, the Company assumed the $400 million in aggregate principal amount of Health Net's 6.375% Senior Notes due 2017, recorded at acquisition date fair value of $418 million.

In June 2016, the Company issued an additional $500 million in aggregate principal amount of 4.75% Senior Notes due 2022 ($500 Million Add-on Notes) at a premium to yield of 4.41%. The $500 Million Add-on Notes were offered as additional debt securities under the indenture governing the $500 million in aggregate principal amount of 4.75% Senior Notes issued in April 2014. The Company used the net proceeds of the offering to repay amounts outstanding under its Revolving Credit Facility and to pay offering related fees and expenses.

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The indentures governing the $425 million in aggregate principal amount of 5.75% Senior Notes due 2017, the $1,400 Million Notes, the $1,000 million of its 4.75% Senior Notes due 2022, and the $1,000 Million Notes contain non-financial and financial covenants of Centene Corporation, including requirements of a minimum fixed charge coverage ratio. The indentures governing the $400 million notes due 2017 contain non-financial and financial covenants of Health Net, Inc., including requirements of a minimum fixed charge coverage ratio. At June 30, 2016, the Company was in compliance with all covenants.

Interest Rate Swaps

The Company uses interest rate swap agreements to convert a portion of its interest rate exposure from fixed rates to floating rates to more closely align interest expense with interest income received on its cash equivalent and variable rate investment balances. The Company has $2,350 million of notional amount of interest rate swap agreements consisting of:

•$250 million expiring on June 1, 2017;
•$600 million expiring on February 15, 2021;
•$500 million expiring on May 15, 2022; and,
•$1,000 million expiring on February 15, 2024.

Under the Swap Agreements, the Company receives a fixed rate of interest and pays an average variable rate of the three month LIBOR plus 3.88% adjusted quarterly. At June 30, 2016, the weighted average rate was 4.51%.

The Swap Agreements are formally designated and qualify as fair value hedges and are recorded at fair value in the Consolidated Balance Sheets in other assets or other liabilities. Gains and losses due to changes in fair value of the interest rate swap agreements completely offset changes in the fair value of the hedged portion of the underlying debt. Therefore, no gain or loss has been recognized due to hedge ineffectiveness. Offsetting changes in fair value of both the interest rate swaps and the hedged portion of the underlying debt both were recognized in interest expense in the Consolidated Statements of Operations. The Company does not hold or issue any derivative instrument for trading or speculative purposes.

Revolving Credit Agreement

In connection with the closing of the Health Net acquisition on March 24, 2016, the Company's existing unsecured $500 million revolving credit facility was terminated and simultaneously replaced with a new $1,000 million unsecured revolving credit facility. Borrowings under the agreement bear interest based upon LIBOR rates, the Federal Funds Rate or the Prime Rate. The agreement has a maturity date of March 24, 2021. As of June 30, 2016, the Company had $185 million of borrowings outstanding under the agreement with a weighted average interest rate of 4.25%, and the Company was in compliance with all covenants.

The revolving credit facility contains non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios and maximum debt-to-EBITDA ratios. The Company is required to not exceed a maximum debt-to-EBITDA ratio of 3.5 to 1.0 prior to December 31, 2016 and 3.0 to 1.0 on and subsequent to December 31, 2016. As of June 30, 2016, there were no limitations on the availability under the revolving credit agreement as a result of the debt-to-EBITDA ratio.

Also, upon the closing of the Health Net acquisition, the Company assumed, fully repaid $285 million in outstanding borrowings under, and terminated the existing Health Net revolving credit facility.

Letters of Credit & Surety Bonds

The Company had outstanding letters of credit of $43 million as of June 30, 2016, which were not part of the revolving credit facility. The Company also had letters of credit for $51 million (valued at June 30, 2016 conversion rate), or €46 million, representing its proportional share of the letters of credit issued to support Ribera Salud's outstanding debt, which are a part of the revolving credit facility. Collectively, the letters of credit bore interest at 1.51% as of June 30, 2016. The Company had outstanding surety bonds of $363 million as of June 30, 2016.

8. Stockholders' Equity

In March 2016, the Company issued 48,449,444 shares of Centene common stock, with a fair value of approximately $3,038 million, paid approximately $2,243 million in cash in exchange for all the outstanding shares of Health Net common stock and outstanding equity awards, and recorded $2 million related to the fair value adjustment to stock based compensation associated with pre-combination service.

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In January 2016, the Company completed a 19% investment in a data analytics business and as a result, issued 1,144,462 shares of Centene common stock to the selling stockholders. The investment is being accounted for using the equity method of accounting.

9. Earnings Per Share

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2016	2015	2016	2015
Earnings attributable to Centene Corporation:				
Earnings from continuing operations, net of tax	$170	$ 88	$154	$ 152
Discontinued operations, net of tax	(1)	—	(2)	(1)
Net earnings	$169	$ 88	$152	$ 151
Shares used in computing per share amounts:				
Weighted average number of common shares outstanding	170,558,779	178,003,569	148,050,912	118,894,269
Common stock equivalents (as determined by applying the treasury stock method)	3,219,759	3,961,442	3,096,713	3,891,190
Weighted average number of common shares and potential dilutive common shares outstanding	173,778,538	181,965,011	151,147,625	122,785,459
Net earnings per common share attributable to Centene Corporation:				
Basic:				
Continuing operations	$1.00	$ 0.74	$1.04	$ 1.28
Discontinued operations	(0.01)	—	(0.01)	(0.01)
Basic earnings per common share	$0.99	$ 0.74	$1.03	$ 1.27
Diluted:				
Continuing operations	$0.98	$ 0.72	$1.02	$ 1.24
Discontinued operations	(0.01)	—	(0.01)	(0.01)
Diluted earnings per common share	$0.97	$ 0.72	$1.01	$ 1.23

The calculation of diluted earnings per common share for the three and six months ended June 30, 2016 excludes the impact of 47,886 and 51,175 shares, respectively, related to anti-dilutive restricted stock and restricted stock units. The calculation of diluted earnings per common share for the three and six months ended June 30, 2015 excludes the impact of 49,754 and 59,828 shares, respectively, related to anti-dilutive restricted stock and restricted stock units.

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10. Segment Information

Centene operates in two segments: Managed Care and Specialty Services.

The Managed Care segment consists of Centene’s health plans including all of the functions needed to operate them. Subsequent to the closing of the Health Net acquisition, the Managed Care segment also includes the operations previously included in Health Net's Western Region Operations Segment, with the exception of certain operations of its pharmaceutical services and behavioral health subsidiaries. The portions of Health Net's Western Region Operations segment included in the Managed Care segment consist of the following Health Net operations: commercial, Medicare, Medicaid and dual eligible health plans, primarily in Arizona, California, Oregon and Washington.

The Specialty Services segment consists of Centene’s specialty companies offering auxiliary healthcare services and products. Subsequent to the closing of the Health Net acquisition, the Specialty Services segment also includes the operations previously included in the Government Contracts segment of Health Net as well as certain operations of its pharmaceutical services and behavioral health subsidiaries, the latter of which Health Net previously included in its Western Region Operations segment. The Government Contracts business includes the Company's government-sponsored managed care support contract with the DoD under the TRICARE program in the North Region, the MFLC contract with the DoD, and other health care related government contracts, including PC3/Choice with the VA.

Segment information for the three months ended June 30, 2016, follows ($ in millions):

	Managed Care	Specialty Services	Eliminations	Consolidated Total
Total revenues from external customers	$ 10,074	$ 823	$ —	$ 10,897
Total revenues from internal customers	54	1,411	(1,465)	—
Total revenues	$ 10,128	$ 2,234	$ (1,465)	$ 10,897
Earnings from operations	$ 336	$ 41	$ —	$ 377

Segment information for the three months ended June 30, 2015, follows ($ in millions):

	Managed Care	Specialty Services	Eliminations	Consolidated Total
Total revenues from external customers	$ 4,967	$ 539	$ —	$ 5,506
Total revenues from internal customers	26	1,176	(1,202)	—
Total revenues	$ 4,993	$ 1,715	$ (1,202)	$ 5,506
Earnings from operations	$ 125	$ 48	$ —	$ 173

Segment information for the six months ended June 30, 2016, follows ($ in millions):

	Managed Care	Specialty Services	Eliminations	Consolidated Total
Total revenues from external customers	$ 16,429	$ 1,421	$ —	$ 17,850
Total revenues from internal customers	88	2,859	(2,947)	—
Total revenues	$ 16,517	$ 4,280	$ (2,947)	$ 17,850
Earnings from operations	$ 314	$ 83	$ —	$ 397

Segment information for the six months ended June 30, 2015, follows ($ in millions):

	Managed Care	Specialty Services	Eliminations	Consolidated Total
Total revenues from external customers	$ 9,579	$ 1,058	$ —	$ 10,637

Total revenues from internal customers	50	2,251	(2,301)	—
Total revenues	$ 9,629	$ 3,309	$ (2,301)	$ 10,637
Earnings from operations	$ 220	$ 82	$ —	$ 302

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As discussed in Note 3. Health Net, the assignment of goodwill to the Company's segment has not been completed at this time. The Company will update segment asset disclosures once a preliminary allocation is available.

