MAGELLAN HEALTH INC
Form 10-K
February 28, 2019
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UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10 K

ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the fiscal year ended December 31, 2018
TRANSITION REPORT PURSUANT TO SECTION 13 or 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the transition period from to

Commission File No. 1 6639

MAGELLAN HEALTH, INC.

(Exact name of registrant as specified in its charter)

Delaware	58 1076937
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
4800 Scottsdale Rd, Suite 4400 Scottsdale, Arizona	85251
(Address of principal executive offices)	(Zip Code)

Registrant's telephone number, including area code: (602) 572 6050

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

Title of Each Class	Name of Each Exchange on which Registered
Common Stock, par value $0.01 per share	The NASDAQ Global Market

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

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

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

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

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

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

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

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

Emerging growth company

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

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

The aggregate market value of the Common Stock ("common stock") held by non affiliates of the registrant based on the closing price on June 30, 2018 (the last business day of the registrant's most recently completed second fiscal quarter) was approximately $2.4 billion.

The number of shares of Magellan Health, Inc.'s common stock outstanding as of February 22, 2019 was 23,925,342.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the definitive proxy statement for the 2019 Annual Meeting of Shareholders are incorporated by reference into Part III of this Form 10 K.

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MAGELLAN HEALTH, INC.

REPORT ON FORM 10 K

For the Fiscal Year Ended December 31, 2018

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PART I

Cautionary Statement Concerning Forward Looking Statements

This Form 10 K includes "forward looking statements" within the meaning of Section 27A of the Securities Act of 1933, as amended (the "Securities Act"), and Section 21E of the Securities Exchange Act of 1934, as amended (the "Exchange Act"). Examples of forward looking statements include, but are not limited to, statements the Company (as defined below) makes regarding our future operating results and liquidity needs. Although the Company believes that its plans, intentions and expectations reflected in such forward looking statements are reasonable, it can give no assurance that such plans, intentions or expectations will be achieved. Prospective investors are cautioned that any such forward looking statements are not guarantees of future performance and involve risks and uncertainties, and that actual results may differ materially from those contemplated by such forward looking statements. Important factors currently known to management that could cause actual results to differ materially from those in forward looking statements are set forth under the heading "Risk Factors" in Item 1A and elsewhere in this Form 10 K. When used in this Form 10 K, the words "estimate," "anticipate," "expect," "believe," "should" and similar expressions are intended to be forward looking statements.

Any forward looking statement made by the Company in this Form 10 K speaks only as of the date on which it is made. Factors or events that could cause our actual results to differ may emerge from time to time, and it is not possible for the Company to predict all of them. The Company undertakes no obligation to publicly update any forward looking statement, whether as a result of new information, future developments or otherwise, except as may be required by law.

You should also be aware that while the Company from time to time communicates with securities analysts, the Company does not disclose to them any material non public information, internal forecasts or other confidential business information. Therefore, to the extent that reports issued by securities analysts contain projections, forecasts or opinions, those reports are not the Company's responsibility and are not endorsed by the Company. You should not assume that the Company agrees with any statement or report issued by any analyst, irrespective of the content of the statement or report.

Item 1. Business

Magellan Health, Inc. ("Magellan") is a leader in managing the fastest growing, most complex areas of healthcare, including special populations, complete pharmacy benefits and other specialty areas of healthcare. The Company develops innovative solutions that combine advanced analytics, agile technology and clinical excellence to drive better decision making, positively impact members' health outcomes and optimize the cost of care for the customers Magellan serves. The Company provides services to health plans and other managed care organizations ("MCOs"), employers, labor unions, various military and governmental agencies and third party administrators ("TPAs"). Magellan operates three segments: Healthcare, Pharmacy Management and Corporate. In this report, references to "we", "us", "our" and the "Company" include Magellan and its subsidiaries. Magellan was incorporated in 1969 under the laws of the State of Delaware.

Healthcare

The Healthcare segment ("Healthcare") is broken down into two reporting units – (i) Behavioral & Specialty Health and (ii) Magellan Complete Care ("MCC").

The Behavioral & Specialty Health reporting unit's customers include health plans, accountable care organizations, employers, state Medicaid agencies, the United States military and various federal government agencies for whom

Magellan provides carve-out management services for behavioral health, employee assistance plans (“EAPs”) and other areas of specialty healthcare including diagnostic imaging, musculoskeletal management, cardiac and physical medicine. These management services can be applied broadly across commercial, Medicaid and Medicare populations, or on a more targeted basis for health plan customers.

The MCC reporting unit contracts with state Medicaid agencies and the Centers for Medicare and Medicaid Services (“CMS”) to manage care for beneficiaries under various Medicaid and Medicare programs. MCC manages a wide range of services from total medical cost to carve out long-term support services. MCC largely focuses on

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managing care for special populations including individuals with serious mental illness ("SMI"), dual eligibles, the aged, blind and disabled ("ABD") and other populations with unique and often complex healthcare needs.

Magellan's coordination and management of these healthcare and long-term support services are provided through its comprehensive network of medical and behavioral health professionals, clinics, hospitals, skilled nursing facilities, home care agencies and ancillary service providers. This network of credentialed providers is integrated with clinical and quality improvement programs to improve access to care and enhance the healthcare experience for individuals in need of care, while at the same time making the cost of these services more affordable for customers. The Company generally does not directly provide or own any provider of treatment services, although it does employ licensed behavioral health counselors to deliver non medical counseling under certain government contracts.

The Company provides its Healthcare management services primarily through: (i) risk based products, where the Company assumes all or a substantial portion of the responsibility for the cost of providing treatment services in exchange for a fixed per member per month fee, or (ii) administrative services only ("ASO") products, where the Company provides services such as utilization review, claims administration and/or provider network management, but does not assume full responsibility for the cost of the treatment services, in exchange for an administrative fee and, in some instances, a gain share.

Pharmacy Management

The Pharmacy Management segment ("Pharmacy Management") is comprised of products and solutions that provide clinical and financial management of pharmaceuticals paid under both the medical and the pharmacy benefit. Pharmacy Management's services include: (i) pharmacy benefit management ("PBM") services, including pharmaceutical dispensing operations; (ii) pharmacy benefit administration ("PBA") for state Medicaid and other government sponsored programs; (iii) clinical and formulary management programs; (iv) medical pharmacy management programs; and (v) programs for the integrated management of specialty drugs across both the medical and pharmacy benefit that treat complex conditions, regardless of site of service, method of delivery, or benefit reimbursement.

These services are available individually, in combination, or on a fully integrated manner. The Company markets its pharmacy management services to health plans, employers, third party administrators, state governments, Medicare Part D beneficiaries, government agencies, exchanges, brokers and consultants. In addition, the Company will continue to upsell its suite of pharmacy services to existing customers and market these pharmacy solutions to the Healthcare customer base.

Pharmacy Management contracts with its customers for services using risk based, gain share or ASO arrangements. In addition, the Pharmacy Management segment provides services to the MCC reporting unit within the Healthcare segment.

Corporate

This segment of the Company is comprised primarily of amounts not allocated to the Healthcare and Pharmacy Management segments that are largely associated with costs related to being a publicly traded company.

See Note 10—"Business Segment Information" to the consolidated financial statements for certain segment financial data relating to our business set forth elsewhere herein.

Recent Acquisitions

Healthcare Acquisitions

In recent years, the Company has expanded its Healthcare segment with various acquisitions. The acquisitions of AlphaCare Holdings, Inc. (“AlphaCare Holdings”) in 2013, The Management Group, LLC (“TMG”) in 2016 and SWH Holdings, Inc. (“SWH”) in 2017 expanded the Company’s MCC reporting unit. Magellan also increased its presence within the federal marketplace through the acquisition of Armed Forces Services Corporation (“AFSC”) in 2016 which falls under the Behavioral & Specialty Health reporting unit.

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Pharmacy Management Acquisitions

In recent years, the Company has expanded its Pharmacy Management segment with various acquisitions. The acquisitions of Partners Rx Management, LLC ("Partners Rx") in 2013, 4D Pharmacy Management Systems, Inc. ("4D") in 2015 and Veridicus Holdings, LLC ("Veridicus") in 2016 expanded the Company's presence in the PBM market. The Company expanded its formulary management programs with the acquisition of CDMI, LLC ("CDMI") in 2014.

Industry

According to the Centers for Medicare and Medicaid Services ("CMS"), national health expenditure growth is expected to average 5.5 percent annually over 2017-2026. Growth in national health spending is projected to be faster than projected growth in Gross Domestic Product ("GDP") by 1.0 percentage point over 2017-2026. As a result, the report projects the health share of GDP to rise from 17.9 percent in 2016 to 19.7 percent by 2026.

With the dynamic economic environment, rising healthcare costs, increased fiscal pressures on federal and state governments and the uncertainty around the future of healthcare reform, healthcare spending will continue to be one of the greatest pressing issues for the American public and government agencies. The rapidly evolving clinical and technological environment demands the expertise of specialized healthcare management services to provide both high quality and affordable care.

Business Strategy

The Company is a leader in managing the fastest growing, most complex areas of health, including special populations, complete pharmacy benefits and other specialty areas of healthcare. Magellan is focused on measured growth while executing against a multi-year margin improvement plan for the current portfolio of customers to bring earnings in line with industry competitive levels. The Company's strategy is organized around four main focus areas:

1. Retain customers and drive new sales
2. Improve margins by reducing cost of care, lowering pharmacy cost of goods sold and driving operational improvements across the Company
3. Maximize and expand the Company's key value drivers
4. Engage Magellan's workforce

Retain customers and drive new sales: To drive revenue and profit growth long term, the Company has targeted plans to retain existing customers and add new customers across both segments. In Pharmacy Management and Healthcare, the Company is targeting growth through new business wins, increased retention and upselling existing and newly developed services to existing customers. MCC will seek growth within current contracts deploying a local market strategy to increase retention and add new members. MCC will also seek to expand its footprint within existing states and selectively target new geographies as new managed Medicaid opportunities emerge for complex populations.

Improve margins by reducing cost of care, lowering Pharmacy costs of goods sold and driving operational improvements across the organization: Within Pharmacy Management, the Company will continue to grow PBM while retaining specialty carve-out contracts and lowering our cost of goods sold. Within Healthcare, the Company will execute against targeted medical action plans and will have market competitive loss ratios for each customer. Further, teams will drive operational improvements across the company to enhance efficiency.

Maximize and expand Magellan's key value drivers:

Pharmacy Management - continued focus on specialty drug management: With advances in specialty drugs driving the majority of pharmaceutical cost increases, Magellan's foundation as an industry leader in specialty drug

management uniquely positions us to deliver programs across all aspects of drug spend – traditional drugs, as well as specialty drugs paid under both the medical and pharmacy benefits. Our value based strategies are designed to support the 2-3 percent of patients driving the majority of spend through advanced analytics, high-touch clinical programs and comprehensive specialty drug solutions centered around complex conditions.

Healthcare: The Company will leverage significant Medicaid, behavioral health, specialty healthcare and

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pharmacy management experience to enhance current and develop new innovative clinical programs for complex populations or niche areas of specialty healthcare, utilizing the Company's unique expertise to improve quality and outcomes for members served while lowering costs for our customers.

Engage the Company's workforce: The Company will focus on talent acquisition, development and retention, as well as streamlining the Company's organizational structure. Employee engagement, communication and training for employees will help ensure the workforce can meet Magellan's evolving needs moving into the future.

Customer Contracts

The Company's contracts with customers typically have terms of one to three years, and in certain cases contain renewal provisions (at the customer's option) for successive terms of between one and two years (unless terminated earlier). Substantially all of these contracts may be immediately terminated with cause and many of the Company's contracts are terminable without cause by the customer or the Company either upon the giving of requisite notice and the passage of a specified period of time (typically between 30 and 180 days) or upon the occurrence of other specified events. In addition, the Company's contracts with federal, state and local governmental agencies generally are conditioned on legislative appropriations. These contracts generally can be terminated or modified by the customer if such appropriations are not made. The Company's contracts for managed healthcare and specialty solutions services generally provide for payment of a per member per month fee to the Company. See "Item 1A. Risk Factors—Risk Based Products" and "Item 1A. Risk Factors—Reliance on Customer Contracts."

The Company provides integrated healthcare services to Medicaid enrollees in the state of Florida pursuant to a contract with the State of Florida (the "Florida Contract"). The Florida Contract generated net revenues that exceeded, in aggregate, ten percent of net revenues for the consolidated Company for the year ended December 31, 2017, however not for the year ended December 31, 2018.

The Company also has significant concentrations of business with various counties in the State of Pennsylvania (the "Pennsylvania Counties") which are part of the Pennsylvania Medicaid Program, with members under its contract with CMS, and with various agencies and departments of the United States federal government. See further discussion related to these significant customers in "Item 1A. Risk Factors—Reliance on Customer Contracts." In addition, see "Item 1A. Risk Factors—Dependence on Government Spending" for discussion of risks to the Company related to government contracts.

Provider Network

The Company's managed healthcare services are primarily provided by a contracted network of third party providers. The number and type of providers in a particular area depend upon customer preference, site, geographic concentration and demographic composition of the beneficiary population in that area. The Company's network consists of approximately 220,000 healthcare providers providing various levels of care nationwide. The Company's network providers are almost exclusively independent contractors located throughout the local areas in which the Company's customers' beneficiary populations reside. Outpatient network providers work out of their own offices, although the Company's personnel are available to assist them with consultation and other needs.

Non facility network providers typically execute standard contracts with the Company under which they are generally paid on a fee for service basis.

The Company contracts with facilities on a per diem or fee for service basis and, in some limited cases, on a "case rate" or capitated basis. The contracts between the Company and inpatient and other facilities typically are for one year terms and are terminable by the Company or the facility upon 30 to 120 days notice.

The Company also provides capability to support client-specific networks. Many of the Company's clients have their own contracted networks. The Company establishes and administers these private networks segregating and reporting to the clients. In addition, the Company can lease networks on behalf of specific entities in order to enhance coverage.

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The Company also has a national network of contracted retail pharmacies which is offered to its pharmacy benefit management customers. We contract with and manage these pharmacies to optimize drug cost and member access to fill covered prescriptions. Pharmacies can work with us both electronically and telephonically at the point of service for member eligibility, claim adjudication and member cost share, if applicable.

Competition

The Company's business is highly competitive. The Company competes with other healthcare organizations as well as with insurance companies, including health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs"), TPAs, independent practitioner associations ("IPAs"), multi disciplinary medical groups, PBMs, healthcare information technology companies and other specialty healthcare and managed care companies. Many of the Company's competitors, particularly certain insurance companies, HMOs, technology companies and PBMs are significantly larger and have greater financial, marketing and other resources than the Company, and some of the Company's competitors provide a broader range of services. The Company competes based upon quality and reliability of its services, a focus on clinical excellence, product and service innovation and proven expertise across its business lines. The Company may also encounter competition in the future from new market entrants. In addition, some of the Company's customers that are managed care companies may seek to provide specialty managed healthcare services directly to their members, rather than subcontracting with the Company for such services. Because of these factors, the Company does not expect to be able to rely to a significant degree on price increases to achieve revenue growth, and expects to continue experiencing pricing pressures.

Insurance

The Company maintains a program of insurance coverage for a broad range of risks in its business. The Company has renewed its general, professional and managed care liability insurance policies with unaffiliated insurers for a one year period from June 17, 2018 to June 17, 2019. The general liability policy is written on an "occurrence" basis, subject to a $0.05 million per claim un aggregated self insured retention. The professional liability and managed care errors and omissions liability policies are written on a "claims made" basis, subject to a $1.0 million per claim ($10.0 million per class action claim) un aggregated self insured retention for managed care errors and omissions liability, and a $0.05 million per claim un aggregated self insured retention for professional liability.

The Company maintains a separate general and professional liability insurance policy with an unaffiliated insurer for its specialty pharmaceutical dispensing operations. The specialty pharmaceutical dispensing operations insurance policy has a one year term for the period June 17, 2018 to June 17, 2019. The general liability policy is written on an "occurrence" basis and the professional liability policy is written on a "claims made" basis, subject to a $0.05 million per claim and $0.25 million aggregated self insured retention.

The Company is responsible for claims within its self insured retentions, and for portions of claims reported after the expiration date of the policies if they are not renewed, or if policy limits are exceeded. The Company also purchases excess liability coverage in an amount that management believes to be reasonable for the size and profile of the organization.

See "Item 1A. Risk Factors—Professional Liability and Other Insurance," for a discussion of the risks associated with the Company's insurance coverage.

Regulation

General

The Company’s operations are subject to extensive and evolving state and federal laws and regulation in the jurisdictions in which we do business. This includes applicable federal and state laws and regulations in connection with its role in providing pharmacy benefit management; behavioral health benefit management; radiology benefit management; utilization review; customer employee benefit plan services; pharmacy; healthcare services; Medicaid; Medicare; health insurance, and laws and regulations impacting its federal government contracts. Regulation of the healthcare industry as well as government contracting is constantly evolving, with new legislative enactments and regulatory initiatives at the state and federal levels being implemented on a regular basis. Consequently, it is possible that a court or regulatory agency may take a position under existing or future laws or regulations, or as a result of a change in

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the interpretation thereof that such laws or regulations apply to the Company in a different manner than the Company believes such laws or regulations apply. In addition, existing laws and regulations may be repealed or modified. Such changes may require significant alterations to the Company's business operations in order to comply with such laws or regulations, or interpretations thereof. Expansion of the Company's business to cover additional geographic areas, to serve different types of customers, to provide new services or to commence new operations could also subject the Company to additional licensure requirements and/or regulation. Failure to comply with applicable regulatory requirements could have a material adverse effect on the Company.

State Licensure and Regulation

The Company is subject to certain state laws and regulations governing the licensing of insurance companies, HMOs, PPOs, TPAs, PBMs, pharmacies and companies engaged in utilization review. In addition, the Company is subject to state laws and regulations concerning the licensing of healthcare professionals, including restrictions on business corporations from providing, controlling or exercising excessive influence over healthcare services through the direct employment of physicians, psychiatrists or, in certain states, psychologists and other healthcare professionals. These laws and regulations vary considerably among states, and the Company may be subject to different types of laws and regulations depending on the specific regulatory approach adopted by each state to regulate the managed care and pharmaceutical management businesses and the provision of healthcare treatment services.

Further, certain regulatory agencies having jurisdiction over the Company possess discretionary powers when issuing or renewing licenses or granting approval of proposed actions such as mergers, a change in ownership, and certain intra corporate transactions. One or multiple agencies may require as a condition of such license or approval that the Company cease or modify certain of its operations or modify the way it operates in order to comply with applicable regulatory requirements or policies. In addition, the time necessary to obtain a license or approval varies from state to state, and difficulties in obtaining a necessary license or approval may result in delays in the Company's plans to expand operations in a particular state and, in some cases, lost business opportunities.

The Company has sought and obtained licenses as a utilization review agent, single service HMO, TPA, PBM, Pharmacy, PPO, HMO and Health Insurance Company in one or more jurisdictions. Numerous states in which the Company does business have adopted regulations governing entities engaging in utilization review. Utilization review regulations typically impose requirements with respect to the qualifications of personnel reviewing proposed treatment, timeliness and notice of the review of proposed treatment and other matters. Many states also license TPA activities. These regulations typically impose requirements regarding claims processing and payments and the handling of customer funds. Some states require TPA licensure for PBM entities as a way to regulate the PBM lines of business.

