MOLINA HEALTHCARE INC
Form 10-K
February 19, 2019

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

Form 10-K
(Mark One)
ý ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
FOR THE FISCAL YEAR ENDED DECEMBER 31, 2018
or
¨ TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
Commission File Number 1-31719

MOLINA HEALTHCARE, INC.
(Exact name of registrant as specified in its charter)

Delaware	13-4204626
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)

200 Oceangate, Suite 100, Long Beach, California 90802
(Address of principal executive offices)
(562) 435-3666
(Registrant's telephone number, including area code)
Securities registered pursuant to Section 12(b) of the Act:

Title of Each Class	Name of Each Exchange on Which Registered
Common Stock, $0.001 Par Value	New York Stock Exchange

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. ý Yes ¨ No
Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act.
¨ Yes ý No
Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. ý Yes ¨ No
Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files).
ý 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. ý

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

Large accelerated filer	ý	Accelerated filer	¨
Non-accelerated filer	¨ (Do not check if a smaller reporting company)	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 Act). ¨ Yes ý No

The aggregate market value of Common Stock held by non-affiliates of the registrant as of June 30, 2018, the last business day of our most recently completed second fiscal quarter, was approximately $6,018.8 million (based upon the closing price for shares of the registrant's Common Stock as reported by the New York Stock Exchange, Inc. on June 30, 2018).

As of February 15, 2019, approximately 62,460,000 shares of the registrant's Common Stock, $0.001 par value per share, were outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's Proxy Statement for the 2019 Annual Meeting of Stockholders to be held on May 8, 2019, are incorporated by reference into Part III of this Form 10-K, to the extent described therein.

MOLINA HEALTHCARE, INC. 2018 FORM 10-K
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(a) Incorporated by reference to “Executive Compensation” in the 2019 Proxy Statement.

(b) Incorporated by reference to “Security Ownership of Certain Beneficial Owners and Management” in the 2019 Proxy Statement.

(c) Incorporated by reference to “Related Party Transactions” and “Corporate Governance and Board of Directors Matters — Director Independence” in the 2019 Proxy Statement.

(d) Incorporated by reference to “Fees Paid to Independent Registered Public Accounting Firm” in the 2019 Proxy Statement.

FORWARD LOOKING STATEMENTS

This Annual Report on Form 10-K (this "Form 10-K") contains forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 that involve risks and uncertainties. Many of the forward-looking statements are located under the heading "Management's Discussion and Analysis of Financial Condition and Results of Operations." Forward-looking statements provide current expectations of future events based on certain assumptions and include any statement that does not directly relate to any historical or current fact. Forward-looking statements can also be identified by words such as "future," "anticipates," "believes," "estimates," "expects," "intends," "plans," "predicts" "would," "could," "can," "may," and similar terms. Readers are cautioned not to place undue reliance on any forward-looking statements, as forward-looking statements are not guarantees of future performance and the Company's actual results may differ significantly due to numerous known and unknown risks and uncertainties. Those known risks and uncertainties include, but are not limited to, the risk factors identified in the section of this Form 10-K titled "Risk Factors," as well as the following:

- the numerous political, judicial and market-based uncertainties associated with the Affordable Care Act (the "ACA") or "Obamacare," including the ultimate outcome on appeal of the Texas et al. v. U.S. et al. matter;
- the market dynamics surrounding the ACA Marketplaces, including but not limited to uncertainties associated with risk adjustment requirements, the potential for disproportionate enrollment of higher acuity members, the discontinuation of premium tax credits, and the adequacy of agreed rates;
- subsequent adjustments to reported premium revenue based upon subsequent developments or new information, including changes to estimated amounts payable or receivable related to Marketplace risk adjustment;
- effective management of the Company's medical costs;
- the Company's ability to predict with a reasonable degree of accuracy utilization rates, including utilization rates associated with seasonal flu patterns or other newly emergent diseases;
- significant budget pressures on state governments and their potential inability to maintain current rates, to implement expected rate increases, or to maintain existing benefit packages or membership eligibility thresholds or criteria;
- the full reimbursement of the ACA health insurer fee, or HIF;
- the success of the Company's efforts to retain existing or awarded government contracts, including the success of any requests for proposal protest filings or defenses;
- the success of the Company's profit improvement and sustainability initiatives, including the timing and amounts of the benefits realized, and administrative and medical cost savings achieved;
- the Company's ability to manage its operations, including maintaining and creating adequate internal systems and controls relating to authorizations, approvals, provider payments, and the overall success of its care management initiatives;
- the Company's receipt of adequate premium rates to support increasing pharmacy costs, including costs associated with specialty drugs and costs resulting from formulary changes that allow the option of higher-priced non-generic drugs;
- the Company's ability to operate profitably in an environment where the trend in premium rate increases lags behind the trend in increasing medical costs;
- the interpretation and implementation of federal or state medical cost expenditure floors, administrative cost and profit ceilings, premium stabilization programs, profit sharing arrangements, and risk adjustment provisions and requirements;
- the Company's estimates of amounts owed for such cost expenditure floors, administrative cost and profit ceilings, premium stabilization programs, profit-sharing arrangements, and risk adjustment provisions;
- the Medicaid expansion medical cost corridor, and any other retroactive adjustment to revenue where methodologies and procedures are subject to interpretation or dependent upon information about the health status of participants other than Molina members;
- the interpretation and implementation of at-risk premium rules and state contract performance requirements regarding the achievement of certain quality measures, and the Company's ability to recognize revenue amounts associated therewith;
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the Company's ability to successfully recognize the intended cost savings and other intended benefits of outsourcing certain services and functions to third parties, and its ability to manage the risk that such third parties may not perform contracted functions and services in a timely, satisfactory and compliant manner;

- cyber-attacks or other privacy or data security incidents resulting in an inadvertent unauthorized disclosure of protected health information;
- the success of the Company's health plan in Puerto Rico, including the resolution of the debt crisis and the effect of the PROMESA law, and the impact of any future significant weather events;

- the success and renewal of the Company's duals demonstration programs in California, Illinois, Michigan, Ohio, South Carolina, and Texas;
- the accurate estimation of incurred but not reported or paid medical costs across the Company's health plans;
- efforts by states to recoup previously paid and recognized premium amounts;
- complications, member confusion, eligibility redeterminations, or enrollment backlogs related to the annual renewal of Medicaid coverage;
- government audits, reviews, comment letters, or potential investigations, and any fine, sanction, enrollment freeze, monitoring program, or premium recovery that may result therefrom;
- changes with respect to the Company's provider contracts and the loss of providers;
- approval by state regulators of dividends and distributions by the Company's health plan subsidiaries;
- changes in funding under the Company's contracts as a result of regulatory changes, programmatic adjustments, or other reforms;
- high dollar claims related to catastrophic illness;
- the favorable resolution of litigation, arbitration, or administrative proceedings, including litigation involving the ACA to which we ourselves are not a direct party;
- the relatively small number of states in which we operate health plans, including the greater scale and revenues of the Company's California, Ohio, Texas, and Washington health plans;
- the availability of adequate financing on acceptable terms to fund and capitalize the Company's expansion and growth, repay the Company's outstanding indebtedness at maturity and meet its liquidity needs, including the interest expense and other costs associated with such financing;
- the Company's failure to comply with the financial or other covenants in its credit agreement or the indentures governing its outstanding notes;
- the sufficiency of the Company's funds on hand to pay the amounts due upon conversion or maturity of its outstanding notes;
- the failure of a state in which we operate to renew its federal Medicaid waiver;
- changes generally affecting the managed care industry;
- increases in government surcharges, taxes, and assessments;
- newly emergent viruses or widespread epidemics, public catastrophes or terrorist attacks, and associated public alarm;
- the unexpected loss of the leadership of one or more of our senior executives; and
- increasing competition and consolidation in the Medicaid industry.

Each of the terms "Molina Healthcare, Inc." "Molina Healthcare," "Company," "we," "our," and "us," as used herein, refers collectively to Molina Healthcare, Inc. and its wholly owned subsidiaries, unless otherwise stated. The Company assumes no obligation to revise or update any forward-looking statements for any reason, except as required by law.