11. Contingencies

Overview

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

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

Kentucky

On July 5, 2013, the Company's subsidiary, Kentucky Spirit Health Plan, Inc. (Kentucky Spirit), terminated its contract with the Commonwealth of Kentucky (the Commonwealth). Kentucky Spirit believed it had a contractual right to terminate the contract and filed a lawsuit in Franklin Circuit Court seeking a declaration of this right. In response, the Commonwealth alleged that Kentucky Spirit's exit would constitute a material breach of contract. The Commonwealth seeks to recover substantial damages and to enforce its rights under Kentucky Spirit's $25 million performance bond. The Commonwealth has asserted that the Commonwealth's expenditures due to Kentucky Spirit's departure range from $28 million to $40 million plus interest, and that the associated CMS expenditures range from $92 million to $134 million. Kentucky Spirit disputes the Commonwealth's alleged damages on several grounds. Prior to terminating the contract, Kentucky Spirit filed a legal complaint in April 2013, amended in October 2014, in Franklin Circuit Court seeking damages against the Commonwealth for losses sustained due to the Commonwealth's alleged breaches.

On February 6, 2015, the Kentucky Court of Appeals affirmed a Franklin Circuit Court ruling that Kentucky Spirit did not have a contractual right to terminate the contract early. The Court of Appeals also found that the contract’s liquidated damages provision “is applicable in the event of a premature termination of the Contract term.” On September 8, 2015, Kentucky Spirit filed a motion for discretionary review seeking Kentucky Supreme Court review of the finding that Kentucky Spirit's departure constituted a breach of contract. On April 27, 2016, the Kentucky Supreme Court declined discretionary review, thereby making the Court of Appeals decision final. The question of damages is pending and will be determined by the Franklin Circuit Court. Kentucky Spirit believes it is not liable for damages because there was a prior breach of the contract by the Commonwealth, as alleged in Kentucky Spirit’s complaint.

On May 26, 2015, the Commonwealth issued a demand for indemnification to its actuarial firm, for "all defense costs, and any resultant monetary awards in favor of Kentucky Spirit, arising from or related to Kentucky Spirit's claims which are predicated upon the alleged omissions and errors in the Data Book and the certified actuarially sound rates." On August 19, 2015, the actuarial firm moved to intervene in the litigation. The Franklin Circuit Court granted the actuarial firm's motion on September 8, 2015 and ordered a forty-five day stay of all pretrial proceedings in order for the firm to review the record. Also, on August 19, 2015, the actuarial firm filed a petition seeking a declaratory judgment that it is not liable to the Commonwealth for indemnification related to the claims asserted by Kentucky Spirit against the Commonwealth. On October 5, 2015, the Commonwealth filed an answer to the actuarial firm's petition and asserted counterclaims/cross-claims against the firm.

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On March 9, 2015, the Secretary of the Kentucky Cabinet for Health and Family Services (CHFS) issued a determination letter finding that Kentucky Spirit owed the Commonwealth $40 million in actual damages plus prejudgment interest at 8 percent. On March 18, 2015, in a letter to the Kentucky Finance and Administration Cabinet (FAC), Kentucky Spirit contested CHFS' jurisdiction to make such a determination. The FAC did not issue a decision within the required 120 days. On August 13, 2015, Kentucky Spirit filed a declaratory judgment action against the Commonwealth in Franklin Circuit Court seeking a declaration that the Commonwealth may not purport to issue a decision against Kentucky Spirit awarding damages to itself when the matter is already before the Kentucky courts. The Commonwealth filed counterclaims seeking a Declaration of Rights and Entry of Judgment on its determination letter. On December 1, 2015 the Franklin Circuit Court consolidated this declaratory judgment action with Kentucky Spirit’s other litigation claims against the Commonwealth. Discovery is proceeding in the consolidated litigation matters.

The resolution of the Kentucky litigation matters is subject to numerous uncertainties and may result in a range of possible outcomes. If Kentucky Spirit prevails on its claims, it would be entitled to damages. If the Commonwealth prevails, a liability to the Commonwealth could be recorded.

California

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

Miscellaneous Proceedings

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

- periodic compliance reviews by various federal and state regulatory agencies with respect to requirements applicable to the Company's business, including, without limitation, payment of out-of-network claims, rules relating to pre-authorization penalties, timely review of grievances and appeals, timely and accurate payment of claims, and the Health Insurance Portability and Accountability Act of 1996;

- litigation arising out of general business activities, such as tax matters, disputes related to health care benefits coverage or reimbursement, and medical malpractice, privacy, real estate, intellectual property and employment-related claims;

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disputes regarding reinsurance arrangements, claims arising out of the acquisition or divestiture of various assets, class actions and claims relating to the performance of contractual obligations to providers, members, employer groups and others, including, but not limited to, the alleged failure to properly pay claims and challenges to the manner in which the Company processes claims, and claims alleging that the Company has engaged in unfair business practices.

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

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

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

OVERVIEW

Key financial metrics for the second quarter of 2016 are summarized as follows:

- Managed care membership of 11.4 million, an increase of 6.8 million members, or 148% year over year.
- Total revenues of $10.9 billion, representing 98% growth year over year.
- Health benefits ratio of 86.6%, compared to 89.1% in 2015.
- General and administrative expense ratio of 9.2%, or 9.0% excluding Health Net acquisition related expenses for the second quarter of 2016, compared to 8.4% in the second quarter of 2015.
- Operating cash flows of $(420) million for the second quarter of 2016, reflecting an increase in premium and related receivables due to the timing of June capitation payments from several of our states.
- Diluted earnings per share for the second quarter of 2016 of $0.98, or $1.29 of Adjusted diluted EPS when excluding Health Net acquisition related expenses and amortization of acquired intangible assets, including a $0.19 per diluted share benefit related to the 2015 risk adjustment and reinsurance reconciliations under the Affordable Care Act (ACA) in connection with our health insurance marketplace business. In comparison, diluted EPS for the second quarter of 2015 was $0.72, or $0.76 Adjusted diluted EPS when excluding Health Net acquisition related expenses and amortization of acquired intangible assets. A reconciliation of GAAP diluted earnings per share to Adjusted diluted EPS is highlighted below:

	Three Months Ended June 30,	
	2016	2015
GAAP diluted earnings per share (EPS)	$0.98	$0.72
Health Net acquisition related expenses	0.16	0.01
Amortization of acquired intangible assets	0.15	0.03
Adjusted diluted EPS	$1.29	$0.76

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

- Arizona. In October 2015, our subsidiary, Cenpatico Integrated Care, in partnership with University of Arizona Health Plan, began operating under a contract with the Arizona Department of Health Services/Division of Behavioral Health Services to be the Regional Behavioral Health Authority for the new southern geographic service area.

- Centurion. In February 2015, Centurion began operating under a new contract with the State of Vermont Department of Corrections to provide comprehensive correctional healthcare services.

In July 2015, Centurion began operating under a new contract with the Mississippi Department of Corrections (MDOC) to provide comprehensive correctional healthcare services.

In April 2016, our Florida subsidiary, Centurion of Florida, LLC, began providing correctional healthcare services for the Florida Department of Corrections in Regions 1, 2 and 3.

In June 2016, Centurion began operating under two new contracts with the State of New Mexico Corrections Department to provide correctional medical health care services and pharmacy services.

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- Florida. In October 2015, Sunshine Health began operating under a two-year, statewide contract with the Florida Healthy Kids Corporation to manage healthcare services for children ages five through 18 in all 11 regions of Florida.

- Health Insurance Marketplaces (HIM). In January 2016, we began serving members enrolled in the federally facilitated Health Insurance Marketplace in the state of New Hampshire.

In January 2016, we started operating under a contract with the New Hampshire Department of Health and Human Services to participate in the Medicaid expansion model that New Hampshire has adopted (referred to as the “premium assistance program”). This contract expires December 31, 2016 and may be extended for subsequent and consecutive one-year terms.

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

- Indiana. In February 2015, our Indiana subsidiary, Managed Health Services, began operating under an expanded contract with the Indiana Family & Social Services Administration to provide Medicaid services under the state's Healthy Indiana Plan 2.0 program.

In April 2015, Managed Health Services began operating under an expanded contract with the Indiana Family & Social Services Administration to provide services to its ABD Medicaid enrollees who qualify for the new Hoosier Care Connect Program.