Other states regulate PBMs through a PBM specific license. The Company has obtained these licenses as required to support the PBM business. Certain insurance licenses are required for the Company to pursue Medicare Advantage and Medicare Part D business. In some cases, single purpose HMO licenses are required for the Company to take risk on business in that state. Some states require PPO or other network licenses to offer a network of providers in the state. Almost all states require licensure for pharmacies dispensing or shipping medications into the state. The Company has obtained all of these necessary licenses.

To the extent that the Company operates or is deemed to operate in some states as an insurance company, HMO, PPO or similar entity, it may be required to comply with certain laws and regulations that, among other things, may require the Company to maintain certain types of assets and minimum levels of deposits, capital, surplus, reserves or net worth. Being licensed as an insurance company, HMO or similar entity could also subject the Company to regulations governing reporting and disclosure, coverage, mandated benefits, rate setting, grievances and appeals, prompt pay laws and other traditional insurance regulatory requirements.

Regulators in a few states have adopted policies that require HMOs or, in some instances, insurance companies, to contract directly with licensed healthcare providers, entities or provider groups, such as IPAs, for the provision of treatment services, rather than with unlicensed intermediary companies. In such states, the Company's customary model of contracting directly is modified so that, for example, the IPAs (rather than the Company) contract directly with the HMO or insurance company, as appropriate, for the provision of treatment services.

The National Association of Insurance Commissioners ("NAIC") has developed a "health organizations risk based capital" formula, designed specifically for managed care organizations, that establishes a minimum amount of

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capital necessary for a managed care organization to support its overall operations, allowing consideration for the organization's size and risk profile. The NAIC also adopted a model regulation in the area of health plan standards, which could be adopted by individual states in whole or in part, and could result in the Company being required to meet additional or new standards in connection with its existing operations. Certain states, for example, have adopted regulations based on the NAIC initiative, and as a result, the Company has been subject to certain minimum capital requirements in those states. Certain other states, such as Maryland, Texas, New York, Florida and New Jersey, have also adopted their own regulatory initiatives that subject entities, such as certain of the Company's subsidiaries, to regulation under state insurance laws. This includes, but is not limited to, requiring adherence to specific financial solvency standards. State insurance laws and regulations may limit the Company's ability to pay dividends, make certain investments and repay certain indebtedness.

Regulators may impose operational restrictions on entities granted licenses to operate as insurance companies or HMOs. For example, the California Department of Managed Health Care has imposed certain restrictions on the ability of the Company's California subsidiaries to fund the Company's operations in other states, to guarantee or cosign for the Company's financial obligations, or to pledge or hypothecate the stock of these subsidiaries and on the Company's ability to make certain operational changes with respect to these subsidiaries. In addition, regulators of certain of the Company's subsidiaries may exercise certain discretionary rights under regulations including, without limitation, increasing its supervision of such entities or requiring additional restricted cash or other security.

Failure to obtain and maintain required licenses typically also constitutes an event of default under the Company's contracts with its customers. The loss of business from one or more of the Company's major customers as a result of an event of default or otherwise could have a material adverse effect on the Company. Licensure requirements may increase the Company's cost of doing business in the event that compliance requires the Company to retain additional personnel to meet the regulatory requirements and to take other required actions and make necessary filings. Although compliance with licensure regulations has not had a material adverse effect on the Company, there can be no assurance that specific laws or regulations adopted in the future would not have such a result.

The provision of healthcare treatment services by physicians, psychiatrists, psychologists, pharmacists and other providers is subject to state regulation with respect to the licensing of healthcare professionals. The Company believes that the healthcare professionals, who provide healthcare treatment on behalf of or under contracts with the Company, and the case managers and other personnel of the health services business, are in compliance with the applicable state licensing requirements and current interpretations thereof. Regulations imposed upon healthcare providers include but are not limited to, provisions relating to the conduct of, and ethical considerations involved in, the practice of medicine, psychiatry, psychology, social work and related behavioral healthcare professions, radiology, pharmacy, privacy, accreditation, government healthcare program participation requirements, reimbursements for patient services, Medicare, Medicaid, federal and state laws governing fraud, waste and abuse and, in certain cases, the common law or statutory duty to warn others of danger or to prevent patient self injury or the statutory duties to report matters of abuse or neglect of individuals. However, there can be no assurance that changes in such requirements or interpretations thereof will not adversely affect the Company's existing operations or limit expansion.

With respect to the Company's employee assistance crisis intervention program, additional licensing of clinicians who provide telephonic assessment or stabilization services to individuals who are calling from out of state may be required if such assessment or stabilization services are deemed by regulatory agencies to be treatment provided in the state of such individual's residence. The Company believes that any such additional licenses could be obtained. In California, the Company's employee assistance programs are regulated by the California Department of Managed Health Care. This subjects the Company to regulations governing reporting and disclosure, coverage, mandated benefits, grievances and appeals and other traditional insurance regulatory requirements.

The laws of some states limit the ability of a business corporation to directly provide, control or exercise excessive influence over healthcare services through the direct employment of physicians, psychiatrists, psychologists, or other healthcare professionals, who are providing direct clinical services. In addition, the laws of some states prohibit physicians, psychiatrists, psychologists, or other healthcare professionals from splitting fees with other persons or entities. These laws and their interpretations vary from state to state and enforcement by the courts and regulatory authorities may vary from state to state and may change over time. There can be no assurance that the Company's existing operations and its contractual arrangements with physicians, psychiatrists, psychologists and other healthcare professionals will not be successfully challenged under state laws prohibiting fee splitting or the practice of a profession by an unlicensed entity, or that the enforceability of such contractual arrangements will not be limited. The Company

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believes that it could, if necessary, restructure its operations to comply with changes in the interpretation or enforcement of such laws and regulations, and that such restructuring would not have a material adverse effect on its operations.

Employee Retirement Income Security Act ("ERISA")

Certain of the Company's services are subject to the provisions of ERISA. ERISA governs certain aspects of the relationship between employer sponsored healthcare benefit plans and certain providers of services to such plans through a series of complex laws and regulations that are subject to periodic interpretation by the Internal Revenue Service ("IRS") and the U.S. Department of Labor ("DOL"). In some circumstances, and under certain customer contracts, the Company may be expressly named as a "fiduciary" under ERISA, or be deemed to have assumed duties that make it an ERISA fiduciary, and thus be required to carry out its operations in a manner that complies with ERISA in all material respects. In other circumstances, particularly in the administration of pharmacy benefits, the Company does not believe that its services are subject to the fiduciary obligations and requirements of ERISA. In addition, the DOL has not yet finalized guidance regarding whether discounts and other forms of remuneration from pharmaceutical manufacturers are required to be reported to ERISA governed plans in connection with ERISA reporting requirements.

Numerous states require the licensing or certification of entities performing TPA activities; however, certain federal courts have held that such licensing requirements are preempted by ERISA. ERISA preempts state laws that mandate employee benefit structures or their administration, as well as those that provide alternative enforcement mechanisms. The Company believes that its TPA activities performed for its self insured employee benefit plan customers are exempt from otherwise applicable state licensing or registration requirements based upon federal preemption under ERISA and have relied on this general principle in determining not to seek licenses for certain of the Company's activities in some states. Existing case law is not uniform on the applicability of ERISA preemption with respect to state regulation of PBM or TPA activities. In some states, the Company has licensed its self funded pharmacy related business as a TPA or PBM after a review of state regulatory requirements and case law. There can be no assurance that additional licenses will not be required with respect to utilization review or TPA activities in certain states.

Some of the state regulatory requirements described herein may be preempted in whole or in part by ERISA, which provides for comprehensive federal regulation of employee benefit plans. However, the scope of ERISA preemption is uncertain and is subject to conflicting court rulings. As a result, the Company could be subject to overlapping federal and state regulatory requirements with respect to certain of its operations and may need to implement compliance programs that satisfy multiple regulatory regimes. There can be no assurance that continuing ERISA compliance efforts or any future changes to ERISA will not have a material adverse effect on the Company.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and Other Privacy Regulation

HIPAA contains standards relating to the transmission, privacy and security of health information by healthcare providers and healthcare plans. Confidentiality and patient privacy requirements are particularly strict in the Company's behavioral managed care business.

The Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), passed as part of the American Recovery and Reinvestment Act of 2009, represented a significant expansion of the HIPAA privacy and security laws.

HIPAA generally does not preempt state law. Therefore, because many states have privacy laws that provide more stringent privacy protections than those imposed by HIPAA, the Company must address privacy issues under those state laws as well.

In addition to HIPAA and the HITECH Act, the Company is also subject to federal laws and regulations governing patient records involving substance abuse treatment, as well as other federal privacy laws and regulations.

The European Union ("EU") General Data Protection Regulation ("GDPR") became effective May 25, 2018. The Company believes its exposure to the GDPR is at present limited to EAP services to US-based companies that decide to offer EAP to their EU-based employees, which is a very small subset of the Company's EAP line of business. The Company does not market its EAP services within the EU or to persons in the EU, or monitor the behavior of persons in the EU, and its EAP contracts with its customers are entered into in the United States with companies

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established in the US. When a US customer chooses to make EAP services available to EU-based employees, the EAP services are managed through an EU-based subcontractor and EAP personal data subject to the GDPR processed by that subcontractor does not leave the EU. The Company has received contractual assurances from its subcontractor of its subcontractor's compliance with the GDPR. Thus, the Company does not believe the GDPR at present poses material compliance risks for the Company. However, there can be no assurances that the GDPR could not be interpreted by EU supervisory authorities or courts in a manner that would require the Company to restructure its EAP services in the EU, or the GDPR could be changed or interpreted in a manner causing material adverse impact on the Company.

Fraud, Waste and Abuse Laws

The Company is subject to federal and state laws and regulations protecting against fraud, waste and abuse. Fraud, waste and abuse prohibitions cover a wide range of activities, including kickbacks and other inducements for referral of members or the coverage of products, billing for unnecessary services by a healthcare provider and improper marketing. Companies involved in public healthcare programs such as Medicare and Medicaid are required to maintain compliance programs to detect and deter fraud, waste and abuse, and are often subject to audits. The regulations and contractual requirements applicable to the Company in relation to these programs are complex and subject to change.

The federal healthcare Anti Kickback Statute (the "Anti Kickback Statute") prohibits, among other things, an entity from paying or receiving, subject to certain exceptions and "safe harbors," any remuneration, directly or indirectly, to induce the referral of individuals covered by federally funded healthcare programs, or the purchase, or the arranging for or recommending of the purchase, of items or services for which payment may be made in whole, or in part, under Medicare, Medicaid, TRICARE or other federally funded healthcare programs. Sanctions for violating the Anti Kickback Statute may include imprisonment, criminal and civil fines and exclusion from participation in the federally funded healthcare programs. The Anti Kickback Statute has been interpreted broadly by courts, the Office of Inspector General ("OIG"), the Department of Health and Human Services ("DHHS") and other administrative bodies.

It also is a crime under the Public Contracts Anti Kickback Act, for any person to knowingly and willfully offer or provide any remuneration to a prime contractor to the United States, in order to obtain favorable treatment in a subcontract. Violators of this law also may be subject to civil monetary penalties. There have been a series of substantial civil and criminal investigations and settlements over the last several years in connection with alleged kickback schemes.

The federal civil monetary penalty ("CMP") statute provides for civil monetary penalties for any person who provides something of value to a beneficiary covered under a federal healthcare program, such as Medicare or Medicaid, in order to influence the beneficiary's choice of a provider. ERISA, to which certain of our customers' services are subject, generally prohibits any person from providing to a plan fiduciary a remuneration in order to affect the fiduciary's selection of or decisions with respect to service providers. Unlike the federal healthcare Anti Kickback Statute, ERISA regulations do not provide specific safe harbors and its application may be unclear.

The Federal Civil False Claims Act imposes civil penalties for knowingly making or causing to be made false claims with respect to government contracts and governmental programs, such as Medicare and Medicaid, for services not rendered, or for misrepresenting actual services rendered, in order to obtain higher reimbursement. Private individuals may bring qui tam or whistleblower suits under the Federal Civil False Claims Act, which authorizes the payment of a portion of any recovery to the individual bringing suit.

Further, pursuant to the Patient Protection and Affordable Care Act ("ACA"), a violation of the Anti Kickback Statute is also a per se violation of the Federal Civil False Claims Act. The Federal Civil False Claims Act generally provides

for the imposition of civil penalties and for treble damages, resulting in the possibility of substantial financial penalties for small billing discrepancies. Criminal provisions that are similar to the Federal Civil False Claims Act provide that a corporation may be fined if it is convicted of presenting to any federal agency a claim or making a statement that it knows to be false, fictitious or fraudulent. Even in situations where the Company does not directly provide services to beneficiaries of federally funded health programs and, accordingly, does not directly submit claims to the federal government, it is possible that the Company could nevertheless become involved in a situation where false claim issues are raised based on allegations that it caused or assisted a government contractor in making a false claim.

The Company is subject to certain provisions of the Deficit Reduction Act of 2005 (the “Act”). The Act requires entities that receive $5 million or more in annual Medicaid payments to establish written policies that provide detailed information about the Federal Civil False Claims Act and the remedies thereunder, as well as any state laws

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pertaining to civil or criminal penalties for false claims and statements, the "whistleblower" protections afforded under such laws, and the role of such laws in preventing and detecting fraud, waste and abuse. The Company is also subject to The Dodd Frank Wall Street Reform and Consumer Protection Act ("Dodd Frank"). Under the law, those with independent knowledge of a financial fraud committed by a business required to report to the U.S. Securities and Exchange Commission ("SEC") or the U.S. Commodity Futures Trading Commission ("CFTC") may be entitled to a percentage of the money recovered. Included in Dodd Frank are provisions which protect employees of publicly traded companies from retaliation for reporting securities fraud, fraud against shareholders and violation of the SEC rules/regulations. Dodd Frank also amends the Sarbanes Oxley Act ("SOX") and Federal Civil False Claims Act to expand their whistleblower protections.

Many states have laws and/or regulations similar to the federal fraud, waste and abuse laws described above. Sanctions for violating these laws may include injunction, imprisonment, criminal and civil fines and exclusion from participation in the state Medicaid programs. The Company has a corporate compliance and ethics program, policies and procedures and internal controls in place designed to ensure that the Company conducts business appropriately. However, there can be no assurance that the Company will not be subject to scrutiny or challenge under such laws or regulations and that any such challenge would not have a material adverse effect on the Company's business, results of operations, financial condition or cash flows.

Mental Health Parity

The Paul Wellstone and Pete Domenici Mental Health Parity Act of 2008 ("MHPAEA") establishes parity in financial requirements (e.g., co pays, deductibles, etc.) and treatment limitations (e.g., limits on the number of visits) between mental health and substance abuse benefits and medical/surgical benefits for health plan members. This law does not require coverage for mental health or substance abuse disorders, but if coverage is provided it must be provided at parity. No specific disorders are mandated for coverage; health plans are able to define mental health and substance abuse to determine what they are going to cover. Under the ACA, non grandfathered individual and small group plans (both on and off of the Health Insurance Exchange) are required to provide mental health and substance abuse disorder benefits as essential health benefits. These mandated benefits under the ACA must be provided at parity in these plans. Under the ACA, grandfathered individual plans are required to comply with parity if they offer behavioral health benefits. Grandfathered small group plans are exempt from requirements to provide essential health benefits and parity requirements. State mandated benefits laws are not preempted. The law applies to ERISA plans, Medicaid managed care plans and State Children's Health Insurance Program ("SCHIP") plans. On November 13, 2013 the Department of the Treasury, the Department of Labor and the Department of Health and Human Services issued Final Rules on the MHPAEA ("Final Rules"). The Final Rules include some concepts not included under the statute including the requirement to conduct the parity review at the category level within the plan, introducing the concept of non quantitative treatment limitations and prohibiting separate but equal deductibles. The Company believes it is in compliance with these requirements. In March 2016, CMS promulgated a final rule on the application of parity to Medicaid Managed Care Plans, CHIP and alternative benefit plans. The Company has been working with our state Medicaid customers on compliance with these rules. On December 7, 2016, the Congress adopted the Twenty-First Century Cures Act, which codified some concepts in the Final Rules. The Company's risk contracts allow for repricing to occur effective the same date that any legislation/regulation becomes effective if that legislation/regulation is projected to have a material effect on cost of care.

Health Care Reform

The ACA is a broad and sweeping piece of legislation creating numerous changes in the healthcare regulatory environment. Some of the regulations interpreting the ACA, most notably the Medical Loss Ratio regulations, the Internal Claims and Appeals and External Review Processes Regulations and Health Insurance Exchanges have an impact on the Company and its business. Others, such as the regulation on dependent coverage to age 26 and coverage

of preventative health services, could impact the nature of the members that we serve and the utilization rates. Medicaid expansion under the ACA has had some impact on the Company's Medicaid business. The Company has customers that are participating in the state and federal Health Insurance Exchanges. The Company has taken necessary steps to support our customers in their administration of these plans.

The ACA also contains provisions related to fees that impact the Company's direct public sector contracts and provisions regarding the non deductibility of those fees. Our state public sector customers have made rate adjustments to cover the direct costs of these fees and a majority of the impact from non deductibility of such fees for federal income

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tax purposes. There may be some impact due to taxes paid for non renewing customers where the timing and amount of recoupment of these additional costs are uncertain. There can be no assurances that public sector customers may make rate adjustments to cover the direct costs of these fees in the future, so there can be no guarantees regarding this adjustment from our state public sector customers and these taxes and fees may have a material impact on the Company.

Federal and State Medicaid Laws and Regulations

The Company directly contracts with various states to provide Medicaid services to states. In addition, the Company directly contracts with various states to provide Medicaid managed care services to state Medicaid beneficiaries. As such, it is subject to certain federal and state laws and regulations affecting Medicaid as well as state contractual requirements. In addition to state regulation, certain Medicaid contracts require the Company to maintain Medicare Advantage special needs plan status, which is regulated by CMS.

The Company also is a sub contractor to health plans that provide Medicaid managed care services to state Medicaid beneficiaries. In the Company's capacity as a subcontractor with these health plans, the Company is indirectly subject to certain federal and state laws and regulations as well as contractual requirements pertaining to the operation of this business. If a state or a health plan customer determines that the Company has not performed satisfactorily as a subcontractor, the state or the health plan customer may require the Company to cease these activities or responsibilities under the subcontract. While the Company believes that it provides satisfactory levels of service under its respective subcontracts, the Company can give no assurances that a state or health plan will not terminate the Company's business relationships insofar as they pertain to these services.

On May 6, 2016, CMS published final regulations that significantly modified the existing federal Medicaid Managed Care and the SCHIP regulations. On June 30, 2017, CMS issued an Informational Bulletin regarding the applicable effective/compliance dates for the new Medicaid Managed Care and the SCHIP regulations. Magellan is working respectively with state Medicaid agencies and Medicaid Managed Care Plans (our Medicaid customers) to ensure ongoing compliance with those sections of the regulations that are specified as effective based on the determination made by the applicable state Medicaid agency. Nonetheless, CMS issued proposed regulations on November 14, 2018, that would modify certain parts of the 2016 regulation.