OVERVIEW

ABOUT MOLINA HEALTHCARE

Molina Healthcare, Inc., a FORTUNE 500, multi-state healthcare organization, arranges for the delivery of health care services to individuals and families who receive their care through the Medicaid and Medicare programs, and through the state insurance marketplaces (the "Marketplace").

Through our locally operated health plans in 14 states and the Commonwealth of Puerto Rico, we served approximately 3.8 million members as of December 31, 2018. These health plans are operated by our respective wholly owned subsidiaries in those states and in the Commonwealth of Puerto Rico, each of which is licensed as a health maintenance organization ("HMO").

Molina was founded in 1980 as a provider organization serving low-income families in Southern California. We were originally organized in California as a health plan holding company and reincorporated in Delaware in 2002.

2018 EXECUTIVE SUMMARY

Following Molina's internal restructuring in mid-2017, the board of directors appointed an experienced industry leader, Joe Zubretsky, as its CEO in November 2017. Mr. Zubretsky made significant changes to the executive management team throughout 2018 by recruiting new, experienced leaders of finance, health plan operations, health plan services, strategic planning and corporate development, and human resources.

We have embarked on a deliberate turn-around strategy aimed at margin recovery and sustainability, pursuit of targeted growth opportunities, enhancement of our talent and culture to align with our strategic initiatives, and development of the future capabilities needed to address the evolving healthcare environment.

We believe that management has demonstrated the effectiveness of this strategy by its accomplishments in 2018, which have included, among others:

- Improving the efficiency of our administrative cost profile;
- Strengthening our balance sheet by reducing our outstanding indebtedness;
- Revamping the contract procurement process;
- Realigning management incentive programs with our strategic objectives;
- Divesting non-core businesses; and
- Producing strong financial results, which have exceeded our initial and revised guidance and expectations.

The following table illustrates the year-over-year improvement in our operating results:

	2018	2017
	(Dollars in millions, except per-share amounts)	
Total Revenue	$18,890	$19,883
Medical Care Ratio ("MCR") [1]	85.9%	90.6%
Pre-Tax Margin [2]	5.3%	(3.1)%
After-Tax Margin [2]	3.7%	(2.6)%
Net Income (Loss) per Diluted Share	$10.61	$(9.07)

(1) Medical care ratio represents medical care costs as a percentage of premium revenue.

(2) Pre-tax margin represents net income (loss) before income taxes as a percentage of total revenue. After-tax margin represents net income (loss) as a percentage of total revenue.

OUR BUSINESS FOOTPRINT TODAY

As of December 31, 2018, our health plans operated in 14 states and the Commonwealth of Puerto Rico. This footprint includes the five largest Medicaid markets—California, Florida, New York, Ohio, and Texas.

OUR SEGMENTS

We currently have two reportable segments: our Health Plans segment and our Other segment. We manage the vast majority of our operations through our Health Plans segment. Our Other segment includes the historical results of the Pathways behavioral health subsidiary, which we sold in the fourth quarter of 2018, and certain corporate amounts not allocated to the Health Plans segment. Effective in the fourth quarter of 2018, we reclassified the historical results relating to our Molina Medicaid Solutions ("MMS") segment, which we sold in the third quarter of 2018, to the Other segment. Previously, results for MMS were reported in a stand-alone segment. We regularly evaluate the appropriateness of our reportable segments, particularly in light of organizational changes, acquisition and divestiture activity, and changing laws and regulations. Therefore, these reportable segments may change in the future.

Refer to Notes to Consolidated Financial Statements, Note 18, "Segments," for segment revenue and profit information, and Note 2, "Significant Accounting Policies" for revenue information by health plan.