- Louisiana. In February 2015, our Louisiana subsidiary, Louisiana Healthcare Connections, began operating under a new contract with the Louisiana Department of Health to serve Healthy Louisiana (Medicaid) beneficiaries. Members previously served under the shared savings program were transitioned to the at-risk program on February 1, 2015.

In December 2015, Louisiana Healthcare Connections began operating under an expanded contract to include behavioral health benefits.

- Michigan. In May 2015, we completed the acquisition of Fidelis SecureCare of Michigan, Inc. (Fidelis). Fidelis began operating under a new contract with the Michigan Department of Community Health and the Centers for Medicare and Medicaid Services to provide integrated healthcare services to members who are dually eligible for Medicare and Medicaid in Macomb and Wayne counties in May 2015. Passive enrollment began in July 2015.

- Mississippi. In July 2014, our Mississippi subsidiary, Magnolia Health, began operating as one of two contractors under a new statewide managed care contract serving members enrolled in the Mississippi Coordinated Access Network program. Program expansion began in December 2014 and continued through July 2015.

In July 2015, Magnolia Health began operating under a two-year CHIP contract with the State of Mississippi. In December 2015, Magnolia Health began operating under an expanded contract to include the inpatient benefit for Medicaid and ABD members.

- Oregon. In September 2015, we completed the acquisition of Agate Resources, Inc., a diversified holding company, that offers primarily Medicaid and other healthcare products and services to Oregon residents through Trillium Community Health Plan.

- South Carolina. In February 2015, our South Carolina subsidiary, Absolute Total Care, began operating under a new contract with the South Carolina Department of Health and Human Services and the Centers for Medicare and Medicaid Services to serve dual-eligible members as part of the state's dual demonstration program.

- Texas. In March 2015, we began operating under an expanded STAR+PLUS contract with the Texas Health and Human Services Commission (HHSC) to include nursing facility benefits.

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In March 2015, we also began operating under a new contract with the Texas HHSC and the Centers for Medicare and Medicaid Services to serve dual-eligible members in three counties as part of the state's dual demonstration program.

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

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

- We expect to realize benefits from the Health Net acquisition completed on March 24, 2016.

- We expect to realize the full year benefit in 2016 of business commenced during 2015 in Arizona, Florida, Indiana, Louisiana, Michigan, Mississippi, Oregon, South Carolina, Texas and Vermont as discussed above.

- In July 2016, it was announced that the Department of Defense awarded our wholly-owned subsidiary, Health Net Federal Services, the TRICARE West Region contract. We will continue to operate in the TRICARE North Region until the middle of 2017, when we expect to start health care delivery for the West Region.

- In July 2016, our subsidiary, Centurion of Mississippi, LLC, began operating under a new three-year contract to provide healthcare services to the MDOC.

- In July 2016, our Louisiana subsidiary, Louisiana Healthcare Connections, began serving Medicaid expansion members pursuant to an executive order, signed by the governor of Louisiana, to expand Medicaid coverage under the Affordable Care Act.

- In June 2016, our Indiana subsidiary, Managed Health Services, was selected by the Indiana Family & Social Services Administration to begin contract negotiations to provide risk-based managed care services for enrollees in the Healthy Indiana Plan and Hoosier Healthwise programs. This new contract is expected to commence on January 1, 2017.

- In May 2016, our specialty solutions division, Envolve, Inc. was selected by Maryland Care Inc. d/b/a Maryland Physicians Care MCO to provide health plan management services for its Medicaid operations in Maryland effective July 1, 2017.

- In April 2016, our Pennsylvania subsidiary, Pennsylvania Health & Wellness, was selected by the Pennsylvania Department of Human Services to service Medicaid recipients enrolled in the HealthChoices program in three zones. In July 2016, the Commonwealth reissued the request for proposal with an anticipated commencement of April 2017.

- In April 2016, our Nebraska subsidiary, Nebraska Total Care, executed a contract with the Nebraska Department of Health and Human Services' Division of Medicaid and Long-Term Care as one of three managed care organizations to administer its new Heritage Health Program for Medicaid, ABD and CHIP enrollees. The contract is expected to commence in the first quarter of 2017, pending regulatory approval.

- In October 2015, our subsidiary, Superior HealthPlan, Inc., was awarded a contract by the Texas HHSC to serve seven delivery areas for STAR Kids Medicaid recipients, more than any other successful bidder. The new contract is expected to commence on November 1, 2016.

- In September 2015, our subsidiary, Peach State Health Plan, was one of the Care Management Organizations selected to serve Medicaid recipients enrolled in the Georgia Families, PeachCare for Kids and Planning for Healthy Babies

programs. The expiration of the current contract was extended for one year and expires June 30, 2017.

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MEMBERSHIP

From June 30, 2015 to June 30, 2016, we increased our managed care membership by 6.8 million, or 148%. The following table sets forth the Company's membership by state for its managed care organizations:

	June 30, 2016	December 31, 2015	June 30, 2015
Arizona	597,700	440,900	210,900
Arkansas	52,800	41,900	45,400
California	3,097,600	186,000	178,700
Florida	726,200	510,400	470,300
Georgia	493,300	408,600	405,000
Illinois	234,700	207,500	209,100
Indiana	291,000	282,100	250,400
Kansas	144,800	141,000	143,000
Louisiana	375,300	381,900	358,900
Massachusetts	47,100	61,500	61,500
Michigan	2,200	4,800	2,700
Minnesota	9,500	9,600	10,900
Mississippi	323,800	302,200	250,600
Missouri	102,900	95,100	82,600
New Hampshire	79,700	71,400	70,800
New Mexico	7,100	—	—
Ohio	319,000	302,700	287,100
Oregon	221,500	98,700	—
South Carolina	113,700	104,000	112,600
Tennessee	20,800	20,000	21,400
Texas	1,037,000	983,100	969,700
Vermont	1,600	1,700	2,800
Washington	239,700	209,400	214,100
Wisconsin	76,100	77,100	78,600
Total at-risk membership	8,615,100	4,941,600	4,437,100
TRICARE eligibles	2,815,700	—	—
Non-risk membership	—	166,300	176,600
Total	11,430,800	5,107,900	4,613,700

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

	June 30, 2016	December 31, 2015	June 30, 2015
Medicaid:			
TANF, CHIP & Foster Care	5,541,200	3,763,400	3,536,000
ABD & LTC	757,500	478,600	454,000
Behavioral Health	455,800	456,800	203,900
Commercial	1,423,400	146,100	167,400
Medicare & Duals	300,700	37,400	28,200
Correctional	136,500	59,300	47,600
Total at-risk membership	8,615,100	4,941,600	4,437,100
TRICARE eligibles	2,815,700	—	—
Non-risk membership	—	166,300	176,600
Total	11,430,800	5,107,900	4,613,700

At June 30, 2016, the Company served 1,004,200 members in Medicaid expansion programs in nine states and 363,600 dual-eligible members, compared to 368,900 members in Medicaid expansion programs in seven states and 187,400 dual-eligible members at June 30, 2015, included in the table above. At June 30, 2016, the Company served 617,700 members in Health Insurance Marketplaces, compared to 167,400 at June 30, 2015.

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RESULTS OF OPERATIONS

The following discussion and analysis is based on our Consolidated Statements of Operations, which reflect our results of operations for the three and six months ended June 30, 2016 and 2015, prepared in accordance with generally accepted accounting principles in the United States.

Summarized comparative financial data for the three and six months ended June 30, 2016 and 2015 is as follows ($ in millions, except per share data):

	Three Months Ended June 30,			Six Months Ended June 30,		
	2016	2015	% Change 2015-2016	2016	2015	% Change 2015-2016
Premium	$9,688	$4,692	106 %	$15,674	$8,991	74 %
Service	588	492	20 %	1,013	954	6 %
Premium and service revenues	10,276	5,184	98 %	16,687	9,945	68 %
Premium tax and health insurer fee	621	322	93 %	1,163	692	68 %
Total revenues	10,897	5,506	98 %	17,850	10,637	68 %
Medical costs	8,385	4,181	101 %	13,696	8,042	70 %
Cost of services	515	419	23 %	882	821	7 %
General and administrative expenses	949	437	117 %	1,671	833	101 %
Amortization of acquired intangible assets	43	5	n.m.	52	12	333 %
Premium tax expense	498	239	108 %	948	520	82 %
Health insurer fee expense	130	52	150 %	204	107	91 %
Earnings from operations	377	173	118 %	397	302	31 %
Other income (expense), net	(20)	(1)	n.m.	(38)	(2)	n.m.
Earnings from continuing operations, before income tax expense	357	172	108 %	359	300	20 %
Income tax expense	188	84	124 %	205	147	39 %
Earnings from continuing operations, net of income tax expense	169	88	92 %	154	153	1 %
Discontinued operations, net of income tax benefit	(1)	—	n.m.	(2)	(1)	(100)%
Net earnings	168	88	91 %	152	152	— %
(Earnings) loss attributable to noncontrolling interests	1	—	n.m.	—	(1)	100 %
Net earnings attributable to Centene Corporation	$169	$88	92 %	$152	$151	1 %
Amounts attributable to Centene Corporation common shareholders:						
Earnings from continuing operations, net of income tax expense	$170	$88	93 %	$154	$152	1 %
Discontinued operations, net of income tax benefit	(1)	—	n.m.	(2)	(1)	(100)%
Net earnings	$169	$88	92 %	$152	$151	1 %
Diluted earnings (loss) per common share attributable to Centene Corporation:						
Continuing operations	$0.98	$0.72	36 %	$1.02	$1.24	(18)%
Discontinued operations	(0.01)	—	n.m.	(0.01)	(0.01)	— %
Total diluted earnings per common share	$0.97	$0.72	35 %	$1.01	$1.23	(18)%

n.m.: not meaningful

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Revenues and Revenue Recognition