In connection with its PBM business, the Company negotiates rebates with and provides services for drug manufacturers. The manufacturers are subject to Medicaid "best price" regulations requiring essentially that the manufacturer provide its deepest level of discounts to the Medicaid program. In some instances, the government has challenged a manufacturer's calculation of best price and we cannot be certain what effect, if any, the outcome of any such investigation or proceeding will have on our ability to negotiate favorable terms.

Medicare Laws and Regulations

The Company is contracted with CMS as a Medicare Advantage Organization ("MAO") and Prescription Drug Plan ("PDP") to provide health services and prescription drug benefits to Medicare beneficiaries. The regulations and contractual requirements applicable to the Company and other participants in Medicare programs are complex and subject to change. CMS regularly audits the performance of contracted health plans to determine compliance with contracts and CMS regulations, and to assess the quality of services provided to Medicare beneficiaries. CMS penalties for noncompliance include premium refunds, civil monetary penalties, prohibiting a company from continuing to market and/or enroll members in the company's Medicare products, exclusion from participation in federally funded healthcare programs and other sanctions. In July 2017 CMS issued a civil monetary penalty against one of the Company's subsidiaries for non-compliance with a contractual standard outlined in its Part D contract. In February 2018 CMS issued civil monetary penalties against the same subsidiary for deficiencies cited as a result of

CMS audits conducted in the 2nd and 3rd quarters of 2017. These penalties have not had a material impact on the Company or its Part D business.

The Company is also a subcontractor to health plans that are MAOs and PDPs. In the Company's capacity as a subcontractor with these health plans, the Company administers benefits to Medicare beneficiaries and is indirectly subject to certain federal laws and regulations, as well as contractual requirements pertaining to the operation of this business. If CMS or a health plan customer determines that the Company has not performed satisfactorily as a subcontractor, CMS or the health plan customer may require the Company to cease these activities or responsibilities under the subcontract. While the Company believes that it provides satisfactory levels of service under its respective

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subcontracts, the Company can give no assurances that CMS or a health plan will not terminate the Company's business relationships with respect to these services.

CMS requires Part D Plans to report all price concessions received for PBM services. The applicable CMS guidance requires Part D Plans to contractually require the right to audit their PBMs as well as require full transparency as to manufacturer rebates and administrative fees paid for drugs or services provided in connection with the sponsor's plan, including the portion of such rebates retained by the PBM. Additionally, CMS requires Part D Plans to ensure through their contractual arrangements with first tier, downstream and related entities (which would include PBMs) that CMS has access to such entities' books and records pertaining to services performed in connection with Part D Plans. The CMS regulations also suggests that Part D Plans should contractually require their first tier, downstream and related entities (subcontractors) to comply with certain elements of the Part D Plan's compliance program. The Company has not experienced, and does not anticipate, that such disclosure and auditing requirements, to the extent required by its Part D Plan partners, will have a materially adverse effect on the Company's business.

The Company expects CMS and the U.S. Congress to continue to closely scrutinize each component of the Medicare program, modify the terms and requirements of the program and possibly seek to modify private insurers' role. Therefore, it is not possible to predict the outcome of any Congressional or regulatory activity, either of which could have a material adverse effect on the Company.

Federal and State Requirements related to Quality and Service Metrics Under Medicare and Medicaid Contracts

The Company's Medicare and Medicaid business is subject to various quality and performance measures. Failure to maintain satisfactory quality and performance measures may negatively affect the Company's premium rates, subject it to penalties, limit or reduce membership, impede the Company's ability to compete for new business in existing or new markets or result in the termination of its contracts, which could have a material adverse effect on our business, rate of growth and results of operations, financial condition and cash flows.

Quality scores are used by certain regulatory agencies to establish premium rates and/or calculate performance incentives. In the case of CMS, for example, quality-based metrics are used to pay quality bonuses to Medicare Advantage plans that enable high scoring plans to offer enhanced health benefits for their MA beneficiaries.

Medicare Advantage plans and Medicare Prescription Drug Plans (together, "MA Plans") with Star Ratings of four (4.0) stars or higher are eligible for year-round open enrollment; conversely, plans with lower Star Ratings have more restricted times for enrollment of beneficiaries. MA Plans with Star Ratings of less than three (3.0) stars in three consecutive years are denoted as "low performing" plans on the CMS website and in the CMS "Medicare and You" handbook. In addition, CMS recently had its authority to terminate MA Plan contracts for plans rated below three (3.0) stars in three consecutive years reinstated. CMS may begin terminations of low rated MA Plans beginning with plan year 2023. As a result, MA Plans that achieve higher Star Ratings may have a competitive advantage over plans with lower Star Ratings. As a result, lower quality scores/Star ratings compared to our competitors could have a material adverse effect on our business, rate of growth, results of operation, financial condition, or cash flows.

For certain state Medicaid programs, plans that do not meet applicable quality and service measures may be subject to a range of penalties including being placed on a corrective action plan, denial of quality performance incentives, financial sanctions, reduction in capitation, enrollment limitations or termination of contract. We are unable to predict with any certainty what actions a state may take, if any, when assessing our contractual performance.

Failure to maintain satisfactory quality and service measures could also adversely affect our ability to establish new health plans or expand the business of our existing health plans. In addition, lower quality scores or Star ratings, when compared to our competitors, may adversely affect our ability to attract members and obtain regulatory approval for acquisitions or expansions, including expansion of Medicare Advantage health plans, or succeed in competitive bidding situations.

Other Federal and State Laws and Regulations

Federal Laws and Regulations affecting Procurement. In addition to the laws and regulations cited in the

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section entitled Fraud, Waste and Abuse laws above, the Company is subject to other federal laws and regulations in connection with its contracts with the federal government. These laws and regulations affect how the Company conducts business with its federal agency customers and may impose added costs on its business. The Company's failure to comply with federal procurement laws and regulations could cause it to lose business, incur additional costs and subject it to a variety of civil and criminal penalties and administrative sanctions, including termination of contracts, forfeiture of profits, harm to reputation, suspension of payments, fines, and suspension or debarment from doing business with federal government agencies. The Company conducts business with federal agency customers and federal contractors to such agencies.

The Company is investigating, with the assistance of outside counsel, matters relating to compliance by AFSC with Small Business Administration ("SBA") regulations and other federal laws applicable to government contractors and has reported findings to the SBA and the Department of Defense, including facts indicating violations of SBA regulations and other federal laws, such as the Anti-Kickback Act, by former AFSC executives, none of which was disclosed to Magellan prior to its acquisition of AFSC. The Company is voluntarily responding to government requests for further information regarding the Company's investigation. Contingencies, if any, arising from the results of this investigation and self-reporting could require us to record balance sheet liabilities or accrue expenses, the amount of which we are not able to currently estimate. While the Company believes that it has responded appropriately by self-reporting findings regarding matters that incepted prior to its acquisition of AFSC in order to mitigate the risk of adverse consequences, should the SBA, Department of Defense and/or other federal agencies seek to hold the Company or AFSC responsible for the reported conduct, we may be required to pay damages and/or penalties and AFSC could be suspended or debarred from government contracting. For 2017 and 2018 AFSC's total revenue comprised approximately 3% and 2%, respectively, of the total revenues of the Company.

The Company also provides services to various state Medicaid programs. Services procurement related to Medicaid programs is governed in part by federal regulations because the federal government provides a substantial amount of funding for the services. The Company's State customers risk loss of federal funding if the Company is not in compliance with federal regulations. The Company's non compliance may also lead to unanticipated, negative financial consequences including corrective action plans or contract default risks.

FDA Regulation. The U.S. Food and Drug Administration ("FDA") generally has authority to regulate drug promotional activities that are performed "by or on behalf of" a drug manufacturer. The Company provides certain consulting and related services to drug manufacturers, and there can be no assurance that the FDA will not attempt to assert jurisdiction over certain aspects of the Company's activities. The impact of future FDA regulation could materially adversely affect the Company's business, results of operations, financial condition or cash flows.

State PBM Regulation. States continue to introduce broad legislation to regulate PBM activities. This legislation encompasses some of the services offered by the Company's PBM business. Legislation in this area is varied and encompasses licensing, audit provisions, network access, recoupment of funds, submission of claims data to state all payor claims databases, potential fiduciary duties, pass through of cost savings and disclosure obligations, including the disclosure of information regarding the company's maximum allowable cost pricing with pharmacies. In some circumstances, claims or inquiries against PBMs have been asserted under state consumer protection laws, which exist in most states. The Company has obtained licenses as necessary to support current business and future opportunities. The various state laws do not appear to have a material adverse effect on the Company's pharmaceutical management business. However, the Company can give no assurance that these and other states will not enact legislation with more adverse consequences in the near future; nor can the Company be certain that future regulations or interpretations of existing laws will not adversely affect its business.

State Legislation Affecting Plan or Benefit Design. Some states have enacted legislation that prohibits certain types of managed care plan sponsors from implementing certain restrictive formulary and network design features, and

many states have legislation regulating various aspects of managed care plans, including provisions relating to pharmacy benefits. Other states mandate coverage of certain benefits or conditions and require health plan coverage of specific drugs, if deemed medically necessary by the prescribing physician. Such legislation does not generally apply to the Company directly, but may apply to certain clients of the Company, such as HMOs and health insurers. These types of laws would generally have an adverse effect on the ability of a PBM to reduce cost for its plan sponsor customers.

Prompt Pay Laws. Under Medicare Part D and some state laws, the Company or customer may be required to pay network pharmacies within certain time periods and/or by electronic transfer instead of by check. The shorter time

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periods may negatively impact our cash flow. We cannot predict whether additional states will enact some form of prompt pay legislation.

Legislation and Regulation Affecting Drug Price and Rebates. Specialty pharmaceutical manufacturers generally report various price metrics to the federal government, including "average sales price" ("ASP"), "average manufacturer price" ("AMP") and "best price" ("BP"). The Company does not calculate these price metrics, but the Company notes that the ASP, AMP and BP methodologies may create incentives for some drug manufacturers to reduce the levels of discounts or rebates available to purchasers, including the Company, or their clients with respect to specialty drugs. Any changes in the guidance affecting pharmaceutical manufacturer price metric calculations could materially adversely affect the Company's business.

Additionally, most of the Company's pharmacy benefit management and dispensing contracts with its customers use "average wholesale price" ("AWP") as a benchmark for establishing pricing. At least one major third party publisher of AWP pricing data has ceased to publish such data in the past few years, and there can be no guarantee that AWP will continue to be an available pricing metric in the future. The discontinuance of AWP reporting by one data source has not had a material adverse effect on the Company's results of operations and the Company expects that were AWP data to no longer be available, other equitable pricing measures would be available to avoid a material adverse impact on the Company's business. Separately, on a monthly basis CMS publishes the National Average Drug Acquisition Cost ("NADAC"), a data set that purports to provide the average acquisition cost of retail drugs based on a nationwide voluntary survey of retail pharmacies. At this time, the Company does not anticipate that NADAC will materially adversely impact its operations, but it is too early to speculate what impact, if any, such a reimbursement shift might have in pharmacy reimbursement and/or costs in the future.

On February 6, 2019, the Department of Health and Human Services Office of Inspector General published a proposed rule which would remove the anti-kickback regulatory safe harbor protection for prescription drug rebates paid by manufacturers to plan sponsors under Medicare Part D and Medicaid managed care. It also would create a new safe harbor protection for price discounts between manufacturers and PBMs if given at the point-of-sale ("POS"). Comments on the proposed rule are due April 8, 2019. This proposed rule would apply only to Medicare Part D and Medicaid managed care, and not commercial rebates. While we do not believe the proposed rule would have a material adverse impact on our business, President Trump in his State of the Union speech on February 6, 2019 also proposed that Congress adopt laws to control drug prices and other related measures, which could materially and adversely affect our commercial pharmacy benefits management rebate business.

Regulations Affecting the Company's Pharmacies. The Company owns three pharmacies that provide services primarily to members of certain of the Company's health plan customers. The activities undertaken by the Company's pharmacies subject the pharmacies to state and federal statutes and regulations governing, among other things, the licensure and operation of mail order and nonresident pharmacies, repackaging of drug products, stocking of prescription drug products and dispensing of prescription drug products, including controlled substances. The Company's pharmacy facilities are located in Florida and Utah, and are duly licensed to conduct business in those states. Almost all states, however, require out of state mail order pharmacies to register with or be licensed by the state board of pharmacy or similar governing body when pharmaceuticals are delivered by mail into the state, and some states require that an out of state pharmacy employ a pharmacist that is licensed in the state into which pharmaceuticals are shipped. The Company holds mail order and nonresident pharmacy licenses where required. The Company also maintains Medicare and Medicaid provider licenses where required for the pharmacies to provide services to these plans. In some states, the Company is not able to obtain Medicaid licenses to dispense because those states require that the pharmacy have a physical location in the state to participate in the Medicaid network.

Regulation of Controlled Substances. The Company's pharmacies must register with the United States Drug Enforcement Administration (the "DEA") and individual state-controlled substance authorities in order to dispense

controlled substances. Federal law requires the Company to comply with the DEA's security, recordkeeping, inventory control and labeling standards in order to dispense controlled substances. State controlled substance law requires registration and compliance with state pharmacy licensure, registration or permit standards promulgated by the state pharmacy licensing authority and in some states drug database reporting requirements.

Employees of the Registrant

At December 31, 2018, the Company had approximately 10,500 full time and part time employees.

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Available Information

The Company makes its annual reports on Form 10 K, quarterly reports on Form 10 Q, current reports on Form 8 K, amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Securities Exchange Act of 1934, and Section 16 filings available, free of charge, on the SEC's website, which contains reports, proxy and information statements, and other information regarding issuers that file electronically with the SEC, at www.sec.gov, and on the Company's website at www.magellanhealth.com as soon as practicable after the Company has electronically filed such material with, or furnished it to, the SEC. The information on the Company's website is not part of or incorporated by reference in this report on Form 10 K.

Item 1A. Risk Factors

Reliance on Customer Contracts—The Company's inability to renew, extend or replace expiring or terminated contracts could adversely affect the Company's liquidity, profitability and financial condition.

Substantially all of the Company's net revenue is derived from contracts that may be terminated immediately with cause and many, including some of the Company's most significant contracts, are terminable without cause by the customer upon notice and the passage of a specified period of time (typically between 60 and 180 days), or upon the occurrence of certain other specified events. The Company's ten largest customers accounted for approximately 43.9 percent, 40.3 percent and 51.7 percent of the Company's net revenue in the years ended December 31, 2016, 2017 and 2018, respectively. Loss of all of these contracts or customers would, and loss of any one of these contracts or customers could, materially reduce the Company's net revenue and have a material adverse effect on the Company's liquidity, profitability and financial condition. See Note 2—"Summary of Significant Accounting Policies—Significant Customers" to the consolidated financial statements set forth elsewhere herein for a discussion of the Company's significant customers.

Integration of Companies Acquired by Magellan—The Company's profitability could be adversely affected if the integration of companies acquired by Magellan is not completed in a timely and effective manner.

One of the Company's growth strategies is to make strategic acquisitions which are complementary to its existing operations. After Magellan closes on an acquisition, it must integrate the acquired company into Magellan's policies, procedures and systems. Failure to effectively integrate an acquired business or the failure of the acquired business to perform as anticipated could result in excessive costs being incurred, a delay in obtaining targeted synergies, decreased customer performance (which could result in contract penalties and/or terminations), increased employee turnover, and lost sales opportunities. Finally, difficulties assimilating acquired operations and services could result in the diversion of capital and management's attention away from other business issues and opportunities.

Changes in the Medical Managed Care Carve Out Industry—Certain changes in the business practices of this industry could negatively impact the Company's resources, profitability and results of operations.

A portion of the Company's Healthcare and Pharmacy Management segments' net revenues are derived from customers in the medical managed healthcare industry, including managed care companies, health insurers and other health plans. Some types of changes in this industry's business practices could negatively impact the Company. For example, if the Company's managed care customers seek to provide services directly to their subscribers, instead of contracting with the Company for such services, the Company could be adversely affected. In this regard, certain of the Company's major customers in the past have not renewed all or part of their contracts with the Company, and instead provided managed healthcare services directly to their subscribers. In addition, the Company has a significant number of contracts with Blue Cross Blue Shield plans and other regional health plans. Consolidation of the healthcare industry through acquisitions and mergers could potentially result in the loss of contracts for the Company. Any of

these changes could reduce the Company's net revenue, and adversely affect the Company's profitability and financial condition.

Changes in the Contracting Model for Medicaid Contracts—Certain changes in the contracting model used by states for managed healthcare services contracts relating to Medicaid lives could negatively impact the Company's resources, profitability and results of operations.

A portion of the Company's Healthcare segment net revenue is derived from direct contracts that it has with state or county governments for the provision of services to Medicaid enrollees. Certain states have recently contracted

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with managed care companies to manage both the behavioral and physical medical care of their Medicaid enrollees. If other governmental entities change the method for contracting for Medicaid business to a fully integrated model, the Company will attempt to subcontract with the managed care organizations to provide behavioral healthcare management for such Medicaid business; however, there is no assurance that the Company would be able to secure such arrangements. Alternatively, the Company may choose to pursue licensure as a health plan to bid on this integrated business. Accordingly, if such a change in the contracting model were to occur, it is possible that the Company could lose current contracted revenues, as well as be unable to bid on potential new business opportunities, thus negatively impacting the Company's profitability and financial condition.

Risk Based Products—Because the Company provides services at a fixed fee, if the Company is unable to maintain historical margins, or is unable to accurately predict and control healthcare costs, the Company's profitability could decline.

The Company derives its net revenue primarily from arrangements under which the Company assumes responsibility for costs of treatment in exchange for a fixed fee. The Company refers to such arrangements as "risk based contracts" or "risk based products," which include EAP services. These arrangements provided 49.1 percent, 49.6 percent and 59.3 percent of the Company's net revenue in the years ended December 31, 2016, 2017 and 2018, respectively.

The profitability of the Company's risk contracts could be reduced if the Company is unable to maintain its historical margins. The competitive environment for the Company's risk products could result in pricing pressures which cause the Company to reduce its rates. In addition, customer demands or expectations as to margin levels could cause the Company to reduce its rates. A reduction in risk rates which are not accompanied by a reduction in services covered or expected underlying care trend could result in a decrease in the Company's operating margins.

Profitability of the Company's risk contracts could also be reduced if the Company is unable to accurately estimate the rate of service utilization by members or the cost of such services when the Company prices its services. The Company's assumptions of utilization and costs when the Company prices its services may not ultimately reflect actual utilization rates and costs, many aspects of which are beyond the Company's control. If the cost of services provided to members under a contract together with the administrative costs exceeds the aggregate fees received by the Company under such contract, the Company will incur a loss on the contract.

The Company's profitability could also be reduced if the Company is required to make adjustments to estimates made in reporting historical financial results regarding cost of care, reflected in the Company's financial statements as medical claims payable. Medical claims payable includes reserves for incurred but not reported ("IBNR") claims, which are claims for covered services rendered by the Company's providers which have not yet been submitted to the Company for payment. The Company estimates and reserves for IBNR claims based on past claims payment experience, including the average interval between the date services are rendered and the date the claims are received and between the date services are rendered and the date claims are paid, enrollment data, utilization statistics, adjudication decisions, authorized healthcare services and other factors. This data is incorporated into contract specific reserve models. The estimates for submitted claims and IBNR claims are made on an accrual basis and adjusted in future periods as required.