MEMBERSHIP BY PROGRAM

	As of December 31,		
	2018	2017	2016
Temporary Assistance for Needy Families ("TANF") and Children's Health Insurance Program ("CHIP")	2,295,000	2,457,000	2,536,000
Medicaid Expansion	660,000	668,000	673,000
Aged, Blind or Disabled ("ABD")	406,000	412,000	396,000
Total Medicaid	3,361,000	3,537,000	3,605,000
Medicare-Medicaid Plan ("MMP") - Integrated	54,000	57,000	51,000
Medicare Special Needs Plans	44,000	44,000	45,000
Total Medicare	98,000	101,000	96,000
Total Medicaid and Medicare	3,459,000	3,638,000	3,701,000
Marketplace	362,000	815,000	526,000
	3,821,000	4,453,000	4,227,000

MEMBERSHIP BY HEALTH PLAN

	As of December 31,		
	2018	2017	2016
California	608,000	746,000	683,000
Florida	313,000	625,000	553,000
Illinois	224,000	165,000	195,000
Michigan	383,000	398,000	391,000
New Mexico	222,000	253,000	254,000
Ohio	302,000	327,000	332,000
Puerto Rico	252,000	314,000	330,000
South Carolina	120,000	116,000	109,000
Texas	423,000	430,000	337,000
Washington	781,000	777,000	736,000
Other [1]	193,000	302,000	307,000
	3,821,000	4,453,000	4,227,000

(1) "Other" includes the Idaho, Mississippi, New York, Utah and Wisconsin health plans, which are not individually significant to our consolidated operating results.

MISSION

Molina's mission is to provide quality health care services to financially vulnerable families and individuals who are covered by government programs.

STRATEGY

Our strategy focuses on the following four key areas, which are described in detail below: margin recovery and sustainability, growth opportunities, talent and culture, and future capabilities.

MARGIN RECOVERY AND SUSTAINABILITY

We are executing a comprehensive, short-term plan designed to restore margins through expense reductions, operating improvements, execution of managed care fundamentals, and divestiture of non-strategic assets. In addition, we are working to enhance our balance sheet by implementing a disciplined approach to capital management.

We are simplifying our provider networks. We are terminating or renegotiating high-cost providers, narrowing networks in certain geographies, evaluating stop-loss thresholds and carve-outs, implementing value-based contracting, and evaluating ancillary services and pharmacy benefit management pricing and operations. In addition, we have exited substantially all direct delivery operations.

We are striving to improve the effectiveness of utilization review and care management. Areas of focus include specialist referrals, pre-authorization, concurrent review, high acuity populations and high utilizers of services, emergency room utilization, and behavioral and medical integration.

We are addressing at-risk revenues and risk adjustment. We seek to more effectively engage in state rate setting, improve Medicare Star Ratings, increase retention of quality revenue withholds, and focus on coding and documentation to achieve risk scores commensurate with the acuity of our population.

We are working to improve our claims payment function. The key areas of improvement we are focusing on include provider experience, payment accuracy, and oversight of claims fraud, waste and abuse.

We are evaluating and outsourcing certain elements of our information technology and management function. We seek to standardize our administrative platform, streamline operations and procedures, evaluate potential co-sourcing and/or outsource operational components, and consolidate data warehousing and data mining capabilities.

GROWTH OPPORTUNITIES

Our immediate goal is to win re-procurements of state contracts and to capitalize on opportunities to achieve measured growth. We see numerous opportunities for growth in our legacy state health plans and programs. We have already experienced some success in the pursuit of new revenue and the defense of existing revenue:

- In May 2018, our Washington health plan was selected by the Washington State Health Care Authority to enter into a managed care contract for the eight remaining regions of the state's Apple Health Integrated Managed Care program, in addition to the two regions previously awarded to us. As of December 31, 2018, we served approximately 751,000 Medicaid members in Washington, which represented premium revenue of approximately $2,035 million in the year ended December 31, 2018.
- In June 2018, our Florida health plan was awarded comprehensive Medicaid Managed Care contracts by the Florida Agency for Health Care Administration in Regions 8 and 11 of the Florida Statewide Medicaid Managed Care Invitation to Negotiate. Under the new contracts, effective January 1, 2019, we serve approximately 98,000 Medicaid members in those regions, which represented premium revenue of approximately $462 million in the year ended December 31, 2018. As of December 31, 2018, we served a total of 272,000 Medicaid members in Florida, which represented premium revenue of approximately $1,479 million in the year ended December 31, 2018.
- In July 2018, our Puerto Rico health plan was selected by the Puerto Rico Health Insurance Administration to be one of the organizations to administer the Commonwealth's new Medicaid Managed Care contract. As of December 31, 2018, we served approximately 252,000 members under the new contract, which represents a reduction in membership compared with 320,000 members served as of September 30, 2018. The new contract commenced on November 1, 2018 and has a three-year term with an optional one year extension. The Puerto Rico health plan's premium revenue amounted to $696 million in the year ended December 31, 2018.
- Our Mississippi health plan commenced operations on October 1, 2018 and served approximately 26,000 Medicaid members as of December 31, 2018. In December 2018, our Mississippi health plan was awarded a contract by the Mississippi Division of Medicaid for the Children's Health Insurance Program ("CHIP"). Services under the new three-year contract were initially set to begin July 1, 2019; however, the start date is now pending the outcome of a protest of the contract awards.