Our health plans generate revenues primarily from premiums we receive from the states in which we operate. We generally receive a fixed premium per member per month pursuant to our state contracts. We generally receive premium payments and recognize premium revenue during the month in which we are obligated to provide services to our members. In some instances, our base premiums are subject to an adjustment, or risk score, based on the acuity of our membership. Generally, the risk score is determined by the state analyzing submissions of processed claims data to determine the acuity of our membership relative to the entire state's membership. Some contracts allow for additional premiums associated with certain supplemental services provided such as maternity deliveries.

Our contracts with states may require us to maintain a minimum health benefits ratio or may require us to share profits in excess of certain levels. In certain circumstances, our plans may be required to return premium to the state in the event profits exceed established levels. We recognize reductions in revenue in the current period for these programs. Other states may require us to meet certain performance and quality metrics in order to receive additional or full contractual revenue. For performance-based contracts, we do not recognize revenue subject to refund until data is sufficient to measure performance.

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

Our specialty services generate revenues under contracts with state and federal programs, healthcare organizations, and other commercial organizations, as well as from our own subsidiaries. Revenues are recognized when the related services are provided or as ratably earned over the covered period of services. The Company recognizes revenue related to administrative services under its government-sponsored managed care support contract with the DoD under the TRICARE program in the North Region (T-3 contract) on a straight-line basis over the option period, when the fees become fixed and determinable. The T-3 contract includes various performance-based incentives and penalties. For each of the incentives or penalties, the Company adjusts revenue accordingly based on the amount that it has earned or incurred at each interim date and are legally entitled to in the event of a contract termination.

In addition to the beneficiaries under the T-3 contract, we also provide behavioral health services to military families under the DoD sponsored Military and Family Life Counseling (MFLC) program and provide services to the VA under the Veteran's Choice and Patient Centered Community Care program (PC3/Choice) through our acquisition of Health Net. The PC3/Choice program provides eligible veterans coordinated, timely access to care through a comprehensive network of non-VA providers who meet VA quality standards when a local VA medical center cannot readily provide the care.

Some states enact premium taxes, similar assessments and provider and hospital pass-through payments, collectively, premium taxes, and these premium taxes are recorded as a component of revenues as well as operating expenses. Additionally, our insurance subsidiaries are subject to the Affordable Care Act annual health insurer fee (HIF). If we are able to negotiate reimbursement of portions of these premium taxes or the HIF, we recognize revenue associated with the HIF on a straight-line basis when we have binding agreements for such reimbursements, including the “gross-up” to reflect the HIFs non-tax deductible nature. We exclude both revenue and expenses associated with the HIF and premium taxes from our key ratios as we believe they are a pass-through of costs and not indicative of our operating performance. Collectively, this revenue is recorded as premium tax and health insurer fee revenue in the Consolidated Statements of Operations.

The Centers for Medicare and Medicaid Services (CMS) deploys a risk adjustment model that retroactively apportions Medicare premiums paid according to health severity and certain demographic factors. The model pays more for members whose medical history indicates they have certain medical conditions. Under this risk adjustment methodology, CMS calculates the risk adjusted premium payment using diagnosis data from hospital inpatient, hospital outpatient, physician treatment settings as well as prescription drug events. The Company estimates the amount of risk adjustment based upon the diagnosis and pharmacy data submitted and expected to be submitted to CMS and records revenues on a risk adjusted basis. Our Health Net acquisition expands our contracts with CMS to include Medicare Advantage products. In addition, with the Health Net acquisition, we now have Medicare Advantage Plus Prescription Drug (MAPD) plans that cover both prescription drugs (Part D) and medical care. The Part D benefit consists of pharmacy benefits for Medicare beneficiaries. We provide prescription drug benefits as part of our Medicare Advantage and dual eligible offerings.

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Premium and service revenues collected in advance are recorded as unearned revenue. Premium and service revenues due to us are recorded as premium and related receivables and are recorded net of an allowance based on historical trends and our management's judgment of the collectibility of these accounts. As we generally receive payments during the month in which services are provided, the allowance is typically not significant in comparison to total revenues and does not have a material impact on the presentation of our financial condition or results of operations.

Operating Expenses

Medical Costs

Medical costs include payments to physicians, hospitals, and other providers for healthcare and specialty services claims. Medical costs also include estimates of medical expenses incurred but not yet reported, or IBNR, and estimates of the cost to process unpaid claims. We use our judgment to determine the assumptions to be used in the calculation of the required IBNR estimate. The assumptions we consider include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, healthcare service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims.

Our development of the IBNR estimate is a continuous process which we monitor and refine on a monthly basis as claims receipts and payment information becomes available. As more complete information becomes available, we adjust the amount of the estimate, and include the changes in estimates in medical expense in the period in which the changes are identified.

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

While we believe our IBNR estimate is appropriate, it is possible future events could require us to make significant adjustments for revisions to these estimates. Accordingly, we cannot assure you that medical costs will not materially differ from our estimates.

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

Cost of Services

Cost of services expense includes the pharmaceutical costs associated with our pharmacy benefit manager and specialty pharmacy's external revenues and certain direct costs to support the functions responsible for generation of our service revenues. These expenses consist of the salaries and wages of the professionals who provide the services and associated expenses. Health care costs associated with Part D of our MAPD plans are recognized as the costs and expenses are incurred.

General and Administrative Expenses

General and administrative expenses, or G&A, primarily reflect wages and benefits, including stock compensation expense, and other administrative costs associated with our health plans, specialty companies and centralized functions that support all of our business units. Our major centralized functions are finance, information systems and claims processing. G&A expenses also include business expansion costs, such as wages and benefits for administrative personnel, contracting costs, and information technology buildouts, incurred prior to the commencement of a new contract or health plan.

The G&A expense ratio represents G&A expenses as a percentage of premium and service revenues, and reflects the relationship between revenues earned and the costs necessary to earn those revenues.

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Health Insurer Fee

The HIF reflects our pro rata share of the annual fee mandated by the ACA to health insurers. The fee is determined based on our premium revenues in the previous year. Each health insurer's fee is calculated by multiplying its market share by the annual fee. Market share is based on commercial, Medicare, and Medicaid premium revenue.

Other Income (Expense)

Other income (expense) consists principally of investment income from cash and investments, earnings in equity method investments, and interest expense on debt.

Discontinued Operations

Our subsidiary, Kentucky Spirit Health Plan (KSHP), ceased serving Medicaid members in Kentucky as of July 6, 2013. Accordingly, the results of operations for KSHP are classified as discontinued operations for all periods presented in our consolidated financial statements. The following discussion and analysis is presented primarily in the context of continuing operations unless otherwise identified.

Three Months Ended June 30, 2016 Compared to Three Months Ended June 30, 2015

Total Revenues

Total revenues increased 98% in the three months ended June 30, 2016 over the corresponding period in 2015 primarily as a result of the acquisition of Health Net as well as the impact from expansions, acquisitions or new programs in many of our states in 2015.

Operating Expenses

Medical Costs

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

The HBR for the three months ended June 30, 2016 was 86.6%, compared to 89.1% in the same period in 2015. The decrease compared to last year is primarily attributable to the acquisition of Health Net, which operates at a lower HBR due to a higher mix of commercial and Medicare business.

Cost of Services

Cost of services increased by $96 million in the three months ended June 30, 2016, compared to the corresponding period in 2015. This was primarily due to the acquisition of Health Net, partially offset by lower specialty pharmacy volumes for Hepatitis C treatments. The cost of service ratio for the three months ended June 30, 2016, was 87.6%, compared to 85.2% in the same period in 2015.

General & Administrative Expenses

General and administrative expenses, or G&A, increased by $512 million in the three months ended June 30, 2016, compared to the corresponding period in 2015. This was primarily due to the acquisition of Health Net.