If such risk based products are not correctly underwritten, the Company's profitability and financial condition could be adversely affected. Factors that affect the Company's ability to price the Company's services, or accurately make estimates of IBNR claims and other expenses for which the Company creates reserves may include differences between the Company's assumptions and actual results arising from, among other things:

- changes in the delivery system;
- changes in utilization patterns;

- changes in the number of members seeking treatment;
- unforeseen fluctuations in claims backlogs;
- unforeseen increases in the costs of the services;

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- the occurrence of catastrophes;
- regulatory changes; and
- changes in benefit plan design.

Some of these factors could impact the ability of the Company to manage and control the medical costs to the extent assumed in the pricing of its services.

If the Company's membership in risk based business continues to grow (which is a major focus of the Company's strategy), the Company's exposure to potential losses from risk based products will also increase.

Expansion of Risk Based Products—Because the Company intends to continue its expansion into clinically integrated management of special populations eligible for Medicaid and Medicare including individuals with SMI, and other unique high cost populations, if the Company is unable to accurately underwrite the healthcare cost risk for this new business and control associated costs, the Company's profitability could decline.

The Company believes that it can leverage its information systems, call center, claims and network infrastructure as well as its financial strength and underwriting expertise to facilitate the development of risk product offerings to states that include behavioral healthcare and physical medical care for their special Medicaid and dual eligible populations, particularly individuals with SMI. As the Company expands into new markets, the Company will incur start up costs to develop and grow this business. The Company's profitability may be negatively impacted until such time that sufficient business is generated to offset these start up costs.

Furthermore, as the Company expands into new markets, there is an increased risk associated with the underwriting and implementation for this business. Profitability of any such business could be adversely affected if the Company is unable to accurately estimate the rate of service utilization or the cost of such services when the Company prices its services. The Company's assumptions of utilization and costs when the Company prices its services may not ultimately reflect actual utilization rates and costs, many aspects of which are beyond the Company's control. If the cost of services provided to members under a contract together with the administrative costs exceeds the aggregate fees received by the Company under such contract, the Company will incur a loss on the contract.

The Company may partner with managed care organizations to create joint ventures in some states. Conflicts or disagreements between the Company and any joint venture partner may negatively impact the benefits to be achieved by the relevant joint venture or may ultimately threaten the ability of any such joint venture to continue. The Company is also subject to additional risks and uncertainties because the Company may be dependent upon, and subject to, liability, losses or reputational damage relating to systems, controls and personnel that are not entirely under the Company's control.

Provider Agreements—Failure to maintain or to secure cost effective healthcare provider contracts may result in a loss of membership or higher medical costs.

The Company's profitability depends, to an extent, upon the ability to contract favorably with certain healthcare providers. The Company may be unable to enter into agreements with providers in new markets on a timely basis or under favorable terms. If the Company is unable to retain its current provider contracts or enter into new provider contracts timely or on favorable terms, the Company's profitability could be reduced. The Company cannot provide any assurance that it will be able to continue to renew its existing provider contracts or enter into new contracts.

Pharmacy Management—Loss of Relationship with Providers—If we lose our relationship, or our relationship otherwise changes in an unfavorable manner, with one or more key pharmacy providers or if significant changes occur within the pharmacy provider marketplace, or if other issues arise with respect to our pharmacy networks, our business could be adversely affected.

Our operations are dependent to a significant extent on our ability to obtain discounts on prescription purchases from retail pharmacies that can be utilized by our clients and their members. Our contracts with retail pharmacies, which are non exclusive, are generally terminable by either party on short notice. If one or more of our top pharmacy chains elects to terminate its relationship with us, or if we are only able to continue our relationship on terms less favorable to

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us, access to retail pharmacies by our clients and their health plan members, and consequently our business, results of operations, financial condition or cash flows could be adversely affected.

Pharmacy Management—Loss of Relationship with Vendors—Our specialty pharmacies, pharmacy claims processing, and mail processing are dependent on our relationships with a limited number of vendors and suppliers and the loss of any of these relationships could significantly impact our ability to sustain our financial performance.

We acquire a substantial percentage of our specialty pharmacies prescription drug supply from a limited number of suppliers. Our agreements with these suppliers may be short term and cancelable by either party without cause with a relatively short time frame of prior notice. These agreements may limit our ability to provide services for competing drugs during the term of the agreement and allow the supplier to dispense through channels other than us. Further, certain of these agreements allow pricing and other terms of these relationships to be periodically adjusted for changing market conditions or required service levels. A termination or modification to any of these relationships could have an adverse effect on our business, financial condition and results of operations. An additional risk related to supply is that many products dispensed by our specialty pharmacy business are manufactured with ingredients that are susceptible to supply shortages. If any products we dispense are in short supply for long periods of time, this could result in a material adverse effect on our business, financial condition and results of operations. Further, we source from a limited number of vendors certain aspects of our pharmacy claims and mail processing capabilities. An interruption of service, termination or modification to the terms to any of these agreements may adversely affect our business and financial condition.

Pharmacy Management—Loss of Relationship with Manufacturers—If we lose relationships with one or more key pharmaceutical manufacturers or third party rebate administrators or if rebate payments we receive from pharmaceutical manufacturers and rebate processing service providers decline, our business, results of operations, financial condition or cash flows could be adversely affected.

We receive fees from our clients for administering rebate programs with pharmaceutical manufacturers based on the use of selected drugs by members of health plans sponsored by our clients, as well as fees for other programs and services. Our business, results of operations, financial condition or cash flows could be adversely affected if:

- we lose relationships with one or more key pharmaceutical manufacturers or third party rebate administrators;
- we are unable to renew or finalize rebate contracts with one or more key pharmaceutical manufacturers in the future, or are unable to negotiate interim arrangements;
- rebates decline due to the failure of our health plan sponsors to meet market share or other thresholds;
- legal restrictions are imposed on the ability of pharmaceutical manufacturers to offer rebates or purchase our programs or services;
- pharmaceutical manufacturers choose not to offer rebates or purchase our programs or services; or
- rebates decline due to contract branded products losing their patients.

Fluctuation in Operating Results—The Company experiences fluctuations in quarterly operating results and, as a consequence, the Company may fail to meet or exceed market expectations, which could cause the Company's stock price to decline.

The Company's quarterly operating results have varied in the past and may fluctuate significantly in the future due to seasonal and other factors, including:

- changes in utilization levels by enrolled members of the Company's risk based contracts, including seasonal utilization patterns (for example, members generally tend to seek services less during the third and fourth quarters of the year than in the first and second quarters of the year);

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- performance based contractual adjustments to net revenue, reflecting utilization results or other performance measures;
- changes in estimates for contractual adjustments under commercial contracts;
- retrospective membership adjustments;
- the timing of implementation of new contracts, enrollment changes and contract terminations;
- pricing adjustments upon contract renewals;
- the timing of acquisitions;
- changes in estimates regarding medical costs and IBNR claims;
- the timing of recognition of pharmacy revenues, including rebates and Medicare Part D; and
- changes in estimates of contingent consideration.

These factors may affect the Company's quarterly and annual net revenue, expenses and profitability in the future and, accordingly, the Company may fail to meet market expectations, which could cause the Company's stock price to decline.

Dependence on Government Spending—The Company can be adversely affected by changes in federal, state and local healthcare policies, programs, funding and enrollments.

A portion of the Company's net revenues are derived, directly or indirectly, from governmental agencies, including state Medicaid programs. Contract rates vary from state to state, are subject to periodic negotiation and may limit the Company's ability to maintain or increase rates. The Company is unable to predict the impact on the Company's operations of future regulations or legislation affecting Medicaid programs, or the healthcare industry in general. Future regulations or legislation may have a material adverse effect on the Company. Moreover, any reduction in government spending for such programs could also have a material adverse effect on the Company (See "Reliance on Customer Contracts"). In addition, the Company's contracts with federal, state and local governmental agencies, under both direct contract and subcontract arrangements, generally are conditioned upon financial appropriations by one or more governmental agencies, especially in the case of state Medicaid programs. These contracts generally can be terminated or modified by the customer if such appropriations are not made. The Company faces increased risks in this regard as state budgets have come under increasing pressure. Finally, some of the Company's contracts with federal, state and local governmental agencies, under both direct contract and subcontract arrangements, require the Company to perform additional services if federal, state or local laws or regulations imposed after the contract is signed so require, in exchange for additional compensation, to be negotiated by the parties in good faith. Government and other third party payors generally seek to impose lower contract rates and to renegotiate reduced contract rates with service providers in a trend toward cost control.

Restrictive Covenants in the Company's Debt Instruments—Restrictions imposed by the Company's debt agreements limit the Company's operating and financial flexibility. These restrictions may adversely affect the Company's ability to finance the Company's future operations or capital needs or engage in other business activities that may be in the Company's interest.

On September 22, 2017, the Company completed the public offering of $400.0 million aggregate principal amount of its 4.400% Senior Notes due 2024 (the "Notes"). The Notes are governed by an indenture, dated as of September 22, 2017 (the "Base Indenture"), between the Company, as issuer and U.S. Bank National Association, as trustee, as supplemented by a first supplemental indenture, dated as of September 22, 2017 (the "First Supplemental Indenture" together, with the Base Indenture, the "Indenture"), between the Company, as issuer, and U.S. Bank National Association, as trustee.

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The Indenture contains certain covenants which restrict the Company's ability to, among other things, create liens on its and its subsidiaries' assets; engage in sale and lease-back transactions; and engage in a consolidation, merger or sale of assets.

On September 22, 2017, the Company entered into a credit agreement with various lenders that provides for a $400.0 million senior unsecured revolving credit facility and a $350.0 million senior unsecured term loan facility to the Company, as the borrower (the "2017 Credit Agreement"). On August 13, 2018, the Company entered into an amendment to the 2017 Credit Agreement, which extended the maturity date by one year. On February 27, 2019, the Company entered into a second amendment to the 2017 Credit Agreement, which amended the total leverage ratio covenant, and which was necessary in order for us to remain in compliance with the terms of the 2017 Credit Agreement. The 2017 Credit Agreement is scheduled to mature on September 22, 2023.

The 2017 Credit Agreement contains covenants that limit management's discretion in operating the Company's business by restricting or limiting the Company's ability, among other things, to:

- incur or guarantee additional indebtedness or issue preferred or redeemable stock;
- pay dividends and make other distributions;
- repurchase equity interests;
- make certain advances, investments and loans;
- enter into sale and leaseback transactions;
- create liens;
- sell and otherwise dispose of assets;
- acquire or merge or consolidate with another company; and
- enter into some types of transactions with affiliates.

These restrictions could adversely affect the Company's ability to finance future operations or capital needs or engage in other business activities that may be in the Company's interest. The 2017 Credit Agreement also requires the Company to comply with specified financial ratios and tests. Failure to do so, unless waived by the lenders under the 2017 Credit Agreement, pursuant to its terms, or amended, would result in an event of default.

Required Assurances of Financial Resources—The Company's liquidity, financial condition, prospects and profitability can be adversely affected by present or future state regulations and contractual requirements that the Company provide financial assurance of the Company's ability to meet the Company's obligations.

Some of the Company's contracts and certain state regulations require the Company or certain of the Company's subsidiaries to maintain specified cash reserves or letters of credit and/or to maintain certain minimum tangible net equity in certain of the Company's subsidiaries as assurance that the Company has financial resources to meet the Company's contractual obligations. Many of these state regulations also restrict the investment activity of certain of the Company's subsidiaries. Some state regulations also restrict the ability of certain of the Company's subsidiaries to pay dividends to Magellan. Additional state regulations could be promulgated that would increase the cash or other security the Company would be required to maintain. In addition, the Company's customers may require additional restricted cash or other security with respect to the Company's obligations under the Company's contracts, including the Company's obligation to pay IBNR claims and other medical claims not yet processed and paid. In addition, certain of the Company's contracts and state regulations limit the profits that the Company may earn on risk based business. The Company's liquidity, financial condition, prospects and profitability could be adversely affected by the effects of such regulations and contractual provisions. See Note 2—"Summary of Significant Accounting Policies—Restricted Assets" to the consolidated financial statements set forth elsewhere herein for a discussion of the Company's restricted assets.

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Competition—The competitive environment in the managed healthcare industry may limit the Company's ability to maintain or increase the Company's rates, which would limit or adversely affect the Company's profitability, and any failure in the Company's ability to respond adequately may adversely affect the Company's ability to maintain contracts or obtain new contracts.

The Company's business is highly competitive. The Company competes with other healthcare organizations as well as with insurance companies, including HMOs, PPOs, TPAs, IPAs, multi disciplinary medical groups, PBMs, specialty pharmacy companies, radiology benefits management companies and other specialty healthcare and managed care companies. Many of the Company's competitors, particularly certain insurance companies, HMOs and PBMs are significantly larger and have greater financial, marketing and other resources than the Company, which can create downward pressure on prices through economies of scale. The entrance or expansion of these larger companies in the managed healthcare industry (including the Company's customers who have in sourced or who may choose to in source healthcare services) could increase the competitive pressures the Company faces and could limit the Company's ability to maintain or increase the Company's rates. If this happens, the Company's profitability could be adversely affected. In addition, if the Company does not adequately respond to these competitive pressures, it could cause the Company to not be able to maintain its current contracts or to not be able to obtain new contracts.

Possible Impact of Federal Healthcare Reform Law—can significantly impact the Company's revenues or profitability.

The ACA is a comprehensive piece of legislation intended to make significant changes to the healthcare system in the United States. The ACA contains various effective dates extending through 2020. Numerous regulations have been promulgated related to the ACA with hundreds more expected in the future.

Significant provisions in the ACA include requiring individuals to purchase health insurance, minimum medical loss ratios for health insurance issuers, significant changes to the Medicare and Medicaid programs and many other changes that affect healthcare insurance and managed care. See "Regulation" above for more information. Therefore, it is uncertain at this time what the financial impact of healthcare reform will be to the Company. The Company cannot predict the effect of this legislation or other legislation that may be adopted by the United States Congress or by the states, and such legislation, if implemented, could have an adverse effect on the Company.

The ACA also contains provisions related to fees that impact the Company's direct public sector contracts and provisions regarding the non deductibility of those fees. Our state public sector customers have made rate adjustments to cover the direct costs of these fees and a majority of the impact from non deductibility of such fees for federal income tax purposes. There may be some impact due to taxes paid for non renewing customers where the timing and amount of recoupment of these additional costs are uncertain. There can be no assurances that public sector customers may make rate adjustments to cover the direct costs of these fees in the future, so there can be no guarantees regarding this adjustment from our state public sector customers and these taxes and fees may have a material impact on the Company.

Possible Impact of Federal Mental Health Parity—can significantly impact the Company's revenues or profitability.

In October 2008, the United States Congress passed the Paul Wellstone and Pete Dominici Mental Health Parity Act of 2008 ("MHPAEA") establishing parity in financial requirements (e.g. co pays, deductibles, etc.) and treatment limitations (e.g., limits on the number of visits) between mental health and substance abuse benefits and medical/surgical benefits for health plan members. This law does not require coverage for mental health or substance abuse disorders but if coverage is provided it must be provided at parity. No specific disorders are mandated for coverage; health plans are able to define mental health and substance abuse to determine what they are going to cover. Under the ACA non grandfathered individual and small group plans (both on and off of the exchange) are required to provide mental health and substance use disorder benefits as essential health benefits. These mandated benefits under

the ACA must be provided at parity in these plans. Under the ACA, grandfathered individual plans are required to comply with parity if they offer behavioral health benefits. Grandfathered small group plans are exempt from requirements to provide essential health benefits and parity requirements. State mandated benefits laws are not preempted. The law applies to ERISA plans, Medicaid managed care plans and SCHIP plans. On February 2, 2010, the Department of the Treasury, the Department of Labor and the Department of Health and Human Services issued Interim Final Rules interpreting the MHPAEA (“IFR”). The IFR applies to ERISA plans and insured business. A State Medicaid Director Letter was issued in January 2013 discussing applicability of parity to Medicaid managed care plans, SCHIP plans and Alternative Benefit (Benchmark) Plans. It is possible that some states will change their behavioral health plan benefits or management

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techniques as a result of this letter. On November 13, 2013 the Department of the Treasury, the Department of Labor and the Department of Health and Human Services issued Final Rules on the MHPAEA ("Final Rules"). The IFR included some concepts not included under the statute including the requirement to conduct the parity review at the category level within the plan, introducing the concept of non quantitative treatment limitations, and prohibiting separate but equal deductibles. While some of the regulatory requirements in the IFR were not anticipated, the Company believes it is in compliance with the requirements of the IFR. The Company does not anticipate any significant impacts from the Final Rules however it is still reviewing and assessing the Final Rules with customers. The Company's risk contracts do allow for repricing to occur effective the same date that any legislation/regulation becomes effective if that legislation/regulation is projected to have a material effect on cost of care.

Government Regulation—The Company is subject to substantial government regulation and scrutiny, which increase the Company's costs of doing business and could adversely affect the Company's profitability.

The managed healthcare industry is subject to extensive and evolving federal and state regulation. Such laws and regulations cover, but are not limited to, matters such as licensure, accreditation, government healthcare program participation requirements, information privacy and security, reimbursement for patient services, and Medicare and Medicaid fraud and abuse. The Company's pharmaceutical management business is also the subject of substantial federal and state governmental regulation and scrutiny.

The Company is subject to certain state laws and regulations and federal laws as a result of the Company's role in management of customers' employee benefit plans.

Regulatory issues may also affect the Company's operations including, but not limited to:

- additional state licenses that may be required to conduct the Company's businesses, including utilization review, PBM, pharmacy, HMO and TPA activities;
- limits imposed by state authorities upon corporations' control or excessive influence over managed healthcare services through the direct employment of physicians, psychiatrists, psychologists or other professionals, and prohibiting fee splitting;
- laws that impose financial terms and requirements on the Company due to the Company's assumption of risk under contracts with licensed insurance companies or HMOs;
- laws in certain states that impose an obligation to contract with any healthcare provider willing to meet the terms of the Company's contracts with similar providers;
- compliance with HIPAA (including the federal HITECH Act, which strengthens and expands HIPAA) and other federal and state laws impacting the confidentiality of member information;
- state legislation regulating PBMs or imposing fiduciary status on PBMs;
- pharmacy laws and regulation;
- legislation imposing benefit plan design restrictions, which limit how our clients can design their drug benefit plans; and
- network pharmacy access laws, including "any willing provider" and "due process" legislation, that affect aspects of our pharmacy network contracts.

The imposition of additional licensing and other regulatory requirements may, among other things, increase the Company's equity requirements, increase the cost of doing business or force significant changes in the Company's operations to comply with these requirements.

The costs associated with compliance with government regulation as discussed above may adversely affect the Company's financial condition and results of operation.

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Proposed changes to current Federal law and regulations could have a material and adverse impact on our PBM business.