Now that our margin recovery efforts have been successful and margin sustainability is well under way, we expect to expand our focus on growth opportunities in new markets.

TALENT AND CULTURE

We intend to drive our strategic initiatives by evolving to a more accountable and performance-driven culture with the right talent in the right jobs. We believe that the success we have had in recruiting new leaders to our current senior executive team has given us a strong start and we are optimistic about this initiative.

FUTURE CAPABILITIES

We are focused on building future capabilities needed to address the evolving healthcare environment and competitive pressures. We believe that key future differentiating capabilities include, but are not limited to, population health management, complex care management, advanced value-based contracting, advanced data analytics, and improved member experience. We are creating a road-map designed to meet these market demands by developing the people, processes, and technologies we require to build these capabilities.

OUR BUSINESS

MEDICAID

Overview

Medicaid was established in 1965 under the U.S. Social Security Act to provide health care and long-term care services and support to low-income Americans. Although jointly funded by federal and state governments, Medicaid is a state-operated and state-implemented program. Subject to federal laws and regulations, states have significant flexibility to structure their own programs in terms of eligibility, benefits, delivery of services, and provider payments. As a result, there are 56 separate Medicaid programs—one for each U.S. state, each U.S. territory, and the District of Columbia.

The federal government guarantees matching funds to states for qualifying Medicaid expenditures based on each state's federal medical assistance percentage ("FMAP"). A state's FMAP is calculated annually and varies inversely with average personal income in the state. The average FMAP across all jurisdictions except Puerto Rico is currently approximately 60%, and currently ranges from a federally established FMAP floor of 50% to as high as 76%. As a result of Hurricane Maria, the FMAP for the Commonwealth of Puerto Rico was temporarily raised from 55% to 100% until late in the third quarter of 2019.

We participate in the following Medicaid programs:

- Temporary Assistance for Needy Families ("TANF") - This is the most common Medicaid program. It primarily covers low-income families with children.
- Medicaid Aged, Blind or Disabled ("ABD") - ABD programs cover low-income persons with chronic physical disabilities or behavioral health impairments. ABD beneficiaries typically use more services than those served by other Medicaid programs because of their critical health issues.
- Children's Health Insurance Program ("CHIP") - CHIP is a joint federal and state matching program that provides health care coverage to children whose families earn too much to qualify for Medicaid coverage. States have the option of administering CHIP through their Medicaid programs.
- Medicaid Expansion - In states that have elected to participate, Medicaid Expansion provides eligibility to nearly all low-income individuals under age 65 with incomes at or below 138% of the federal poverty line.

Our state Medicaid contracts generally have terms of three to five years. These contracts typically contain renewal options exercisable by the state Medicaid agency, and allow either the state or the health plan to terminate the contract with or without cause. Such contracts are subject to risk of loss in states that issue requests for proposal ("RFP") open to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may not be renewed.

In addition to contract renewal, our state Medicaid contracts may be periodically amended to include or exclude certain health benefits (such as pharmacy services, behavioral health services, or long-term care services); populations such as the aged, blind or disabled; and regions or service areas.