The G&A expense ratio was 9.2%, or 9.0% excluding Health Net acquisition related expenses for the second quarter of 2016, compared to 8.4% in the second quarter of 2015. The increase in the G&A expense ratio is primarily attributable to the addition of the Health Net business.

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Other Income (Expense)

The following table summarizes the components of other income (expense) for the three months ended June 30, ($ in millions):

	2016	2015
Investment and other income	$32	$10
Interest expense	(52)	(11)
Other income (expense), net	$(20)	$(1)

The increase in investment income in 2016 reflects an increase in investment balances over 2015. Interest expense increased in 2016 compared to 2015, primarily reflecting the issuance of an additional $2.4 billion in Senior Notes in February 2016 in connection with the financing of the Health Net transaction, the issuance of an additional $500 million in Senior Notes in June 2016, and the assumption of Health Net's $400 million in Senior Notes.

Income Tax Expense

Our effective tax rate for the three months ended June 30, 2016 and 2015, was 52.7% and 48.8%, respectively. The effective tax rate is higher than the applicable statutory rate primarily as a result of the non-deductibility of the HIF.

Segment Results

The following table summarizes our consolidated operating results by segment for the three months ended June 30, ($ in millions):

	2016	2015	% Change 2015-2016
Total Revenues			
Managed Care	$10,128	$4,993	103 %
Specialty Services	2,234	1,715	30 %
Eliminations	(1,465)	(1,202)	(22)%
Consolidated Total	$10,897	$5,506	98 %
Earnings from Operations			
Managed Care	$336	$125	169 %
Specialty Services	41	48	(15)%
Consolidated Total	$377	$173	118 %

Managed Care

The Managed Care segment consists of Centene’s health plans including all of the functions needed to operate them. Subsequent to the closing of the Health Net acquisition, the Managed Care segment also includes the operations previously included in Health Net's Western Region Operations Segment, with the exception of certain operations of its pharmaceutical services and behavioral health subsidiaries. The portions of Health Net's Western Region Operations segment included in the Managed Care segment consist of the following Health Net operations: commercial, Medicare, Medicaid and dual eligible health plans, primarily in Arizona, California, Oregon and Washington.

Total revenues increased 103% in the three months ended June 30, 2016, primarily as a result of the acquisition of Health Net, as well as expansions, new programs or growth in many of our states, particularly Florida, Louisiana, Mississippi, Oregon, Texas, and Washington. Earnings from operations increased $211 million between years primarily reflecting the acquisition of Health Net and growth in the business.

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Specialty Services

The Specialty Services segment consists of Centene's specialty companies offering auxiliary healthcare services and products. Subsequent to the closing of the Health Net acquisition, the Specialty Services segment also includes the operations previously included in the Government Contracts segment of Health Net as well as certain operations of its pharmaceutical services and behavioral health subsidiaries, the latter of which Health Net previously included in its Western Region Operations segment. The Government Contracts business includes the Company's government-sponsored managed care support contract with the DoD under the TRICARE program in the North Region, the MFLC contract with the DoD, and other health care related government contracts, including PC3/Choice with the VA.

Total revenues increased 30% in the three months ended June 30, 2016, resulting primarily from the acquisition of Health Net, growth in our behavioral health business, increased services associated with membership growth in the Managed Care segment, and growth in our correctional services business. Earnings from operations decreased $7 million in the three months ended June 30, 2016, primarily due to lower earnings in our home health business partially offset by an increase in earnings due to the Health Net acquisition.

Six Months Ended June 30, 2016 Compared to Six Months Ended June 30, 2015

Total Revenues

Total revenues increased 68% in the six months ended June 30, 2016 over the corresponding period in 2015 primarily as a result of the acquisition of Health Net, as well as the impact from expansions, acquisitions or new programs in many of our states in 2015. During the six months ended June 30, 2016, we received premium rate adjustments which yielded a net 1% composite change across all of our markets.

Operating Expenses

Medical Costs

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

The HBR for the six months ended June 30, 2016, was 87.4%, compared to 89.4% in the same period in 2015. The decrease compared to last year is primarily attributable to the acquisition of Health Net (which operates at a lower HBR due to a higher mix of commercial and Medicare business) and membership growth in Medicaid expansion and Health Insurance Marketplace, which all operate at a lower HBR, as well as improvement in medical expense in the higher acuity populations.

Cost of Services

Cost of services increased by $61 million in the six months ended June 30, 2016, compared to the corresponding period in 2015. This was primarily due to the acquisition of Health Net, partially offset by lower specialty pharmacy volumes for Hepatitis C treatments. The cost of service ratio for the six months ended June 30, 2016, was 87.1%, compared to 86.1% in the same period in 2015.

General & Administrative Expenses

G&A increased by $838 million in the six months ended June 30, 2016, compared to the corresponding period in 2015. This was primarily due to the acquisition of Health Net, acquisition related expenses, and restructuring and integration costs. During the six months ended June 30, 2016, we recorded approximately $214 million of Health Net acquisition related expenses, which reduced our diluted earnings per share by $0.89.

The consolidated G&A expense ratio for the six months ended June 30, 2016 was 10.0%, or 8.7% excluding Health Net acquisition related expenses, compared to 8.4% for the six months ended June 30, 2015.

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Other Income (Expense)

The following table summarizes the components of other income (expense) for the six months ended June 30, ($ in millions):

	2016	2015
Investment and other income	$47	$19
Interest expense	(85)	(21)
Other income (expense), net	$(38)	$(2)

The increase in investment income in 2016 reflects an increase in investment balances over 2015. Interest expense increased during the six months ended June 30, 2016 by $64 million primarily reflecting the issuance of an additional $2.4 billion in Senior Notes in February 2016 in connection with the financing of the Health Net transaction, the issuance of an additional $500 million in Senior Notes in June 2016, and the assumption of Health Net's $400 million in Senior Notes.

Income Tax Expense

Our effective tax rate for the six months ended June 30, 2016 and 2015, was 57.1% and 49.0%, respectively. The effective tax rate is higher than the applicable statutory rate primarily as a result of the non-deductibility of the HIF as well as the non-deductibility of certain acquisition related costs incurred in connection with the closing of our acquisition of Health Net.

Segment Results

The following table summarizes our consolidated operating results by segment for the six months ended June 30, ($ in millions):

	2016	2015	% Change 2015-2016
Total Revenues			
Managed Care	$16,517	$9,629	72%
Specialty Services	4,280	3,309	29%
Eliminations	(2,947)	(2,301)	(28)%
Consolidated Total	$17,850	$10,637	68%
Earnings from Operations			
Managed Care	$314	$220	43%
Specialty Services	83	82	1%
Consolidated Total	$397	$302	31%

Managed Care

Total revenues increased 72% in the six months ended June 30, 2016, primarily as a result of the acquisition of Health Net and expansions or new programs in many of our states, particularly Florida, Louisiana, Mississippi, Oregon, Texas, and Washington. Earnings from operations increased $94 million between years primarily reflecting the acquisition of Health Net and growth in the business.

Specialty Services

Total revenues increased 29% in the six months ended June 30, 2016, resulting primarily from the acquisition of Health Net, growth in our behavioral health business, increased services associated with membership growth in the Managed Care segment, and growth in our correctional services business. Earnings from operations increased $1 million in the six months ended June 30, 2016, representing an increase in earnings due to the acquisition of Health Net, partially offset by lower earnings in our home health business.

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LIQUIDITY AND CAPITAL RESOURCES

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

	Six Months Ended June 30,	
	2016	2015
Net cash (used in) provided by operating activities	$(225)	$395
Net cash used in investing activities	(1,319)	(299)
Net cash provided by financing activities	2,494	261
Net increase in cash and cash equivalents	$950	$357

Cash Flows (Used in) Provided by Operating Activities

Normal operations are funded primarily through operating cash flows and borrowings under our revolving credit facility. Operating activities used cash of $225 million in the six months ended June 30, 2016, compared to cash provided of $395 million in the comparable period in 2015. The cash used in operating activities in 2016 reflects an increase in premium and related receivables of approximately $600 million due to the timing of June capitation payments from several of our states (substantially all of which has been collected in July).

Cash flows provided by operations in 2015 was primarily related to an increase in medical claims liabilities resulting from the growth in the business and an increase in other long term liabilities, partially offset by increases in premium and related receivables.

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

The reimbursement of the HIF from our state customers may be settled as a separate payment or monthly in combination with our other premium payments. The vast majority of our state customers are settling the reimbursement through a separate payment after verification of each state's portion of our HIF, resulting in an increase in premium and related receivables at June 30, 2016. The table below details the impact to cash flows from operations from the timing of payments from our states ($ in millions).