On February 6, 2019, the Department of Health and Human Services Office of Inspector General published a proposed rule which would remove the anti-kickback regulatory safe harbor protection for prescription drug rebates paid by manufacturers to plan sponsors under Medicare Part D and Medicaid managed care. It also would create a new safe harbor protection for price discounts between manufacturers and PBMs if given at the point-of-sale. Comments on the proposed rule are due April 8, 2019 by 5:00 p.m. Eastern. This proposed rule would apply only to Medicare Part D and Medicaid managed care, and not commercial rebates. While we do not believe the proposed rule would have a material adverse impact on our business, additional legislative action could materially and adversely affect other parts of our pharmacy benefits management rebate business.

Noncompliance with Regulations—Noncompliance with regulations may have a material adverse effect on the Company's business, financial condition and results of operations, including from monetary or criminal liabilities and penalties, investigations or regulatory actions, additional compliance requirements, heightened governmental scrutiny, or exclusion from participating in government programs.

Extensive laws and regulation are applicable to all of our business operations. In addition to laws and regulations generally applicable to our business, the Company is subject to other federal laws and regulations in connection with its contracts with the federal government. These laws and regulations affect how the Company conducts business with its federal agency customers and may impose added costs on its business. Noncompliance by the Company with these laws and regulations may have a material adverse effect on the Company's business, financial condition and results of operations.

Government investigations and allegations have become more frequent concerning possible violations of statutes and regulations by healthcare organizations. The Company also conducts its own investigations into these matters and may choose to self-report its findings to governmental agencies. Violations by the Company with certain laws and regulations may result in it being excluded from participating in government healthcare programs, subject to fines or penalties or required to repay amounts received from the government for previously billed services. The Company's failure to comply with federal procurement laws and regulations could cause it to lose business, incur additional costs and subject it to a variety of civil and criminal penalties and administrative sanctions, including termination of contracts, forfeiture of profits, harm to reputation, suspension of payments, fines, and suspension or debarment from doing business with federal government agencies. In addition, alleged violations may result in litigation or regulatory action. A subsequent legal liability or a significant regulatory action against the Company could have a material adverse effect on the Company's business, financial condition and results of operations. Moreover, even if the Company ultimately prevails in any litigation, regulatory action or investigation, such litigation, regulatory action or investigation could have a material adverse effect on the Company's business, financial condition and results of operations.

The Company also receives notifications from and engages in discussions with various government agencies concerning the Company's businesses and operations. As a result of these contacts with regulators, the Company may, as appropriate, be required to implement changes to the Company's operations, revise the Company's filings with such agencies and/or seek additional licenses to conduct the Company's business. The Company's inability to comply with the various regulatory requirements may have a material adverse effect on the Company's business.

Reference is made to information set forth under "Regulation—Other Federal and State Laws and Regulations" under Item 1 of this Report.

Medicare Part D—The Company's participation in Medicare Part D is subject to government regulation and failure to comply with regulatory requirements could adversely impact the Company's profitability.

There are many uncertainties about the financial and regulatory risks of participating in the Medicare Part D program, and we can give no assurance these risks will not materially adversely impact the Company's results. Certain of the Company's subsidiaries have been approved by CMS to offer Medicare Part D prescription drug plans to individual beneficiaries and employer groups. Such subsidiaries are required to comply with Medicare Part D laws and regulations and, because CMS requires that Medicare Part D sponsors be licensed as risk bearing entities, also with applicable state laws and regulations regarding the business of insurance. The Company also provides services in support of our clients'

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Medicare Part D plans and must be able to deliver such services in a manner that complies with applicable regulatory requirements. We have made substantial investments in both human resources and the technology required to administer Medicare Part D benefits. The adoption of new or more complex regulatory requirements or changes in the interpretation of existing regulatory requirements associated with Medicare Part D may require us to incur significant costs or otherwise impact our ability to earn a profit on such business. In addition, the Company's receipt of federal funds made available through the Medicare Part D program is subject to compliance with the laws and regulations governing the federal government's payment for healthcare goods and services, including the federal anti kickback law and false claims acts. If we fail to comply materially with applicable regulatory or contractual requirements, whether identified through CMS or other government audits, client audits, or otherwise, we may be subject to certain sanctions, penalties, or other remedies, including, but not limited to, suspension of marketing or enrollment activities, restrictions on expanding our service area, civil monetary penalties or other monetary amounts, termination of our contract(s) with CMS or Part D clients, and exclusion from federal healthcare programs.

Medicare and Medicaid: Quality and Performance Measures - Failure to maintain satisfactory quality and performance measures may negatively affect our premium rates, subject us to penalties, limit or reduce our membership, or impede our ability to compete for new business in existing or new markets or result in the termination of our contracts, affect our ability to establish new health plans or expand current health plans, which could have a material adverse effect on our business, rate of growth and results of operations, financial condition and cash flows.

Quality scores are used by certain regulatory agencies to establish premium rates and/or calculate performance incentives. In the case of CMS, for example, quality based metrics are used to pay quality bonuses to Medicare Advantage plans that enable high scoring plans to offer enhanced health benefits for their MA beneficiaries.

MA Plans with Star Ratings of four (4.0) stars or higher are eligible for year-round open enrollment; conversely, plans with lower Star Ratings have more restricted times for enrollment of beneficiaries. MA Plans with Star Ratings of less than three (3.0) stars in three consecutive years are denoted as "low performing" plans on the CMS website and in the CMS "Medicare and You" handbook. In addition, in 2018 CMS had its authority reinstated to terminate MA Plan contracts for plans rated below three (3.0) stars in three consecutive years. CMS may begin terminations of low rated plans of MA Plans beginning with plan year 2023. As a result, MA Plans that achieve higher Star Ratings may have a competitive advantage over plans with lower Star Ratings. As a result, lower quality scores/Star ratings compared to our competitors could have a material adverse effect on our business, rate of growth, results of operation, financial condition, or cash flows.

For certain state Medicaid programs, plans that do not meet applicable quality and service measures may be subject to a range of penalties including being placed on a corrective action plan, denial of quality performance incentives, financial sanctions, reduction in capitation, enrollment limitations or termination of contract. We are unable to predict with any certainty what actions a state may take, if any, when assessing our contractual performance.

Failure to maintain satisfactory quality and service measures could also adversely affect our ability to establish new health plans or expand the business of our existing health plans. In addition, lower quality scores or Star ratings, when compared to our competitors, may adversely affect our ability to attract members and obtain regulatory approval for acquisitions or expansions, including expansion of Medicare Advantage health plans, or succeed in competitive bidding situations.

The Company faces risks related to unauthorized disclosure of sensitive or confidential member and other information.

As part of its normal operations, the Company collects, processes and retains confidential member information making the Company subject to various federal and state laws and rules regarding the use and disclosure of

confidential member information, including HIPAA. The Company also maintains other confidential information related to its business and operations. Despite appropriate security measures, the Company is subject to security breaches, acts of vandalism, computer viruses, misplaced or lost data, programming and/or human errors or other similar events. Noncompliance with any privacy or security laws and regulations (including, but not limited to, GDPR) or any security breach, whether by the Company or by its vendors, could result in enforcement actions, material fines and penalties and could also subject the Company to litigation.

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Cyber Security—The Company faces risks related to a breach or failure in our operational security systems or infrastructure, or those of third parties with which we do business.

Our business requires us to securely store, process and transmit confidential, proprietary and other information in our operations. Security breaches may arise from computer hackers penetrating our systems and approaching our employees to obtain personal information for financial gain, attempting to cause harm to our operations, or intending to obtain competitive information. Our data assets and systems are also subject to attack by viruses, worms, phishing attempts and other malicious software programs. We maintain a comprehensive system of preventive and detective controls through our security programs; however, our prevention and detection controls may not prevent or identify all such attacks. The costs to update our security protocols to mitigate a security breach could be significant. A breach or failure in our operational security systems may result in loss of data or an unauthorized disclosure of sensitive or confidential member or employee information and could result in significant penalties or fines, litigation, loss of customers, significant damage to our reputation and business, and other losses, which could adversely impact the Company's financial condition and results of operations.

We are subject to risks associated with outsourcing services and functions to third parties.

We contract with third party vendors and service providers who provide services to us and our subsidiaries or to whom we delegate selected functions. Some of these third-parties also have direct access to our systems. Our arrangements with third party vendors and service providers may make our operations vulnerable if those third parties fail to satisfy their obligations to us, including their obligations to maintain and protect the security and confidentiality of our information and data or the information and data relating to our members or customers. We are also at risk of a data security incident involving a vendor or third party, which could result in a breakdown of such third party's data protection processes or cyber-attackers gaining access to our infrastructure through the third party.

To the extent that a vendor or third party suffers a data security incident that compromises its operations, we could incur significant costs and possible service interruption, which could have an adverse effect on our business and operations. In addition, we may have disagreements with third party vendors and service providers regarding relative responsibilities for any such failures or incidents under applicable business associate agreements or other applicable outsourcing agreements.

Any contractual remedies and/or indemnification obligations we may have for vendor or service provider failures or incidents may not be adequate to fully compensate us for any losses suffered as a result of any vendor's failure to satisfy its obligations to us or under applicable law. Further, we may not be adequately indemnified against all possible losses through the terms and conditions of our contracts with third party vendors and service providers. Our outsourcing arrangements could be adversely impacted by changes in vendors' or service providers' operations or financial condition or other matters outside of our control.

If we fail to adequately monitor and regulate the performance of our third party vendors and service providers, we could be subject to additional risk, including significant cybersecurity risk. Violations of, or noncompliance with, laws and/or regulations governing our business (including, but not limited to, GDPR) or noncompliance with contract terms by third party vendors and service providers could increase our exposure to liability to our members, providers, or other third parties, or sanctions and/or fines from the regulators that oversee our business. In turn, this could increase the costs associated with the operation of our business or have an adverse impact on our business and reputation. Moreover, if these vendor and service provider relationships were terminated for any reason, we may not be able to find alternative partners in a timely manner or on acceptable financial terms, and may incur significant costs and/or disruption to our operations in connection with any such vendor or service provider transition. As a result, we may not be able to meet the full demands of our members or customers and, in turn, our business, financial condition, or results of operations may be harmed. In addition, we may not fully realize the anticipated economic and other benefits from

our outsourcing projects or other relationships we enter into with third party vendors and service providers, as a result of regulatory restrictions on outsourcing, unanticipated delays in transitioning our operations to the third party, vendor or service provider noncompliance with contract terms or violations of laws and/or regulations, or otherwise. This could result in substantial costs or other operational or financial problems that could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

The Company faces additional regulatory risks associated with its Pharmacy Management segment which could subject it to additional regulatory scrutiny and liability and which could adversely affect the profitability of the

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Pharmacy Management segment in the future.

Various aspects of the Company's Pharmacy Management segment are governed by federal and state laws and regulations. Pharmaceutical management services are provided by the Company to Medicaid and Medicare plans as well as commercial insurance plans. There has been enhanced scrutiny on federal programs and the Company must remain vigilant in ensuring compliance with the requirements of these programs. In addition, there are provisions of the ACA which may impact the Company's business. For example, the ACA imposes transparency requirements on PBMs. PBMs have also increasingly become the target of federal and state litigation over alleged practices relating to prescription drug switching, soliciting, and receiving unlawful remuneration, handling rebates, and fiduciary duties, among others. Significant sanctions may be imposed for violations of these laws and compliance programs are a significant operational requirement of the Company's business. There are significant uncertainties involving the application of many of these legal requirements to the Company. Accordingly, the Company may be required to incur additional administrative and compliance expenses in determining the applicable requirements and in adapting its compliance practices, or modifying its business practices, in order to satisfy changing interpretations and regulatory policies. In addition, there are numerous proposed healthcare laws and regulations at the federal and state levels, many of which, if adopted, could adversely affect the Company's business. See "Regulation" above.

Risks Related to Realization of Goodwill and Intangible Assets—The Company's profitability could be adversely affected if the value of intangible assets is not fully realized.

The Company's total assets at December 31, 2018 reflect goodwill of approximately $1.0 billion, representing approximately 34.1 percent of total assets. The Company completed its annual impairment analysis of goodwill as of October 1, 2018, noting that no impairment was identified.

At December 31, 2018, identifiable intangible assets (customer lists, contracts, provider networks and trade names) totaled approximately $231.9 million. Intangible assets are generally amortized over their estimated useful lives, which range from approximately one to eighteen years. The amortization periods used may differ from those used by other entities. In addition, the Company may be required to shorten the amortization period for intangible assets in future periods based on changes in the Company's business. There can be no assurance that such goodwill or intangible assets will be realizable.

The Company evaluates, on a regular basis, whether for any reason the carrying value of the Company's intangible assets and other long lived assets may no longer be completely recoverable, in which case a charge to earnings for impairment losses could become necessary. When events or changes in circumstances occur that indicate the carrying amount of long lived assets may not be recoverable, the Company assesses the recoverability of long lived assets other than goodwill by determining whether the carrying value of such assets will be recovered through the future cash flows expected from the use of the asset and its eventual disposition.

The 2018 annual goodwill impairment testing as of October 1, 2018, determined that the fair value of the MCC reporting unit had declined, largely due to continued economic challenges in certain markets, and was in excess of its carrying value by a margin of approximately 5%. We considered our observed fourth quarter performance in our October 1, 2018 test. At December 31, 2018, we evaluated whether our forecast for 2019 and beyond would have changed from what was used in our October 1, 2018 test. Based on this evaluation, we continue to believe that the fair value of the MCC reporting unit exceeds its carrying value by a margin of approximately 5%. While the reporting unit was not determined to be impaired at this time, the MCC reporting unit goodwill is at risk of future impairment in the event of significant unfavorable changes in the Company's forecasted future results and cash flows. In addition, market factors utilized in the impairment analysis, including long-term growth rates or discount rates, could negatively impact the fair value of our reporting units. For testing purposes, management's best estimates of the expected future results are the primary driver in determining the fair value. Fair value determinations require considerable judgment and are

sensitive to changes in underlying assumptions and factors. As a result, there can be no assurance that the estimates and assumptions made for purposes of the annual goodwill test will prove to be an accurate prediction of the future.

Examples of events or circumstances that could reasonably be expected to negatively affect the underlying key assumptions and ultimately impact the estimated fair value of our reporting units may include such items as: (i) a decrease in expected future cash flows, specifically, a decrease in membership or rates or customer attrition and increase in costs that could significantly impact our immediate and long-range results, unfavorable working capital changes and an inability to successfully achieve our cost savings targets, (ii) adverse changes in macroeconomic conditions or an

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economic recovery that significantly differs from our assumptions in timing and/or degree (such as a recession); and (iii) volatility in the equity and debt markets or other country specific factors which could result in a higher weighted-average cost of capital.

Based on known facts and circumstances, we evaluate and consider recent events and uncertain items, as well as related potential implications, as part of our annual assessment and incorporate into the analyses as appropriate. These facts and circumstances are subject to change and may impact future analyses.

While historical performance and current expectations have resulted in fair values of our reporting units and indefinite-lived intangible assets in excess of carrying values, if our assumptions are not realized, it is possible that an impairment charge may need to be recorded in the future.

Any event or change in circumstances leading to a future determination requiring write off of a significant portion of unamortized intangible assets or goodwill would adversely affect the Company's profitability.

Claims for Professional Liability—Pending or future actions or claims for professional liability (including any associated judgments, settlements, legal fees and other costs) could require the Company to make significant cash expenditures and consume significant management time and resources, which could have a material adverse effect on the Company's profitability and financial condition.

The Company's operating activities entail significant risks of liability. In recent years, participants in the healthcare industry generally, as well as the managed healthcare industry, have become subject to an increasing number of lawsuits. From time to time, the Company is subject to various actions and claims of professional liability alleging negligence in performing utilization review and other managed healthcare activities, as well as for the acts or omissions of the Company's employees, including employed physicians and other clinicians, network providers, pharmacists, or others. In the normal course of business, the Company receives reports relating to deaths and other serious incidents involving patients whose care is being managed by the Company. Such incidents occasionally give rise to malpractice, professional negligence and other related actions and claims against the Company, the Company's employees or the Company's network providers. The Company is also subject to actions and claims for the costs of services for which payment was denied. Many of these actions and claims seek substantial damages and require the Company to incur significant fees and costs related to the Company's defense and consume significant management time and resources. While the Company maintains professional liability insurance, there can be no assurance that future actions or claims for professional liability (including any judgments, settlements or costs associated therewith) will not have a material adverse effect on the Company's profitability and financial condition.

Professional Liability and Other Insurance—Claims brought against the Company that exceed the scope of the Company's liability coverage or denial of coverage could materially and adversely affect the Company's profitability and financial condition.

The Company maintains a program of insurance coverage against a broad range of risks in the Company's business. As part of this program of insurance, the Company carries professional liability insurance, subject to certain deductibles and self insured retentions. The Company also is sometimes required by customer contracts to post surety bonds with respect to the Company's potential liability on professional responsibility claims that may be asserted in connection with services the Company provides. As of December 31, 2018, the Company had approximately $80.1 million of such bonds outstanding. The Company's insurance may not be sufficient to cover any judgments, settlements or costs relating to present or future claims, suits or complaints. Upon expiration of the Company's insurance policies, sufficient insurance may not be available on favorable terms, if at all. To the extent the Company's customers are entitled to indemnification under their contracts with the Company relating to liabilities they incur arising from the operation of the Company's programs, such indemnification may not be covered under the Company's insurance

policies. To the extent that certain actions and claims seek punitive and compensatory damages arising from the Company's alleged intentional misconduct, such damages, if awarded, may not be covered, in whole or in part, by the Company's insurance policies. If the Company is unable to secure adequate insurance in the future, or if the insurance the Company carries is not sufficient to cover any judgments, settlements or costs relating to any present or future actions or claims, such judgments, settlements or costs may have a material adverse effect on the Company's profitability and financial condition. If the Company is unable to obtain needed surety bonds in adequate amounts or make alternative arrangements to satisfy the requirements for such bonds, the Company may no longer be able to operate in those states, which would have a material adverse effect on the Company.

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Class Action Suits and Other Legal Proceedings—The Company is subject to class action and other lawsuits that could result in material liabilities to the Company or cause the Company to incur material costs, to change the Company's operating procedures in ways that increase costs or to comply with additional regulatory requirements.

Managed healthcare companies and PBM companies have been targeted as defendants in national class action lawsuits regarding their business practices. The Company has in the past been subject to such national class actions as defendants and is also subject to or a party to other class actions, lawsuits and legal proceedings in conducting the Company's business, including but not limited to, claims by network providers. In addition, certain of the Company's customers are parties to pending class action lawsuits regarding the customers' business practices for which the customers could seek indemnification from the Company. These lawsuits may take years to resolve and cause the Company to incur substantial litigation expense, and the outcomes could have a material adverse effect on the Company's profitability and financial condition. In addition to potential damage awards, depending upon the outcomes of such cases, these lawsuits may cause or force changes in practices of the Company's industry and may also cause additional regulation of the industry through new federal or state laws or new applications of existing laws or regulations. Such changes could increase the Company's operating costs.

Negative Publicity—The Company may be subject to negative publicity which may adversely affect the Company's business, financial position, results of operations or cash flows.

From time to time, the managed healthcare industry has received negative publicity. This publicity has led to increased legislation, regulation, review of industry practices and private litigation. These factors may adversely affect the Company's ability to market our services, require the Company to change its services, or increase the overall regulatory burden under which the Company operates. Any of these factors may increase the costs of doing business and adversely affect the Company's business, financial position, results of operations or cash flows.