	Six Months Ended June 30,	
	2016	2015
Increase in premium and related receivables	$(1,121)	$(341)
Decrease in unearned revenue	(50)	(102)
Net decrease in operating cash flow	$(1,171)	$(443)

Cash Flows Used in Investing Activities

Investing activities used cash of $1,319 million for the six months ended June 30, 2016, and $299 million in the comparable period in 2015. Cash flows used in investing activities in 2016 primarily consisted of our acquisition of Health Net, net additions to the investment portfolio of our regulated subsidiaries, including transfers from cash and

cash equivalents to long term investments, and capital expenditures.

In March 2016, we completed the acquisition of Health Net for approximately $5,986 million, including the assumption of $703 million of debt. The total consideration for the acquisition was $5,283 million, consisting of Centene common shares valued at $3,038 million, $2,243 million in cash, and $2 million related to the fair value adjustment to stock based compensation associated with pre-combination service.

We spent $94 million and $58 million in the six months ended June 30, 2016 and 2015, respectively, on capital expenditures for system enhancements and market expansions.

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As of June 30, 2016, our investment portfolio consisted primarily of fixed-income securities with an average duration of 3.3 years. We had unregulated cash and investments of $196 million at June 30, 2016, compared to $78 million at December 31, 2015.

Cash Flows Provided by Financing Activities

Our financing activities provided cash of $2,494 million in the six months ended June 30, 2016, compared to $261 million in the comparable period in 2015. During 2016, our financing activities primarily related to the proceeds from the issuance of Senior Notes in February 2016 associated with the Health Net acquisition and the issuance of additional Senior Notes in June 2016, partially offset by the repayment of debt.

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

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

In June 2016, we issued an additional $500 million of 4.75% Senior Notes due 2022 at a premium to yield 4.41% ($500 Million Add-on Notes). The $500 Million Add-on Notes were offered as additional debt securities under the indenture governing the $500 million of 4.75% Senior Notes issued April 2014. We used the net proceeds of the offering to repay amounts outstanding under our Revolving Credit Facility and to pay offering related fees and expenses.

During 2015, our financing activities primarily related to the proceeds from the issuance of senior debt and increased borrowings on our revolving credit agreement. In January 2015, we issued an additional $200 million of 4.75% Senior Notes at par. In connection with the January 2015 issuance, we entered into interest rate swap agreements for a notional amount of $200 million.

Liquidity Metrics

The credit agreement underlying our Revolving Credit Facility contains non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios and maximum debt-to-EBITDA ratios. We are required to not exceed a maximum debt-to-EBITDA ratio of 3.5 to 1.0 prior to December 31, 2016 and 3.0 to 1.0 on and subsequent to December 31, 2016. As of June 30, 2016, we had $185 million in borrowings outstanding under our revolving credit facility, and we were in compliance with all covenants. As of June 30, 2016, there were no limitations on the availability under the revolving credit agreement as a result of the debt-to-EBITDA ratio.

We had outstanding letters of credit of $43 million as of June 30, 2016, which were not part of our revolving credit facility. We also had letters of credit for $51 million (valued at the June 30, 2016 conversion rate), or €46 million,

representing our proportional share of the letters of credit issued to support Ribera Salud's outstanding debt which are a part of the revolving credit facility. Collectively, the letters of credit bore weighted interest of 1.51% as of June 30, 2016. In addition, we had outstanding surety bonds of $363 million as of June 30, 2016.

The indentures governing the $425 million notes due 2017, the $1,400 Million Notes, the $1,000 million notes due 2022, and the $1,000 Million Notes contain non-financial and financial covenants of Centene Corporation, including requirements of a minimum fixed charge coverage ratio. The indentures governing the $400 million notes due 2017 contain non-financial and financial covenants of Health Net, Inc., including requirements of a minimum fixed charge coverage ratio.

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At June 30, 2016, we had working capital, defined as current assets less current liabilities, of negative $961 million, compared to negative $24 million at December 31, 2015. The negative balance at June 30, 2016 is primarily due to the current portion of long term debt. We manage our short term and long term investments with the goal of ensuring that a sufficient portion is held in investments that are highly liquid and can be sold to fund short term requirements as needed.

At June 30, 2016, our debt to capital ratio, defined as total debt divided by the sum of total debt and total equity, was 44.8%, compared to 36.0% at December 31, 2015. Excluding the $66 million non-recourse mortgage note, our debt to capital ratio was 44.4% as of June 30, 2016, compared to 34.7% at December 31, 2015. We utilize the debt to capital ratio as a measure, among others, of our leverage and financial flexibility.

2016 Expectations

During the remainder of 2016, we expect to make net capital contributions to our insurance subsidiaries of approximately $473 million associated with our growth and spend approximately $256 million in additional capital expenditures primarily associated with system enhancements and market expansions. These amounts are expected to be funded by unregulated cash flow generation in 2016 and borrowings on our Revolving Credit Facility.

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

CONTRACTUAL OBLIGATIONS

The following table summarizes future contractual obligations. These obligations contain estimates and are subject to revision under a number of circumstances. Our debt consists of borrowings from our senior notes, Revolving Credit Facility, mortgages and capital leases. The purchase obligations consist primarily of software purchases and maintenance contracts. The contractual obligations and estimated period of payment over the next five years and beyond are as follows ($ in millions):

	Payments Due by Period				
	Total	Less Than 1 Year	1-3 Years	3-5 Years	Thereafter
Medical claims liability	$3,950	$3,950	$ —	$ —	$ —
Debt and interest	5,806	1,117	413	360	3,916
Operating lease obligations	641	123	215	161	142
Purchase obligations	586	311	272	3	—
Other long term liabilities [1]	—	—	—	—	—
Total	$10,983	$5,501	$ 900	$ 524	$ 4,058

[1] Our Consolidated Balance Sheet as of June 30, 2016, includes $1,346 million of other long term liabilities. This consists primarily of long term deferred income taxes, liabilities under our deferred compensation plan, reserves for uncertain tax positions and retirement benefit obligations. These liabilities have been excluded from the table above as the timing and/or amount of any cash payment is uncertain.

Commitments

In connection with obtaining regulatory approval of the Health Net Acquisition from the California Department of Insurance and the California Department of Managed Health Care, we committed to certain undertakings (the Undertakings). The Undertakings included, among other items, operational commitments around premiums, dividend restrictions, minimum Risk Based Capital (RBC) levels, local offices, growth, accreditation, HEDIS scores and other quality measures, network adequacy, certifications, investments and capital expenditures. Specifically, we agreed to, among other things:

- invest an additional $30 million through the California Organized Investment Network over the five years following completion of the acquisition;
- build a service center in an economically distressed community in California, investing $200 million over ten years and employing at least 300 people;

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- contribute $65 million to improve enrollee health outcomes ($10 million over ten years), support locally-based consumer assistance programs ($5 million over five years) and strengthen the health care delivery system ($50 million over five years), (of which, the present value of $62 million was expensed in the six months ended June 30, 2016 and classified as general and administrative expenses in the Consolidated Statements of Operations); and
- invest $75 million of its investment portfolio in vehicles supporting California's health care infrastructure.

REGULATORY CAPITAL AND DIVIDEND RESTRICTIONS

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

Our regulated subsidiaries are required to maintain minimum capital requirements prescribed by various regulatory authorities in each of the states in which we operate. As of June 30, 2016, our subsidiaries had aggregate statutory capital and surplus of $3,694 million, compared with the required minimum aggregate statutory capital and surplus requirements of $2,210 million. During the six months ended June 30, 2016, we contributed net $152 million of statutory capital to our subsidiaries. For our subsidiaries that file with the National Association of Insurance Commissioners (NAIC), we estimate our RBC percentage (including KSHP) to be in excess of 350% of the Authorized Control Level (excluding the interim impact of the health insurer fee).

The NAIC has adopted rules which set minimum risk based capital requirements for insurance companies, managed care organizations and other entities bearing risk for healthcare coverage. As of June 30, 2016, each of our health plans was in compliance with the risk-based capital requirements enacted in those states.

RECENT ACCOUNTING PRONOUNCEMENTS

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

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ITEM 3. Quantitative and Qualitative Disclosures About Market Risk.

INVESTMENTS AND DEBT

As of June 30, 2016, we had short term investments of $443 million and long term investments of $4,367 million, including restricted deposits of $137 million. The short term investments generally consist of highly liquid securities with maturities between three and 12 months. The long term investments consist of municipal, corporate and U.S. Treasury securities, government sponsored obligations, life insurance contracts, asset-backed securities and equity securities and have maturities greater than one year. Restricted deposits consist of investments required by various state statutes to be deposited or pledged to state agencies. Due to the nature of the states' requirements, these investments are classified as long term regardless of the contractual maturity date. Substantially all of our investments are subject to interest rate risk and will decrease in value if market rates increase. Assuming a hypothetical and immediate 1% increase in market interest rates at June 30, 2016, the fair value of our fixed income investments would decrease by approximately $143 million. Declines in interest rates over time will reduce our investment income.