Investment Portfolio—The value of the Company's investments is influenced by varying economic and market conditions, and a decrease in value may result in a loss charged to income.

All of the Company's investments are classified as "available for sale" and are carried at fair value. The Company's available for sale investment securities were $385.7 million and represented 12.9 percent of the Company's total assets at December 31, 2018.

The current economic environment and recent volatility of securities markets increase the difficulty of assessing investment impairment and the same influences tend to increase the risk of potential impairment of these assets. The Company believes it has adequately reviewed its investment securities for impairment and that its investment securities are carried at fair value. However, over time, the economic and market environment may provide additional insight regarding the fair value of certain securities, which could change the Company's judgment regarding impairment. This could result in realized losses relating to other than temporary declines being charged against future income. Given the current market conditions and the significant judgments involved, there is a risk that declines in fair value may occur and material other than temporary impairments may be charged to income in future periods, resulting in realized losses. In addition, if it became necessary for the Company to liquidate its investment portfolio on an accelerated basis, it could have an adverse effect on the Company's results of operations.

Adverse Economic Conditions—Adverse changes in national economic conditions could adversely affect the Company's business and results of operations.

Changes in national economic conditions could adversely affect the Company's reimbursement from state Medicaid programs in its Healthcare segment. Adverse economic conditions could also adversely affect the Company's customers in the Healthcare and Pharmacy Management segments resulting in increased pressures on the Company's

operating margins. In addition, economic conditions may result in decreased membership in the Healthcare and Pharmacy Management segments, thereby adversely affecting the revenues to the Company from such customers as well as the Company's operating profitability.

Adverse economic conditions in the debt markets could affect the Company's ability to refinance the Company's existing Credit Agreement upon its maturity on acceptable terms, or at all.

If we are unable to successfully execute our margin improvement initiatives and plans, or if we fail to realize the

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anticipated benefits of those initiatives and plans, our business, cash flows, financial position, or results of operations could be materially and adversely affected.

In December 2018, we announced the implementation of a margin and profitability improvement plan. The margin improvement plan includes flattening our organizational structure, standardizing our healthcare administrative functions and automating certain core operating processes.

Our restructuring plan and profit improvement initiatives may create uncertainties, including the effect of the initiatives and plan on our business, operations, revenues, and profitability, potential disruptions to our business as a result of management's attention to the initiatives and plan, uncertainty regarding the potential amount and timing of future cost savings associated with the initiatives and plan, and the potential negative impact of the initiatives and plan on employee morale. The success of the initiatives and plan will depend, in part, on factors that are beyond our control. Accordingly, we can provide no assurance that the goals of the initiatives and plan will be fully achieved. Failure in this regard could have a material and adverse impact on our business, cash flows, financial position, or results of operations.

Tax matters, including the changes in corporate tax rates, disagreements with taxing authorities and imposition of new taxes could impact our results of operations and financial condition.

We are subject to income and other taxes in the U.S. and our operations, plans and results of operations are affected by tax and other initiatives. As a result of the passage of the Tax Cuts and Jobs Act (the "Tax Act"), corporate tax rates in the United States decreased in 2018, which resulted in changes to our valuation of our deferred tax asset and liabilities. These changes in valuation were material to our income tax expense and deferred tax balances.

We are also subject to regular reviews, examinations, and audits by the Internal Revenue Service and other taxing authorities with respect to our taxes. Although we believe our tax estimates are reasonable, if a taxing authority disagrees with the positions we have taken, we could face additional tax liability, including interest and penalties. There can be no assurance that payment of such additional amounts upon final adjudication of any disputes will not have a material impact on our results of operations and financial position.

Our effective tax rate in the future could be adversely affected by changes to our operating structure, changes in the mix of earnings in jurisdictions with differing statutory tax rates, changes in the valuation of deferred tax assets and liabilities, changes in the application or interpretation of the Tax Act, or other changes in tax laws.

Item 1B. Unresolved Staff Comments

None.

Item 2. Properties

The Company currently leases approximately 1.1 million square feet of office space comprising 68 offices in 25 states and the District of Columbia with terms expiring between February 28, 2019 and November 30, 2025. The Company's principal executive offices are located in Scottsdale, Arizona, which lease expires in October 2019. The Company believes that its current facilities are suitable for and adequate to support the level of its present operations.

Item 3. Legal Proceedings

The Company's operating activities entail significant risks of liability. From time to time, the Company is subject to various actions and claims arising from the acts or omissions of its employees, network providers or other parties. In the normal course of business, the Company receives reports relating to deaths and other serious incidents involving patients whose care is being managed by the Company. Such incidents occasionally give rise to malpractice, professional negligence and other related actions and claims against the Company or its network providers. Many of these actions and claims received by the Company seek substantial damages and therefore require the Company to incur significant fees and costs related to their defense.

The Company is also subject to or party to certain class actions and other litigation and claims relating to its operations or business practices. The Company has recorded reserves that, in the opinion of management, are adequate to cover litigation, claims or assessments that have been or may be asserted against the Company, and for which the

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outcome is probable and reasonably estimable. Management believes that the resolution of such litigation and claims will not have a material adverse effect on the Company's financial condition or results of operations; however, there can be no assurance in this regard.

Item 4. Mine Safety Disclosures

Not applicable.

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PART II

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

Shares of the Company's Common Stock, $0.01 par value per share ("common stock") trade on the NASDAQ Stock Market under the symbol "MGLN." For further information regarding the Company's common stock, see Note 6—"Stockholders' Equity" to the consolidated financial statements set forth elsewhere herein.

As of December 31, 2018, there were approximately 227 stockholders of record of the Company's common stock. The stockholders of record data for common stock does not reflect persons whose stock was held on that date by the Depository Trust Company or other intermediaries.

Comparison of Cumulative Total Return

The following graph compares the change in the cumulative total return on the Company's common stock to (a) the change in the cumulative total return on the stocks included in the Standard & Poor's ("S&P") 500 Stock Index and (b) the change in the cumulative total return on the stocks included in the S&P 500 Managed Health Care Index, assuming an investment of $100 made at the close of trading on December 31, 2013, and comparing relative values on December 31, 2014, 2015, 2016, 2017 and 2018. The Company did not pay any dividends during the period reflected in the graph. The common stock price performance shown below should not be viewed as being indicative of future performance.

	December 31,					
	2013	2014	2015	2016	2017	2018
Magellan Health, Inc.	$ 100	$ 100.20	$ 102.92	$ 125.61	$ 161.16	$ 94.96
S&P 500 Index	100	113.69	115.26	129.05	157.22	150.33
S&P 500 Managed Health Care Index(1)	100	133.61	162.83	194.60	280.36	310.62

(1) The S&P 500 Managed Health Care Index consists of Anthem, Inc., Centene Corporation, Humana, Inc., UnitedHealth Group, Inc. and WellCare Health Plans, Inc.

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The information set forth above under the "Comparison of Cumulative Total Return" does not constitute soliciting material and should not be deemed filed or incorporated by reference into any other of the Company's filings under the Securities Act or the Exchange Act, except to the extent the filing specifically incorporates such information by reference therein.

Stock Repurchases

The Company's board of directors has previously authorized a series of stock repurchase plans. Stock repurchases for each such plan could be executed through open market repurchases, privately negotiated transactions, accelerated share repurchases or other means. The board of directors authorized management to execute stock repurchase transactions from time to time and in such amounts and via such methods as management deemed appropriate. Each stock repurchase program could be limited or terminated at any time without prior notice.

On October 26, 2015, the Company's board of directors approved a stock repurchase plan which authorized the Company to purchase up to $200 million of its outstanding common stock through October 22, 2017 (the "2015 Repurchase Program"). On July 26, 2017, the Company's board of directors approved an extension of the 2015 Repurchase Program through October 22, 2018. On May 24, 2018, the Company's board of directors approved an increase of $200 million to the current $200 million stock repurchase plan which now authorizes the Company to purchase up to $400 million of its outstanding common stock under the 2015 Repurchase Program. The board also extended the program from October 22, 2018 to October 22, 2020. Pursuant to the 2015 Repurchase Program, the Company made purchases during the three months ended December 31, 2018 as follows (aggregate cost excludes broker commissions and is reflected in millions):

Period	Total number of Shares Purchased	Average Price Paid per Share(1)	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Approximate Dollar Value of Shares that May Yet Be Purchased Under the Plans(1)(2)
October 1 - 31, 2018	165,039	$ 67.87	165,039	$ 199.8
November 1 - 30, 2018	101,927	60.87	101,927	193.6
December 1 - 31, 2018	63,237	56.72	63,237	190.0
	330,203		330,203	

(1) Excludes amounts that could be used to repurchase shares acquired under the Company's equity incentive plans to satisfy withholding tax obligations of employees and non-employee directors upon the vesting of restricted stock units.

(2) Excludes broker commissions

The Company made additional open market purchases of 60,901 shares of the Company's common stock at an aggregate cost of $3.7 million (excluding broker commissions) during the period from January 1, 2019 through February 22, 2019.

Dividends

The Company does not expect to pay a dividend in 2019. Should the Company pay any dividends in the future, there can be no assurance that the Company will continue to pay such dividends.

Recent Sales of Unregistered Securities

During the quarter ended December 31, 2018, the Company had no sales of unregistered securities.

Item 6. Selected Financial Data

The following table sets forth selected historical consolidated financial information of the Company as of and for the years ended December 31, 2014, 2015, 2016, 2017 and 2018.

Selected consolidated financial information for the years ended December 31, 2016, 2017 and 2018 and as of December 31, 2017 and 2018 presented below, have been derived from, and should be read in conjunction with, the

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audited consolidated financial statements and the notes thereto included elsewhere herein. Selected consolidated financial information for the years ended December 31, 2014 and 2015 has been derived from the Company's audited consolidated financial statements not included in this Form 10 K. The selected financial data set forth below also should be read in conjunction with the Company's financial statements and accompanying notes and "Management's Discussion and Analysis of Financial Condition and Results of Operations" appearing elsewhere herein.

MAGELLAN HEALTH, INC. AND SUBSIDIARIES

(In thousands, except per share amounts)

	Year Ended December 31,				
	2014	2015	2016	2017	2018
Statement of Operations Data:					
Net revenue	$ 3,760,118	$ 4,597,400	$ 4,836,884	$ 5,838,583	$ 7,314,151
Cost of care	2,088,595	2,274,755	1,882,614	2,413,770	3,762,412
Cost of goods sold	732,949	1,321,877	1,818,720	2,211,910	2,283,022
Direct service costs and other operating expenses(1)(2)(3)	723,498	822,392	876,612	941,883	1,071,535
Depreciation and amortization	91,070	102,844	106,046	115,706	132,660
Interest expense	7,387	6,581	10,193	25,977	35,396
Interest and other income	(1,301)	(2,165)	(2,818)	(5,887)	(14,068)
Income before income taxes	117,920	71,116	145,517	135,224	43,194
Provision for income taxes	43,689	42,409	69,728	25,083	19,013
Net income	74,231	28,707	75,789	110,141	24,181
Less: net loss attributable to non-controlling interest	(5,173)	(2,706)	(2,090)	(66)	—
Net income attributable to Magellan	$ 79,404	$ 31,413	$ 77,879	$ 110,207	$ 24,181
Net income per common share attributable to Magellan:					
Basic	$ 2.98	$ 1.26	$ 3.36	$ 4.72	$ 0.99
Diluted	$ 2.90	$ 1.21	$ 3.22	$ 4.51	$ 0.97

	December 31,				
	2014	2015	2016	2017	2018
Balance Sheet Data:					
Current assets	$ 1,140,323	$ 1,097,682	$ 1,319,267	$ 1,483,353	$ 1,547,167
Current liabilities	585,840	724,235	1,092,850	892,303	898,893
Property and equipment, net	171,916	174,745	172,524	158,638	150,748
Total assets	2,068,943	2,069,060	2,443,687	2,957,234	2,979,056
Total debt, capital lease and deferred financing obligations	269,841	257,309	618,379	853,737	752,882
Stockholders' equity	1,133,558	1,066,183	1,099,719	1,276,494	1,285,303

(1) Includes stock compensation expense of $40,584, $50,384, $37,422, $39,116 and $29,472 for the years ended December 31, 2014, 2015, 2016, 2017 and 2018, respectively.

(2) Includes changes in fair value of contingent consideration of $6,172, $44,257, $(104), $696 and $1,307 for the years ended December 31, 2014, 2015, 2016, 2017 and 2018, respectively.

(3) Includes impairment of intangible assets of $4,800 for the year ended December 31, 2016.

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

The following discussion and analysis of the Company's financial condition and results of operations should be read in conjunction with the Company's selected financial data and the Company's financial statements and the accompanying notes included herein. The following discussion may contain "forward looking statements" within the

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meaning of the Securities Act and the Exchange Act. When used in this Form 10 K, the words “estimate,” “anticipate,” “expect,” “believe,” “should” and similar expressions are intended to be forward looking statements. Although the Company believes that its plans, intentions and expectations reflected in such forward looking statements are reasonable, it can give no assurance that such plans, intentions or expectations will be achieved. Prospective investors are cautioned that any such forward looking statements are not guarantees of future performance and involve risks and uncertainties, and that actual results may differ materially from those contemplated by such forward looking statements. Important factors currently known to management that could cause actual results to differ materially from those in forward looking statements are set forth under the heading “Risk Factors” in Item 1A and elsewhere in this Form 10 K. Capitalized or defined terms included in this Item 7 have the meanings set forth in Item 1 of this Form 10 K.

Business Overview

The Company is engaged in the healthcare management business, and is focused on meeting needs in areas of healthcare that are fast growing, highly complex and high cost, with an emphasis on special population management. The Company provides services to health plans and other MCOs, employers, labor unions, various military and governmental agencies, TPAs, consultants and brokers. The Company’s business is divided into three segments, based on the services it provides and/or the customers that it serves. See Item 1—“Business” for more information on the Company’s business segments.

Summarized Results

Summarized below are the key financial highlights for the year ended December 31, 2018 (“2018”). For additional Information see the “Results of Operations” section, which discusses both consolidated and segment results in more detail:

- Net revenue for 2018 increased to $7.3 billion from the year ended December 31, 2017 (“2017”).
- Income before income taxes for 2018 decreased to $43.2 million from 2017.
- Net income attributable to Magellan for 2018 decreased to $24.2 million from 2017.

- Segment profit(1) for 2018 decreased to $228.0 million from 2017.
- Adjusted net income(1) for 2018 decreased to $61.7 million from 2017.

(1) See Non-GAAP Measures section for a discussion of these non-GAAP financial measures and a reconciliation to the most comparable GAAP item.

Key Developments and Accomplishments

- On March 12, 2018, the Company entered into a contract with the State of Arizona as one of seven integrated managed care organizations that will coordinate physical and behavioral health services for approximately one million Medicaid eligible members in the central geographic service area effective October 1, 2018.

- On April 16, 2018, the Company entered into a contract with the Commonwealth of Virginia to participate statewide in the Medallion 4 program. The Company was selected through a competitive procurement and is one of six health plans to contract with Virginia for this program. The Medallion program will collectively serve over 700,000 TANF Medicaid enrollees commencing on August 1, 2018.

· In May, the Company announced that it had been named to the annual Fortune 500 list of America's largest corporations by revenue for the first time in the Company's history.

Results of Operations

The following table summarizes, for the periods indicated, consolidated operating results (in thousands):

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Consolidated Results	December 31, 2016	2017	2018	Change '16 vs '17	Change '17 vs '18
Statement of Operations Data:					
Net revenue	$ 4,836,884	$ 5,838,583	$ 7,314,151	20.7%	25.3%
Cost of Care	1,882,614	2,413,770	3,762,412	28.2%	55.9%
Cost of goods sold	1,818,720	2,211,910	2,283,022	21.6%	3.2%
Direct service costs and other operating expenses (1)(2)(3)	876,612	941,883	1,071,535	7.4%	13.8%
Depreciation and amortization	106,046	115,706	132,660	9.1%	14.7%
Interest expense	10,193	25,977	35,396	154.9%	36.3%
Interest and other income	(2,818)	(5,887)	(14,068)	108.9%	139.0%
Income before income taxes	145,517	135,224	43,194	(7.1%)	(68.1%)
Provision for income taxes	69,728	25,083	19,013	(64.0%)	(24.2%)
Net income	75,789	110,141	24,181	45.3%	(78.0%)
Less: net income (loss) attributable to non-controlling interest	(2,090)	(66)	—		
Net income attributable to Magellan	$ 77,879	$ 110,207	$ 24,181	41.5%	(78.1%)

(1) Includes stock compensation expense of $37,422, $39,116 and $29,472 for the years ended December 31, 2016, 2017 and 2018, respectively.
(2) Includes changes in fair value of contingent consideration of $(104), $696 and $1,307 for the years ended December 31, 2016, 2017 and 2018, respectively.
(3) Includes impairment of intangible assets of $4,800 for the year ended December 31, 2016.

2018 compared to 2017

Net revenue, Cost of care, Cost of goods sold, and Direct service costs and other operating expenses

Net revenue, cost of care, cost of goods sold, and direct service costs and other operating expense variances are addressed within the segment results that follow.

Depreciation and amortization

Depreciation and amortization expense increased by 14.7 percent or $17.0 million from 2017 to 2018, primarily due to asset additions after 2017 and acquisition activity.

Interest Expense

Interest expense increased by $9.4 million from 2017 to 2018 mainly due to an increase in interest rates and the amount of outstanding debt.

Interest and other income

Interest and other income increased by $8.2 million from 2017 to 2018 primarily due to higher yields and invested balances.

Income taxes

The Company’s effective income tax rate was 18.6 percent in 2017 and 44.0 percent in 2018. These rates differ from the applicable federal statutory income tax rate for each year primarily due to state income taxes, remeasurement of deferred tax balances in 2017 due to the Tax Act, permanent differences between book and tax income, and changes to the valuation allowances. The Company also accrues interest and penalties related to uncertain tax positions in its provision for income taxes. Although the federal statutory rate was reduced under the Tax Act from 35% in 2017 to 21% in 2018, the effective income tax rate for 2018 was higher than 2017, primarily due to (i) suspension of the non-

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deductible Patient Protection and Affordable Care Act health insurer fee ("HIF") fees in 2017, (ii) a significant reversal of valuation allowances in 2017 for the AlphaCare net operating loss carryforwards ("NOLs"), (iii) remeasurement of deferred tax balances in 2017 as a result of the Tax Act, (iv) a significant increase in the amount of non-deductible executive compensation in 2018 as a result of the Tax Act, and (v) an increased relative impact in 2018 of the permanent differences for non-deductible HIF fees and non-deductible executive compensation as a result of reduced earnings.

The statutes of limitations regarding the assessment of federal and most state and local income taxes for 2014 expired during 2018. As a result, $3.0 million of tax contingency reserves recorded as of December 31, 2017 were reversed in 2018, of which $2.4 million was reflected as a reduction to income tax expense and $0.6 million as a decrease to deferred tax assets. Additionally, $0.2 million of accrued interest was reversed in 2018 and reflected as a reduction to income tax expense due to the closing of statutes of limitations on tax assessments.

The statutes of limitations regarding the assessment of federal and most state and local income taxes for 2013 expired during 2017. As a result, $3.0 million of tax contingency reserves recorded as of December 31, 2016 were reversed in 2017, of which $2.0 million was reflected as a reduction to income tax expense and $1.0 million as a decrease to deferred tax assets. Additionally, $0.2 million of accrued interest was reversed in 2017 and reflected as a reduction to income tax expense due to the closing of statutes of limitations on tax assessments.

2017 compared to 2016

Net revenue, Cost of care, Cost of goods sold, and Direct service costs and other operating expenses

Net revenue, cost of care, cost of goods sold, and direct service costs and other operating expense variances are addressed within the segment results that follow.

Depreciation and amortization

Depreciation and amortization expense increased by 9.1 percent or $9.7 million from 2016 to 2017, primarily due to asset additions after 2016 and acquisition activity.

Interest expense

Interest expense increased by $15.8 million from 2016 to 2017 mainly due to an increase in interest rates, an increase in the amount of outstanding debt and higher amortization cost related to debt financing.

Interest and other income

Interest and other income increased by $3.1 million from 2016 to 2017 primarily due to higher yields and invested balances.

Income taxes

The Company's effective income tax rate was 47.9 percent in 2016 and 18.6 percent in 2017. These rates differ from the 2017 federal statutory income tax rate primarily due to state income taxes, remeasurement of deferred tax balances due to the Tax Act, permanent differences between book and tax income, and changes to the valuation allowances. The Company also accrues interest and penalties related to uncertain tax positions in its provision for income taxes. The effective income tax rate for 2017 was lower than 2016 mainly due to suspension for 2017 of the non-deductible HIF fees, reversal of valuation allowances in 2017 of AlphaCare NOLs as a result of a change in judgment about their

realizability due to internal restructuring as a result of the acquisition of SWH, remeasurement of deferred tax balances as a result of the Tax Act, and more significant excess tax deductions from equity compensation in 2017.

The statutes of limitations regarding the assessment of federal and most state and local income taxes for 2013 expired during 2017. As a result, $3.0 million of tax contingency reserves recorded as of December 31, 2016 were reversed in 2017, of which $2.0 million was reflected as a reduction to income tax expense and $1.0 million as a decrease to deferred tax assets. Additionally, $0.2 million of accrued interest was reversed in 2017 and reflected as a reduction to income tax expense due to the closing of statutes of limitations on tax assessments.

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The statutes of limitations regarding the assessment of federal and most state and local income taxes for 2012 expired during 2016. As a result, $2.2 million of tax contingency reserves recorded as of December 31, 2015 were reversed in 2016, of which $1.5 million was reflected as a reduction to income tax expense and $0.7 million as a decrease to deferred tax assets. Additionally, $0.1 million of accrued interest was reversed in 2016 and reflected as a reduction to income tax expense due to the closing of statutes of limitations on tax assessments.

Segment Results

The Company manages and measures operational performance through three segments: Healthcare, Pharmacy Management and Corporate. The Company evaluates performance of its segments based on Segment Profit. Management uses Segment Profit information for internal reporting and control purposes and considers it important in making decisions regarding the allocation of capital and other resources, risk assessment and employee compensation, among other matters. Stock compensation expense and changes in fair value of contingent consideration recorded in relation to acquisitions are included in direct service costs and other operating expenses; however, these amounts are excluded from the computation of Segment Profit. The non-controlling portion of AlphaCare's Segment Profit (Loss) is also excluded from the computation of Segment Profit in 2016 and 2017.

Healthcare

The Healthcare segment includes the Company's: (i) management of behavioral healthcare services and EAP services, (ii) management of other specialty areas including diagnostic imaging and musculoskeletal management, and (iii) the integrated management of physical, behavioral and pharmaceutical healthcare for special populations, delivered through Magellan Complete Care. The Healthcare segment's Behavioral & Specialty Health division provides management services to health plans, accountable care organizations, employers, state Medicaid agencies, the United States military and various federal government agencies for whom Magellan provides carve-out management services for behavioral health, employee assistance plans, and other areas of specialty healthcare including diagnostic imaging, musculoskeletal management, cardiac, and physical medicine. The MCC division contracts with state Medicaid agencies and CMS to manage care for beneficiaries under various Medicaid and Medicare programs.

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The following table summarizes, for the periods indicated, operating results for the Healthcare segment (in thousands):

Healthcare Segment Results	December 31, 2016	2017	2018	Change '16 vs '17	Change '17 vs '18
Behavioral & Specialty Health revenue					
Risk-based, non-EAP	$ 1,390,846	$ 1,461,159	$ 1,511,532	5.1%	3.4%
EAP risk-based	295,391	382,047	349,751	29.3%	(8.5%)
ASO	244,141	257,310	247,953	5.4%	(3.6%)
Magellan Complete Care revenue					
Risk-based, non-EAP	687,536	1,053,916	2,473,570	53.3%	134.7%
ASO	41,771	51,845	55,816	24.1%	7.7%
Managed care and other revenue	2,659,685	3,206,277	4,638,622	20.6%	44.7%
Cost of care	1,882,614	2,413,770	3,762,412	28.2%	55.9%
	777,071	792,507	876,210	2.0%	10.6%
Direct service costs and other	573,706	601,201	735,366	4.8%	22.3%
	203,365	191,306	140,844	(5.9%)	(26.4%)
Stock compensation expense	4,440	10,689	6,982	140.7%	(34.7%)
Changes in fair value of contingent consideration	(231)	696	1,307		
Impairment of intangible assets	4,800	—	—		
Less: non-controlling interest segment loss	(567)	(56)	—		
Segment profit	$ 212,941	$ 202,747	$ 149,133	(4.8%)	(26.4%)
Direct service cost as % of revenue	21.6%	18.8%	15.9%		
MLR Behavioral & Specialty Health risk	83.3%	88.5%	87.0%		
MLR Behavioral & Specialty Health EAP risk	61.2%	68.6%	68.4%		
MLR Magellan Complete Care risk	79.1%	81.5%	89.3%		
Membership					
Behavioral & Specialty Health					
Risk (1)	12,109	13,030	12,321		
EAP risk	14,586	14,471	15,189		
ASO	27,159	27,825	26,655		
Magellan Complete Care					
Risk	61	120	139		
ASO	20	20	23		

(1) May include some duplicate count of membership for customers that contract with Magellan for both behavioral and other specialty management services.

2018 compared to 2017

Managed Care and Other Revenue

Net revenue related to Healthcare increased by 44.7 percent or $1,432.3 million from 2017 to 2018. The increase in revenue is primarily due to revenue for Senior Whole Health acquired on October 31, 2017 of $1,011.6 million, new

contracts implemented during (or after) 2017 of $376.9 million, higher membership partially offset by unfavorable rate changes of $180.6 million, net revenue recorded for HIF fees in 2018 of $31.1 million, customer settlements in 2018 of $22.3 million, a performance penalty in 2017 of $4.6 million, the revenue impact of net favorable prior period medical claims recorded in 2017 of $4.1 million and the revenue impact of favorable prior period medical claims recorded in 2018 of $1.6 million. These increases were partially offset by terminated contracts of $111.4 million, net retroactive program changes recorded in 2017 of $23.3 million, program changes of $21.8 million, unfavorable retroactive membership and rate adjustments in 2018 of $18.3 million, retroactive profit share in 2017 of $2.6 million, favorable customer settlements in 2017 of $2.0 million, retroactive rate adjustments in 2017 of $1.5 million and other net unfavorable variances of $19.6 million.

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Cost of Care

Cost of care increased by 55.9 percent or $1,348.6 million from 2017 to 2018. The increase in cost of care is primarily due to care cost for Senior Whole Health acquired on October 31, 2017 of $889.5 million, new contracts implemented after (or during) 2017 of $346.8 million, increased membership and higher care from existing customers partially offset by unfavorable rate changes of $160.6 million, favorable customers settlements in 2017 of $11.1 million, net favorable prior period medical claims development recorded in 2017 of $7.5 million and care trends and other net unfavorable variances of $87.9 million. These increases were partially offset by terminated contracts of $93.6 million, program changes of $27.3 million, net retroactive program changes recorded in 2017 of $21.2 million, net favorable care development recorded in 2018 of $9.7 million and litigation settlements in 2017 of $3.0 million. For our behavioral and specialty health contracts, cost of care as a percentage of risk revenue (excluding EAP business) decreased from 88.5 percent in 2017 to 87.0 percent in 2018, mainly due to revenue growth from new business and favorable rate changes, partially offset by terminated contracts. For our MCC contracts, cost of care increased as a percentage of risk revenue (excluding EAP business) from 81.5 percent in 2017 to 89.3 percent in 2018, mainly due to care trends and business mix.

Direct Service Costs

Direct service costs increased by 22.3 percent or $134.2 million from 2017 to 2018 primarily due to costs related to Senior Whole Health, new business and contract implementation costs, and HIF fees in 2018. Direct service costs decreased as a percentage of revenue from 18.8 percent in 2017 to 15.8 percent in 2018, mainly due to increased revenue from business growth and acquisition activity partially offset by terminated contracts.

2017 compared to 2016

Managed Care and Other Revenue

Net revenue related to Healthcare increased by 20.6 percent or $546.6 million from 2016 to 2017. The increase in revenue is mainly due to higher membership and net favorable rate changes of $220.5 million, new contracts implemented after (or during) 2016 of $210.8 million, revenue for Senior Whole Health acquired on October 31, 2017 of $186.6 million, revenue for AFSC acquired on July 1, 2016 of $92.3 million, net retroactive program changes recorded in 2017 of $23.3 million, revenue for TMG acquired February 29, 2016 of $8.5 million, retroactive profit share in 2017 of $2.6 million, favorable customer settlements in 2017 of $2.0 million and retroactive rate adjustments in 2017 of $1.5 million. These increases were partially offset by terminated contracts of $139.9 million, net revenue recorded for HIF in 2016 of $44.0 million, program changes of $5.5 million, performance penalty in 2017 of $4.6 million, the revenue impact of net favorable prior period medical claims development recorded in 2017 of $4.1 million, favorable retroactive rate adjustments recorded in 2016 of $3.3 million and other net decreases of $0.1 million.

Cost of Care

Cost of care increased by 28.2 percent or $531.2 million from 2016 to 2017. The increase in cost of care is primarily due to new contracts implemented after (or during) 2016 of $197.2 million, increased membership and higher care associated with net favorable rate changes of $187.6 million, care cost for Senior Whole Health acquired on October 31, 2017 of $158.9 million, care cost for AFSC acquired on July 1, 2016 of $77.5 million, net retroactive program changes recorded in 2017 of $21.2 million, net favorable prior period medical claims development recorded in 2016 of $10.3 million, litigation settlements in 2017 of $3.0 million and care trends and other net unfavorable variances of $15.3 million. These increases were partially offset by terminated contracts of $109.1 million, favorable customer settlements in 2017 of $11.1 million, net favorable prior period medical claims development recorded in 2017 of

$7.5 million, program changes of $6.4 million and favorable 2016 medical claims development recorded after 2016 of $5.7 million. For our behavioral & specialty health contracts, cost of care as a percentage of risk revenue (excluding EAP business) increased from 83.3 percent in 2016 to 88.5 percent in 2017, mainly due to unfavorable care trends. For our MCC contracts, cost of care increased as a percentage of risk revenue (excluding EAP business) from 79.1 percent in 2016 to 81.5 percent in 2017, mainly due to business mix and higher revenue in 2016 due to HIF fees.

Direct Service Costs

Direct service costs increased by 4.8 percent or $27.5 million from 2016 to 2017 primarily due to costs related to TMG, AFSC, and Senior Whole Health, new business and contract implementation costs, which increases were

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partially offset by terminated contracts, an impairment of intangible assets in 2016 and HIF fees in 2016. Direct service costs decreased as a percentage of revenue from 21.6 percent in 2016 to 18.8 percent in 2017, mainly due to an increase in revenue from business growth and acquisition activity, partially offset by terminated contracts and additional costs due to the acquisitions of TMG, AFSC and SWH.

Pharmacy Management

The Pharmacy Management segment comprises products and solutions that provide clinical and financial management of pharmaceuticals paid under medical and pharmacy benefit programs. Pharmacy Management's services include: (i) PBM services; (ii) PBA for state Medicaid and other government sponsored programs; (iii) pharmaceutical dispensing operations; (iv) clinical and formulary management programs; (v) medical pharmacy management programs; and (vi) programs for the integrated management of specialty drugs. Pharmacy Management's services are provided under contracts with health plans, employers, state Medicaid programs, Medicare Part D and other government agencies.

The following table summarizes, for the periods indicated, operating results for the Pharmacy Management segment (in thousands, except state count):

Pharmacy Segment Results	December 31, 2016	2017	2018	Change '16 vs '17	Change '17 vs '18
Formulary management	$ 85,400	$ 91,900	$ 70,900	7.6%	(22.9%)
PBA and other	158,161	181,589	169,527	14.8%	(6.6%)
Managed care and other revenue	243,561	273,489	240,427	12.3%	(12.1%)
PBM, including dispensing	1,780,388	1,980,044	2,183,151	11.2%	10.3%
Medicare Part D	272,800	511,000	442,266	87.3%	(13.5%)
PBM revenue	2,053,188	2,491,044	2,625,417	21.3%	5.4%
Total net revenue	2,296,749	2,764,533	2,865,844	20.4%	3.7%
Cost of goods sold	1,933,086	2,341,979	2,468,170	21.2%	5.4%
	363,663	422,554	397,674	16.2%	(5.9%)
Direct service costs and other	261,570	302,525	298,713	15.7%	(1.3%)
	102,093	120,029	98,961	17.6%	(17.6%)
Stock compensation expense	20,509	19,881	5,458	(3.1%)	(72.5%)
Changes in fair value of contingent consideration	127	—	—	(100.0%)	
Segment profit	$ 122,729	$ 139,910	$ 104,419	14.0%	(25.4%)
Direct service cost as % of revenue	11.4%	10.9%	10.4%		
COGS as % of PBM revenue	94.2%	94.0%	94.0%		
Pharmacy Operational Statistics					
Adjusted commercial network claims	24,000	29,100	31,321		
Adjusted PBA claims	72,600	80,700	70,429		
Total adjusted claims	96,600	109,800	101,750		
Generic dispensing rate	84.9%	87.3%	87.4%		

Commercial PBM covered lives	1,700	1,900	1,986
Medical pharmacy covered lives	12,500	13,100	13,910
Total states and DC that participate in PBA	26	27	27

2018 compared to 2017

Managed Care and Other Revenue

Managed care and other revenue related to Pharmacy Management decreased by 12.1 percent or $33.1 million from 2017 to 2018. This decrease is primarily due to decreased formulary management revenue of $20.5 million, lower revenue in government pharmacy of $5.6 million, decreased medical pharmacy revenue of $3.3 million, terminated contracts of $1.2 million and other net unfavorable variances of $5.0 million. These decreases were partially offset by new contracts implemented after (or during) 2017 of $2.5 million.

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PBM and Dispensing Revenue

PBM and dispensing revenue related to Pharmacy Management increased by 5.4 percent or $134.4 million from 2017 to 2018. This increase is primarily due to new contracts implemented after (or during) 2017 of $154.4 million and other net favorable variances of $0.3 million. These increases were partially offset by terminated contracts of $17.0 million and customer guarantee penalties in 2018 of $3.3 million.

Cost of Goods Sold

Cost of goods sold increased by 5.4% percent or $126.2 million from 2017 to 2018. This increase is primarily due to new contracts implemented after (or during) 2017 of $147.2 million, partially offset by terminated contracts of $16.3 million and decreased membership and utilization of $4.7 million. As a percentage of the portion of net revenue that relates to PBM, cost of goods sold is consistent with 2017 at 94.0 percent.

Direct Service Costs

Direct service costs decreased by 1.3 percent or $3.8 million from 2017 to 2018. The decrease is primarily due to a decrease in stock compensation due to acquisition related awards which became fully vested in the prior year, partially offset by higher costs to support new business.

2017 compared to 2016

Managed Care and Other Revenue

Managed care and other revenue related to Pharmacy Management increased by 12.3 percent or $29.9 million from 2016 to 2017. This increase is primarily due to Medical pharmacy revenue of $11.7 million, new contracts implemented after (or during) 2016 of $8.3 million, increased formulary management revenue of $6.2 million, revenue for Veridicus acquired on December 13, 2016 of $4.8 million and other net favorable variances of $2.1 million. These increases were partially offset by terminated contracts of $3.2 million.

PBM and Dispensing Revenue

PBM and dispensing revenue related to Pharmacy Management increased by 21.3 percent or $437.9 million from 2016 to 2017. This increase is primarily due to increased membership and utilization of $294.4 million, new contracts implemented after (or during) 2016 of $210.2 million, revenue for Veridicus acquired on December 13, 2016 of $173.9 million, government pharmacy revenue of $11.1 million and other net favorable variances of $1.2 million. These increases were partially offset by terminated contracts of $252.9 million.

Cost of Goods Sold

Cost of goods sold increased by 21.2 percent or $408.9 million from 2016 to 2017. This increase is primarily due to an increased membership and utilization of $274.1 million, new contracts implemented after (or during) 2016 of $207.5 million, Veridicus acquired on December 13, 2016 of $159.8 million, government pharmacy of $10.9 million and other net unfavorable variances of $3.9 million. These increases were partially offset by terminated contracts of $247.3 million. As a percentage of the portion of net revenue that relates to PBM and dispensing activity, cost of goods sold decreased from 94.2 percent in 2016 to 94.0 percent in 2017, mainly due to increases in formulary management and medical pharmacy revenue and changes in business mix.

Direct Service Costs

Direct service costs increased by 15.7 percent or $41.0 million from 2016 to 2017. This increase is mainly due to the acquisition of Veridicus, contract implementation costs and ongoing costs to support new business. As a percentage of revenue, direct service costs decreased from 11.4 percent in 2016 to 10.9 percent in 2017, mainly due to an increase in revenue from business growth and acquisitions and a decrease in stock compensation expense.

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Corporate Segment

The Corporate segment of the Company is comprised primarily of amounts not allocated to the Healthcare and Pharmacy Management segments that are largely associated with costs related to being a publicly traded company.

The following table summarizes, for the periods indicated, operating results for the Corporate segment (in thousands):

Corporate Segment & Eliminations	December 31, 2016	2017	2018	Change '16 vs '17	Change '17 vs '18
Managed care and other revenue	$ (304)	$ (584)	$ (607)	92.1%	3.9%
PBM revenue	(119,246)	(131,643)	(189,708)	10.4%	44.1%
Cost of goods sold	114,366	130,069	185,148	13.7%	42.3%
	(5,184)	(2,158)	(5,167)	(58.4%)	139.4%
Direct service costs and other	41,336	38,157	37,456	(7.7%)	(1.8%)
	(46,520)	(40,315)	(42,623)	(13.3%)	5.7%
Stock compensation expense	12,473	8,546	17,032	(31.5%)	99.3%
Less: non-controlling interest segment loss	(170)	(3)	—	(98.2%)	(100.0%)
Segment loss	$ (33,877)	$ (31,766)	$ (25,591)	(6.2%)	(19.4%)

2018 compared to 2017

Net expenses related to Corporate, which includes eliminations, decreased 19.4 percent or $6.2 million, primarily due to lower discretionary benefits in 2018, higher corporate development costs in 2017 related to the SWH acquisition and a litigation settlement recorded in 2017 partially offset by higher stock compensation expense in 2018. As a percentage of revenue, corporate and elimination decreased from 0.5 percent in 2017 to 0.3 percent in 2018, mainly due to increased revenue from business growth, higher corporate development costs in 2017 and lower discretionary benefits.