We have interest rate swap agreements for a notional amount of $2,350 million with creditworthy financial institutions to manage the impact of market interest rates on interest expense. Our swap agreements convert a portion of our interest expense from fixed to variable rates to better match the impact of changes in market rates on our variable rate cash equivalent investments. As a result, the fair value of $2,350 million of our long term debt varies with market interest rates. Assuming a hypothetical and immediate 1% increase in market interest rates at June 30, 2016, the fair value of our debt would decrease by approximately $116 million. An increase in interest rates decreases the fair value of the debt and conversely, a decrease in interest rates increases the value.

For a discussion of the interest rate risk that our investments are subject to, see Part II, Item 1A. "Risk Factors–Risks Related to Our Business–Our investment portfolio may suffer losses from reductions in market interest rates and changes in market conditions which could materially and adversely affect our results of operations or liquidity."

INFLATION

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

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

ITEM 4. Controls and Procedures.

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

principal financial officer, as appropriate to allow timely decisions regarding required disclosure.

In connection with the filing of this Form 10-Q, management evaluated, under the supervision and with the participation of our Chief Executive Officer and Chief Financial Officer, the effectiveness of the design and operation of our disclosure controls and procedures as of June 30, 2016. Based upon that evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective at the reasonable assurance level as of June 30, 2016.

Changes in Internal Control Over Financial Reporting - No change in our internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act) occurred during the quarter ended June 30, 2016 that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

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On March 24, 2016, we acquired Health Net, Inc. Management is currently in the process of evaluating the internal controls and procedures of Health Net and plans to integrate Health Net's internal controls over financial reporting with our existing internal controls over financial reporting. This integration may lead to changes in the internal controls over financial reporting for us or the acquired Health Net business in future periods. Management expects the integration process to be completed during 2016.

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PART II
OTHER INFORMATION

ITEM 1. Legal Proceedings.

A description of the legal proceedings to which the Company and its subsidiaries are a party is contained in Note 11 to the consolidated financial statements included in Part I of this Quarterly Report on Form 10-Q, and is incorporated herein by reference.

ITEM 1A. Risk Factors.

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

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

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

The majority of our revenues come from government subsidized healthcare programs including Medicaid, Medicare, TRICARE, VA, CHIP, LTC, ABD, Foster Care and Health Insurance Marketplace premiums. Under most programs, the base premium rate paid for each program differs, depending on a combination of factors such as defined upper payment limits, a member’s health status, age, gender, county or region and benefit mix. Since Medicaid was created in 1965, the federal government and the states have shared the costs for this program, with the federal share currently averaging around 57%.

Future levels of funding and premium rates may be affected by continuing government efforts to contain healthcare costs and may further be affected by state and federal budgetary constraints. Governments periodically consider reducing or reallocating the amount of money they spend for Medicaid, Medicare, TRICARE, VA, CHIP, LTC, ABD and Foster Care. Furthermore, Medicare remains subject to the automatic spending reductions imposed by the Budget Control Act of 2011 and the American Taxpayer Relief Act of 2012 (“sequestration”), subject to a 2% cap. In addition, reductions in defense spending could have an adverse impact on certain government programs in which we currently participate by, among other things, terminating or materially changing such programs, or by decreasing or delaying payments made under such programs. Adverse economic conditions may continue to put pressures on state budgets as tax and other state revenues decrease while the population that is eligible to participate in these programs increases, creating more need for funding. We anticipate this will require government agencies to find funding alternatives, which may result in reductions in funding for programs, contraction of covered benefits, and limited or no premium rate increases or premium rate decreases. A reduction (or less than expected increase), a protracted delay, or a change in allocation methodology in government funding for these programs, as well as termination of the contract for the convenience of the government, may materially and adversely affect our results of operations, financial position and cash flows.

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

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Further, we are also exposed to other risks associated with U.S. and state government contracting or participating in programs involving a government payor, including but not limited to the general ability of the federal and/or state government to terminate contracts with it, in whole or in part, without prior notice, for convenience or for default based on performance; potential regulatory or legislative action that may materially modify amounts owed; and our dependence upon Congressional or legislative appropriation and allotment of funds and the impact that delays in government payments could have on our operating cash flow and liquidity. There can be no assurance that we will avoid payment delays from government payors in the future, which, if extended for any significant period of time, could have a material adverse effect on our results of operations, financial position, cash flows or liquidity. In addition, delays in obtaining, or failure to obtain or maintain, governmental approvals, or moratoria imposed by regulatory authorities, could adversely affect our revenue or membership, increase costs or adversely affect our ability to bring new products to market as forecasted. Other changes to our government programs could affect our willingness or ability to participate in these programs or otherwise have a material adverse effect on our business, financial condition or results of operations.

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

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

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

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

Our profitability, to a significant degree, depends on our ability to estimate and effectively manage expenses related to health benefits through our ability to contract favorably with hospitals, physicians and other healthcare providers. For example, our Medicaid revenue is often based on bids submitted before the start of the initial contract year. If our actual medical expense exceeds our estimates, our HBR, or our expenses related to medical services as a percentage of premium revenue, would increase and our profits would decline. Because of the narrow margins of our health plan business, relatively small changes in our health benefits ratio can create significant changes in our financial results. Changes in healthcare regulations and practices, the level of utilization of healthcare services, hospital and pharmaceutical costs, major epidemics or pandemics, new medical technologies, pharmaceutical compounds, increases in provider fraud and other external factors, including general economic conditions such as inflation and unemployment levels, are generally beyond our control and could reduce our ability to accurately predict and effectively control the costs of providing health benefits.

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

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Additionally, when we commence operations in a new state, region or product, we have limited information with which to estimate our medical claims liability. For a period of time after the inception of the new business, we base our estimates on state-provided historical actuarial data and limited actual incurred and received claims and inpatient acuity information. The addition of new categories of individuals who are eligible under new legislation may pose the same difficulty in estimating our medical claims liability. Similarly, we may face difficulty in estimating our medical claims liability in 2016 for the relatively new and evolving Health Insurance Marketplaces.

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

The implementation of the Health Reform Legislation and other reforms could materially and adversely affect our results of operations, financial position and cash flows.

In March 2010, the Patient Protection and Affordable Care Act and the accompanying Health Care and Education Affordability Reconciliation Act, collectively referred to as the Affordable Care Act (ACA), were enacted. While the constitutionality of the ACA was generally upheld by the Supreme Court in 2012, the Court determined that states could elect to opt out of the Medicaid expansion portion of ACA without losing all federal money for their existing Medicaid programs.

Under the ACA, Medicaid coverage was expanded to all individuals under age 65 with incomes up to 138% of the federal poverty level beginning January 1, 2014, subject to each states' election. The federal government will pay the entire costs for Medicaid coverage for newly eligible beneficiaries for three years (2014 through 2016). Beginning in 2017, the federal share begins to decline, ending at 90% for 2020 and subsequent years. As of June 30, 2016, 31 states and the District of Columbia have expanded Medicaid eligibility, and additional states continue to discuss expansion. The ACA also maintained CHIP eligibility standards through September 2019.

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

Any failure to adequately price products offered in the Health Insurance Marketplaces may have a negative impact on our results of operations, financial position and cash flow. Among other things, we may be adversely selected by individuals who have a higher acuity level than the anticipated pool of participants. In addition, the risk corridor, reinsurance and risk adjustment ("three Rs") provisions of the ACA established to apportion risk amongst insurers may not be effective in appropriately mitigating the financial risks related to the Marketplace product. Further, the reinsurance and risk corridor components may not be adequately funded. Any variation from our expectations regarding acuity, enrollment levels, adverse selection, the three Rs, or other assumptions utilized in setting adequate premium rates could have a material adverse effect on our results of operations, financial position and cash flows.

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

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

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There are numerous steps required to implement the legislation, including the promulgation of a substantial number of new and potentially more onerous federal regulations. Further, legal challenges, additional legislative initiatives and various health insurance reform proposals continue to emerge at both the state and federal levels. For example, in 2015, the U.S. House of Representatives filed suit asserting that the Executive Branch violated the U.S. Constitution by making cost-sharing reduction (CSR) payments to health insurance issuers that had not been appropriated. In May 2016, a federal district court ruled that Congress did not appropriate funds for the ACA's CSR subsidies and enjoined the government from making CSR reimbursements to health insurance issuers, but stayed the ruling pending an appeal. Because of the unsettled nature of these reforms and the numerous steps still required to implement them, we cannot predict what additional requirements will be implemented at the federal or state level, or the effect that any legal challenges or future legislation or regulation will have on our business or our growth opportunities. Although we believe the legislation may provide us with significant opportunities to grow our business, the enacted reforms, as well as future regulations and legislative changes and changes resulting from legal challenges, may in fact have a material adverse effect on our business, results of operations, financial position or liquidity. If we fail to effectively implement or appropriately adjust our operational and strategic initiatives with respect to the implementation of healthcare reform, or do not do so as effectively as our competitors, our results of operations may be materially adversely affected.

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

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

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

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

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

Our contracts with states may require us to maintain a minimum health benefits ratio (HBR) or may require us to share profits in excess of certain levels. In certain circumstances, our plans may be required to return premium back to the state in the event profits exceed established levels or HBR does not meet the minimum requirement. Other states may require us to meet certain performance and quality metrics in order to maintain our contract or receive additional or full contractual revenue.

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

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

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

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

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

If any of our government contracts are terminated or are not renewed or we receive an adverse review, audit or investigation, our business will suffer.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

increase our revenue growth, pricing flexibility and control over medical cost trends may be adversely affected.

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

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

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

From time to time healthcare providers assert or threaten to assert claims seeking to terminate non-cancelable agreements due to alleged actions or inactions by us. In addition, from time to time, we may be subject to class action lawsuits by healthcare providers with respect to claim payment procedures or similar lawsuits. Regardless of whether any lawsuits brought against us are successful or have merit, they will still be time-consuming and costly and could distract our management’s attention. As a result, we may incur significant expenses and may be unable to operate our business effectively. If we are unable to retain our current provider contract terms or enter into new provider contracts timely or on favorable terms, our profitability may be harmed.

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

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

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

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

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

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

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

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

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

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

In addition, HIPAA broadened the scope of fraud and abuse laws applicable to healthcare companies. HIPAA established new enforcement mechanisms to combat fraud and abuse, including civil and, in some instances, criminal penalties for failure to comply with specific standards relating to the privacy, security and electronic transmission of protected health information. The HITECH Act expanded the scope of these provisions by mandating individual notification in instances of breaches of protected health information, providing enhanced penalties for HIPAA violations, and granting enforcement authority to states' Attorneys General in addition to the HHS Office for Civil Rights. It is possible that Congress may enact additional legislation in the future to increase penalties and to create a private right of action under HIPAA, which could entitle patients to seek monetary damages for violations of the privacy rules. In addition, HHS has announced that it will continue its audit program to assess HIPAA compliance efforts by covered entities with a focus on security risk assessments. An audit resulting in findings or allegations of noncompliance could have a material adverse effect on our results of operations, financial position and cash flows.

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Under HIPAA, health plans are required to have the capacity to accept and send all covered transactions in a standardized electronic format. Penalties can be imposed for failure to comply with these requirements. The transaction standards were modified to version 5010 prior to the implementation of the ICD-10 coding system, on October 1, 2015. While we prepared for and have completed the transition to ICD-10, if unforeseen circumstances arise, it is possible that we could be exposed to investigations and allegations of noncompliance. In addition, if some providers continue to use ICD-9 codes on claims for dates of service on or after October 1, 2015, we may have to reject such claims, which may lead to claim resubmissions, increased call volume and provider and customer dissatisfaction. Further, providers may use ICD-10 codes differently than they used ICD-9 codes in the past, which could result in higher costs and reimbursement levels, or lost revenues under risk adjustment. As a result, circumstances following the implementation of ICD-10 may have a material adverse effect on our results of operations, financial position and cash flows.

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

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

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

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

Security breaches may arise from external or internal threats. External breaches include hacking personal information for financial gain, attempting to cause harm or interruption to our operations, or intending to obtain competitive information. We experience attempted external hacking or malicious attacks on a regular basis. We maintain a rigorous system of preventive and detective controls through our security programs; however, our prevention and detection controls may not prevent or identify all such attacks on a timely basis, or at all. Internal breaches may result from inappropriate security access to confidential information by rogue employees, consultants or third party service providers. Any security breach involving the misappropriation, loss or other unauthorized disclosure or use of confidential member information, financial data, competitively sensitive information, or other proprietary data,

whether by us or a third party, could have a material adverse effect on our business reputation, financial condition, cash flows, or results of operations.

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

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

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

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

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

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

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

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

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

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

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

will depend, in part, upon management's ability to design and implement strategic initiatives that address not only the integration of two discrete companies, but also the increased scale and scope of the combined business with its associated increased costs and complexity. We will also have to manage the integration and our expanded operations in compliance with certain undertakings with regulators that were agreed to in connection with the approval of the acquisition. These undertakings require significant investments by us, may restrict or impose additional costs on our future operations and strategic initiatives in certain geographies, and subject us to various enforcement mechanisms. There can be no assurances that we will be successful in managing our expanded operations or that we will realize the expected operating efficiencies, cost savings and other benefits.

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We are significantly more leveraged today than we were prior to our acquisition of Health Net.

We incurred additional indebtedness in connection with the acquisition of Health Net. As of June 30, 2016, we had consolidated indebtedness of approximately $4,494 million, which is significantly greater than the indebtedness of Centene prior to the acquisition. This increased indebtedness and higher debt-to-equity ratio will have the effect, among other things, of reducing our flexibility to respond to changing business and economic conditions and increasing borrowing costs.

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

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

Issuer Purchases of Equity Securities
Second Quarter 2016

Period	Total Number of Shares Purchased [1]	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number of Shares that May Yet Be Purchased Under the Plans or Programs[2]
April 1 - April 30, 2016	33,025	$ 61.76	—	3,335,448
May 1 - May 31, 2016	20,177	57.74	—	3,335,448
June 1 - June 30, 2016	22,510	66.03	—	3,335,448
Total	75,712	$ 61.96	—	3,335,448

(1) Shares acquired represent shares relinquished to the Company by certain employees for payment of taxes or option cost upon vesting of restricted stock units or option exercise.

(2) Our Board of Directors adopted a stock repurchase program which allows for repurchases of up to a remaining amount of 3,335,448 shares. No duration has been placed on the repurchase program.

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ITEM 6. Exhibits.

EXHIBIT NUMBER	DESCRIPTION
4.1	Officer's Certificate, dated May 18, 2007, establishing the terms and form of the 6.375% Senior Notes due 2017 (incorporated by reference to Exhibit 4.2 to the Current Report on Form 8-K of Health Net, Inc. ("Health Net") filed with the SEC on May 18, 2007 (File No. 1-12718)).
10.1*	Form of Restricted Stock Unit Agreement for eligible employees of Health Net under the Health Net, Inc. Amended and Restated 2006 Long-Term Incentive Plan (incorporated by reference to Exhibit 10.29 to Health Net's Annual Report on Form 10-K for the year ended December 31, 2011 (File No. 1-12718)).
10.2*	Form of Performance Share Award Agreement for eligible employees of Health Net under the Health Net, Inc. Amended and Restated 2006 Long-Term Incentive Plan (incorporated by reference to Exhibit 10.25 to Health Net's Annual Report on Form 10-K for the year ended December 31, 2014 (File No. 1-12718)).
10.3*	Form of Restricted Stock Unit Agreement for eligible employees of Health Net under the Health Net, Inc. Amended and Restated 2006 Long-Term Incentive Plan (incorporated by reference to Exhibit 10.4 to Health Net's Quarterly Report on Form 10-Q for the quarter ended June 30, 2015 (File No. 1-12718)).
10.4*	Form of Restricted Stock Unit Agreement for non-employee directors of Health Net under the Health Net, Inc. Amended and Restated 2006 Long-Term Incentive Plan (incorporated by reference to Exhibit 10.3 to Health Net's Quarterly Report on Form 10-Q for the quarter ended June 30, 2015 (File No. 1-12718)).
10.5*	Form of Amended and Restated Indemnification Agreement for directors and executive officers of Health Net (incorporated by reference to Exhibit 10.3 to Health Net's Current Report on Form 8-K filed with the SEC on December 9, 2008 (File No. 1-12718)).
12.1	Computation of ratio of earnings to fixed charges.
31.1	Certification of Chairman, President and Chief Executive Officer pursuant to Rule 13(a)-14(a) under the Securities Exchange Act of 1934, as amended.
31.2	Certification of Executive Vice President and Chief Financial Officer pursuant to Rule 13(a)-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of Chairman, President and Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Executive Vice President and Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.1	XBRL Taxonomy Instance Document.
101.2	XBRL Taxonomy Extension Schema Document.
101.3	XBRL Taxonomy Extension Calculation Linkbase Document.

101.4 XBRL Taxonomy Extension Definition Linkbase Document.

101.5 XBRL Taxonomy Extension Label Linkbase Document.

101.6 XBRL Taxonomy Extension Presentation Linkbase Document.

* Indicates a management contract or compensatory plan or arrangement.

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SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized as of July 26, 2016.

CENTENE CORPORATION

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

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

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