2017 compared to 2016

Net expenses related to Corporate, which includes eliminations, decreased by 6.2 percent or $2.1 million, primarily due to lower stock compensation expense and discretionary benefits in 2017, partially offset by a litigation settlement in 2017. As a percentage of revenue, corporate and elimination decreased from 0.7 percent in 2016 to 0.5 percent in 2017, mainly due to higher revenue due to acquisitions and new business, lower discretionary benefits and stock compensation expenses.

Inter segment revenues and expenses

Healthcare subcontracts with Pharmacy Management to provide pharmacy benefits management services for certain of Healthcare's customers. In addition, Pharmacy Management provides pharmacy benefits management for the Company's employees covered under its medical plan. As such, revenue, cost of goods sold and direct service costs and other related to these arrangements are eliminated within the Corporate segment.

Non GAAP Measures

The Company reports its financial results in accordance with GAAP, however the Company's management also assesses business performance and makes business decisions regarding the Company's operations using certain non GAAP measures.

In addition to Segment Profit, as defined above, the Company also uses adjusted net income attributable to Magellan ("Adjusted Net Income") and adjusted net income per common share attributable to Magellan on a diluted basis ("Adjusted EPS"). Adjusted Net Income and Adjusted EPS reflect certain adjustments made for acquisitions

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completed after January 1, 2013 to exclude non cash stock compensation expense resulting from restricted stock purchases by sellers, changes in the fair value of contingent consideration, amortization of identified acquisition intangibles, as well as impairment of identified acquisition intangibles. The Company believes these non GAAP measures provide a more useful comparison of the Company's underlying business performance from period to period and are more representative of the earnings capacity of the Company. Non GAAP financial measures disclosed, such as Segment Profit, Adjusted Net Income and Adjusted EPS, should not be considered a substitute for, or superior to, financial measures determined or calculated in accordance with GAAP.

The following table reconciles income before income taxes to segment profits for the years ended December 31, 2017, 2017 and 2018 (in thousands):

	2016	2017	2018
Income before income taxes	$ 145,517	$ 135,224	$ 43,194
Stock compensation expense	37,422	39,116	29,472
Changes in fair value of contingent consideration	(104)	696	1,307
Impairment of intangible assets	4,800	—	—
Non-controlling interest segment (profit) loss	737	59	—
Depreciation and amortization	106,046	115,706	132,660
Interest expense	10,193	25,977	35,396
Interest and other income	(2,818)	(5,887)	(14,068)
Segment Profit	$ 301,793	$ 310,891	$ 227,961

The following table reconciles net income attributable to Magellan to Adjusted Net Income for the years ended December 31, 2016, 2017 and 2018:

	2016	2017	2018
Net income attributable to Magellan	$ 77,879	$ 110,207	$ 24,181
Adjusted for acquisitions starting in 2013			
Stock compensation expense	19,181	16,215	530
Changes in fair value of contingent consideration	(104)	696	1,307
Amortization of acquired intangibles	25,324	37,265	49,078
Impairment of intangible assets, net of non-controlling interest	3,936	—	—
Tax impact	(16,676)	(19,558)	(13,435)
Adjusted Net Income	$ 109,540	$ 144,825	$ 61,661

The following table reconciles net income per common share attributable to Magellan—diluted to Adjusted EPS for the years ended December 31, 2016, 2017 and 2018:

	2016	2017	2018
Net income per common share attributable to Magellan—diluted	$ 3.22	$ 4.51	$ 0.97
Adjusted for acquisitions starting in 2013			
Stock compensation expense	0.79	0.66	0.02
Changes in fair value of contingent consideration	—	0.03	0.05
Amortization of acquired intangibles	1.05	1.52	1.96

Impairment of intangible assets, net of non-controlling interest	0.16	—	—
Tax impact	(0.69)	(0.80)	(0.54)
Adjusted EPS	$ 4.53	$ 5.92	$ 2.46

Outlook—Results of Operations

The Company's Segment Profit and net income are subject to significant fluctuations from period to period. These fluctuations may result from a variety of factors such as those set forth under Item 1A—"Risk Factors" as well as a variety of other factors including: (i) changes in utilization levels by enrolled members of the Company's risk based contracts, including seasonal utilization patterns; (ii) contractual adjustments and settlements; (iii) retrospective membership adjustments; (iv) timing of implementation of new contracts, enrollment changes and contract terminations; (v) pricing adjustments upon contract renewals (and price competition in general); (vi) the timing of acquisitions;

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(vii) changes in estimates regarding medical costs and IBNR; (viii) the timing of recognition of pharmacy revenues, including rebates and Medicare Part D; and (ix) changes in the estimates of contingent consideration.

A portion of the Company's business is subject to rising care costs due to an increase in the number and frequency of covered members seeking healthcare services and higher costs of such services. Many of these factors are beyond the Company's control. Future results of operations will be heavily dependent on management's ability to obtain customer rate increases that are consistent with care cost increases and/or to reduce operating expenses.

Interest Rate Risk. Changes in interest rates affect interest income earned on the Company's cash equivalents and investments, as well as interest expense on variable interest rate borrowings under the 2017 Credit Agreement. In addition, interest rates on the Notes are subject to adjustment upon the occurrence of certain credit rating events. Based on the amount of cash equivalents and investments and the borrowing levels under the 2017 Credit Agreement and the principal amount of the Notes as of December 31, 2018, a hypothetical 10 percent increase or decrease in the interest rate associated with these instruments, with all other variables held constant, would not materially affect the Company's future earnings and cash outflows.

Historical—Liquidity and Capital Resources

2018 compared to 2017

Operating Activities. The Company reported net cash provided by operating activities of $162.3 million and $164.8 million for 2017 and 2018, respectively. The $2.5 million increase in operating cash flows from 2017 to 2018 is mainly attributable to favorable working capital changes and decreased tax payments between years, mainly offset by a decrease in Segment Profit, increased interest payments between years and ACA activity.

The net favorable impact of working capital changes between periods totaled $66.3 million. For 2017, operating cash flows were impacted by net unfavorable working capital changes of $89.2 million, which were largely attributable to timing related to receivables and payables. For 2018, operating cash flows were impacted by net unfavorable working capital changes of $22.9 million, which were largely attributable to an increase in accounts receivable, partially offset by an increase in payables.

Segment Profit for 2018 decreased $82.9 million from 2017. Tax payments for 2018 decreased $19.3 million from 2017.

Investing Activities. The Company utilized $57.2 million and $68.3 million during 2017 and 2018, respectively, for capital expenditures. The additions related to hard assets (equipment, furniture, and leaseholds) and capitalized software for 2017 were $16.0 million and $41.2 million, respectively, as compared to additions for 2018 related to hard assets and capitalized software of $26.3 million and $42.0 million, respectively.

During 2017 and 2018 the Company used net cash of $26.8 million and $59.2 million for the net purchase of "available-for-sale" securities. During 2017, the Company used net cash of $232.4 million related to investments in businesses and the acquisition of Veridicus and SWH. During 2018, the Company used net cash of $1.0 million related to investments in businesses.

Financing Activities. During 2017, the Company paid $798.1 million on debt obligations, $21.8 million for the repurchase of treasury stock under the Company's share repurchase program, $9.9 million in debt issuance fees, $5.3 million on capital lease obligations and had other net unfavorable items of $2.7 million. In addition, the Company received $1,041.7 million from the issuance of debt and $44.4 million from the exercise of stock options.

During 2018, the Company paid $110.0 million on debt obligations, $62.6 million for the repurchase of treasury stock under the Company's share repurchase program, $12.2 million on capital lease obligations and had other net unfavorable items of $1.0 million. In addition, the Company received $23.1 million from the exercise of stock options.

2017 compared to 2016

Operating Activities. The Company reported net cash provided by operating activities of $66.7 million and $162.3 million for 2016 and 2017, respectively. The $95.6 million increase in operating cash flows from 2016 to 2017 is mainly

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attributable to favorable working capital changes and an increase in Segment Profit partially offset by increased tax payments between years.

The net favorable impact of working capital changes between periods totaled $91.5 million. For 2016, operating cash flows were impacted by net unfavorable working capital changes of $180.7 million, which were largely attributable to contingent consideration payments of $91.7 million, of which $51.1 million is reflected as operating activities, working capital changes of approximately $113.8 million related to our Medicare Part D business, primarily receivables, and other net unfavorable working capital changes due to timing related to receivables and payables. For 2017, operating cash flows were impacted by net unfavorable working capital changes of $89.2 million, which were largely attributable to timing related to receivables and payables.

Segment Profit for 2017 increased $9.1 million from 2016. Tax payments for 2017 increased $5.0 million from 2016.

Investing Activities. The Company utilized $60.9 million and $57.2 million during 2016 and 2017, respectively, for capital expenditures. The additions related to hard assets (equipment, furniture, and leaseholds) and capitalized software for 2016 were $15.2 million and $45.7 million, respectively, as compared to additions for 2017 related to hard assets and capitalized software of $16.0 million and $41.2 million, respectively.

During 2016 the Company received net cash of $15.8 million from the net maturity of "available-for-sale" securities, with the Company using $26.8 million during 2017 for the net purchase of "available-for-sale" securities. During 2016, the Company used net cash of $16.0 million, $110.9 million and $72.8 million for the acquisitions of TMG, AFSC and Veridicus, respectively, partially offset by a working capital adjustment of $0.5 million related to the acquisition of 4D Pharmacy Management Systems, Inc. During 2017, the Company used net cash of $232.4 million related to investments in businesses and the acquisition of Veridicus and SWH.

Financing Activities. During 2016, the Company paid $106.8 million for the repurchase of treasury stock under the Company’s share repurchase program, $15.6 million on debt obligations and $5.3 million on capital lease obligations. The Company made a contingent consideration payment totaling $91.7 million, of which $40.6 million was related to financing activities. In addition, the Company received $375.0 million from the issuance of debt, $25.2 million from exercise of stock options, and had other net favorable items of $1.2 million.

During 2017, the Company paid $798.1 million on debt obligations, $21.8 million for the repurchase of treasury stock under the Company's share repurchase program, $9.9 million in debt issuance fees, $5.3 million on capital lease obligations and had other net unfavorable items of $2.7 million. In addition, the Company received $1,041.7 million from the issuance of debt and $44.4 million from the exercise of stock options.

Outlook—Liquidity and Capital Resources

Liquidity. The Company may draw on the 2017 Credit Agreement as required to meet working capital needs associated with the timing of receivables and payables, fund share repurchases or support acquisition activities. The Company currently expects to have adequate liquidity to satisfy its existing financial commitments over the periods in which they will become due. The Company plans to maintain its current investment strategy of investing in a diversified, high quality, liquid portfolio of investments and continues to closely monitor the financial markets. The

Company estimates that it has no risk of any material permanent loss on its investment portfolio; however, there can be no assurance the Company will not experience any such losses in the future.

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Contractual Obligations and Commitments

The following table sets forth the future financial commitments of the Company as of December 31, 2018 (in thousands):

	Payments due by period				
Contractual Obligations	Total	Less than 1 year	1 3 years	3 5 years	More than 5 years
Senior Notes	$ 400,000	$ —	$ —	$ —	$ 400,000
Term loan	328,125	17,500	35,000	275,625	—
Operating leases(1)	82,230	20,888	30,464	20,502	10,376
Letters of credit(2)	66,096	—	—	—	—
Capital lease and deferred financing obligations(3)	34,573	8,916	14,348	7,454	3,855
Contingent consideration	8,000	8,000	—	—	—
Purchase commitments(4)	1,171	1,171	—	—	—
Income tax contingencies(5)	15,683	—	—	—	—
	$ 935,878	$ 56,475	$ 79,812	$ 303,581	$ 414,231

(1) Operating lease obligations include estimated future lease payments for both open and closed offices.
(2) These letters of credit typically act as a guarantee of payment to certain third parties in accordance with specified terms and conditions.
(3) Capital lease and deferred financing obligations include imputed interest of $3.3 million and are net of leasehold improvement allowances.
(4) Purchase commitments include open purchase orders as of December 31, 2018 relating to ongoing capital expenditure and operational activities.
(5) The Company is unable to make a reasonably reliable estimate of the period of the cash settlement (if any) with the respective taxing authorities for these contingencies. However, settlement of such amounts could require the utilization of working capital. See further discussion in Note 7—“Income Taxes” to the consolidated financial statements set forth elsewhere herein.

The Company also has a variety of other contractual agreements related to acquiring materials and services used in the Company’s operations. However, the Company does not believe these other agreements contain material noncancelable commitments.

Stock Repurchases

The Company’s board of directors has previously authorized a series of stock repurchase plans. Stock repurchases for each such plan could be executed through open market repurchases, privately negotiated transactions, accelerated share repurchases or other means. The board of directors authorized management to execute stock repurchase transactions from time to time and in such amounts and via such methods as management deemed appropriate. Each stock repurchase program could be limited or terminated at any time without prior notice. See Note 6—“Stockholders’ Equity” to the consolidated financial statements for more information on the Company’s share repurchase program.

Off Balance Sheet Arrangements

As of December 31, 2018, the Company has no material off balance sheet arrangements.

Senior Notes

On September 22, 2017, the Company completed the public offering of $400.0 million aggregate principal amount of its 4.400% Senior Notes due 2024 (the “Notes”). The Notes are governed by an indenture, dated as of September 22, 2017 (the “Base Indenture”), between the Company, as issuer and U.S. Bank National Association, as

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trustee, as supplemented by a first supplemental indenture, dated as of September 22, 2017 (the "First Supplemental Indenture" together, with the Base Indenture, the "Indenture"), between the Company, as issuer, and U.S. Bank National Association, as trustee.

For more information on the Company's Senior Notes see Note 5—"Long Term Debt, Capital Lease and Deferred Financing Obligations" to the consolidated financial statements set forth elsewhere herein.

Credit Agreements

On September 22, 2017, the Company entered into the 2017 Credit Agreement with various lenders that provides for a $400.0 million senior unsecured revolving credit facility and a $350.0 million senior unsecured term loan facility to the Company, as the borrower. On August 13, 2018, the Company entered into an amendment to the 2017 Credit Agreement, which extended the maturity date by one year. On February 27, 2019, the Company entered into a second amendment to the 2017 Credit Agreement, which amended the total leverage ratio covenant, and which was necessary in order for us to remain in compliance with the terms of the 2017 Credit Agreement. The 2017 Credit Agreement is scheduled to mature on September 22, 2023.

For more information on the Company's Credit Agreements see Note 5—"Long Term Debt, Capital Lease and Deferred Financing Obligations" to the consolidated financial statements set forth elsewhere herein.

Restrictive Covenants in Debt Agreements

The 2017 Credit Agreement contains covenants that limit management's discretion in operating the Company's business by restricting or limiting the Company's ability, among other things, to:

- incur or guarantee additional indebtedness or issue preferred or redeemable stock;
- pay dividends and make other distributions;
- repurchase equity interests;
- make certain advances, investments and loans;
- enter into sale and leaseback transactions;
- create liens;
- sell and otherwise dispose of assets;
- acquire, merge or consolidate with another company; and
- enter into some types of transactions with affiliates.

These restrictions could adversely affect the Company's ability to finance future operations or capital needs or engage in other business activities that may be in the Company's interest.

The 2017 Credit Agreement also requires the Company to comply with specified financial ratios and tests. Failure to do so, unless waived by the lenders under the 2017 Credit Agreement, pursuant to its terms, or amended, would result in an event of default under the 2017 Credit Agreement. As of December 31, 2018, the Company was in compliance with all covenants, including financial covenants, under the 2017 Credit Agreement.

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Critical Accounting Policies and Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates. The Company considers the following to be its critical accounting policies and estimates:

Cost of Care, Medical Claims Payable and Other Medical Liabilities

Cost of care is recognized in the period in which members receive managed healthcare services. In addition to actual benefits paid, cost of care in a period also includes the impact of accruals for estimates of medical claims payable. Medical claims payable represents the liability for healthcare claims reported but not yet paid and claims IBNR related to the Company's managed healthcare businesses. Such liabilities are determined by employing actuarial methods that are commonly used by health insurance actuaries and that meet actuarial standards of practice. Cost of care for the Company's EAP contracts, which are mainly with the United States federal government, pertain to the costs to employ licensed behavioral health counselors to deliver non-medical counseling for these contracts.

The IBNR portion of medical claims payable is estimated based on past claims payment experience for member groups, enrollment data, utilization statistics, authorized healthcare services and other factors. This data is incorporated into contract specific actuarial reserve models and is further analyzed to create "completion factors" that represent the average percentage of total incurred claims that have been paid through a given date after being incurred. Factors that affect estimated completion factors include benefit changes, enrollment changes, shifts in product mix, seasonality influences, provider reimbursement changes, changes in claims inventory levels, the speed of claims processing and changes in paid claim levels. Completion factors are applied to claims paid through the financial statement date to estimate the ultimate claim expense incurred for the current period. Actuarial estimates of claim liabilities are then determined by subtracting the actual paid claims from the estimate of the ultimate incurred claims. For the most recent incurred months (generally the most recent two months), the percentage of claims paid for claims incurred in those months is generally low. This makes the completion factor methodology less reliable for such months. Therefore, incurred claims for any month with a completion factor that is less than 70 percent are generally not projected from historical completion and payment patterns; rather they are projected by estimating claims expense based on recent monthly estimated cost incurred per member per month times membership, taking into account seasonality influences, benefit changes and healthcare trend levels, collectively considered to be "trend factors." For new contracts, the Company estimates IBNR based on underwriting data until it has sufficient data to utilize these methodologies.

Medical claims payable balances are continually monitored and reviewed. If it is determined that the Company's assumptions in estimating such liabilities are significantly different than actual results, the Company's results of operations and financial position could be impacted in future periods. Adjustments of prior period estimates may result in additional cost of care or a reduction of cost of care in the period an adjustment is made. Further, due to the considerable variability of healthcare costs, adjustments to claim liabilities occur each period and are sometimes significant as compared to the net income recorded in that period. Prior period development is recognized immediately upon the actuary's judgment that a portion of the prior period liability is no longer needed or that additional liability

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should have been accrued. The following table presents the components of the change in medical claims payable for the years ended December 31, 2016, 2017 and 2018 (in thousands):

	2016	2017	2018
Claims payable and IBNR, beginning of period	$ 253,299	$ 188,618	$ 326,642
Cost of care:			
Current year	1,892,914	2,421,270	3,772,112
Prior years(3)	(10,300)	(7,500)	(9,700)
Total cost of care	1,882,614	2,413,770	3,762,412
Claim payments and transfers to other medical liabilities(1):			
Current year	1,733,310	2,210,346	3,402,010
Prior years	213,985	161,798	292,904
Total claim payments and transfers to other medical liabilities	1,947,295	2,372,144	