Status of Contract Re-procurements

In November 2018, our Texas health plan submitted two separate RFP responses: one with regard to the Texas ABD program, known in Texas as the Star Plus program; and the other with regard to the Texas TANF and CHIP programs, known in Texas as the Star program. We expect the Star Plus award to be announced in the second quarter of 2019, with an effective date of June 1, 2020. We expect the Star award to be announced in the third quarter of 2019, with an effective date of September 1, 2020. As of December 31, 2018, the membership of our Texas health plan under the existing Star Plus contract was 87,000 members, and the related premium revenues for 2018 were $1,605 million. As of December 31, 2018, the membership of our Texas health plan under the existing Star contract was 122,000 members, and the related premium revenues for 2018 were $316 million.

We have received information that the Medicaid contracts of both our Ohio and California health plans may be subject to RFP either in late 2019 or early 2020. A loss of any of our Texas, Ohio, or California Medicaid contracts would have a material adverse effect on our business, financial condition, cash flows, and results of operations.

In January 2018, we were notified by the New Mexico Medicaid agency that we had not been selected for a tentative award of a 2019 Medicaid contract. A hearing was held on our judicial protest on October 17, 2018, and our protest was rejected. We filed an appeal with the New Mexico Court of Appeals on January 28, 2019. We are continuing to manage the business in run-off until the determination of these further appeals or our decision not to pursue our appeal rights. As of December 31, 2018, we served approximately 196,000 Medicaid members in New Mexico, and Medicaid premium revenue amounted to $1,181 million in the year ended December 31, 2018. Our New Mexico health plan continues to serve Medicare and Marketplace members, but, effective January 1, 2019, no longer has Medicaid members.

Member Enrollment and Marketing

Most states allow eligible Medicaid members to select the Medicaid plan of their choice. This opportunity to choose a plan is almost always afforded to the member at the time of first enrollment and, at a minimum, annually thereafter. In some of our states, a substantial majority of new Medicaid members voluntarily select a plan with the remainder

subject to the auto-assignment process described below, while in other states less than half of new members voluntarily choose a plan.

Our Medicaid health plans may benefit from auto-assignment of individuals who do not choose a plan, but for whom participation in managed care programs is mandatory. Each state differs in its approach to auto-assignment, but one or more of the following criteria is typical in auto-assignment algorithms: a Medicaid beneficiary's previous enrollment with a health plan or experience with a particular provider contracted with a health plan, enrolling family members in the same plan, a plan's quality or performance status, a plan’s network and enrollment size, awarding all auto-assignments to a plan with the lowest bid in a county or region, and equal assignment of individuals who do not choose a plan in a specified county or region.

Our Medicaid marketing efforts are regulated by the states in which we operate, each of which imposes different requirements for, or restrictions on, Medicaid sales and marketing. These requirements and restrictions are revised from time to time. None of the jurisdictions in which we operate permit direct sales by Medicaid health plans.

MEDICARE

Overview

Medicare Advantage. Medicare is a federal program that provides eligible persons age 65 and over and some disabled persons with a variety of hospital, medical insurance, and prescription drug benefits. Medicare is funded by Congress, and administered by the Centers for Medicare and Medicaid Services (“CMS”). Medicare beneficiaries may enroll in a Medicare Advantage plan, under which managed care plans contract with CMS to provide benefits that are comparable to original Medicare. Such benefits are provided in exchange for a fixed per-member per-month (“PMPM”) premium payment that varies based on the county in which a member resides, the demographics of the member, and the member’s health condition. Since 2006, Medicare beneficiaries have had the option of selecting a prescription drug benefit from an existing Medicare Advantage plan. The drug benefit, available to beneficiaries for a monthly premium, is subject to certain cost sharing depending upon the specific benefit design of the selected plan.

Medicare-Medicaid Plans, or MMPs. Over 10 million low-income elderly and disabled people are covered under both the Medicare and Medicaid programs. These beneficiaries are more likely than other Medicare beneficiaries to be frail, live with multiple chronic conditions, and have functional and cognitive impairments. Medicare is their primary source of health insurance coverage. Medicaid supplements Medicare by paying for services not covered by Medicare, such as dental care and long-term care services and support, and by helping to cover Medicare’s premiums and cost-sharing requirements. Together, these two programs help to shield very low-income Medicare beneficiaries from potentially unaffordable out-of-pocket medical and long-term care costs. To coordinate care for those who qualify to receive both Medicare and Medicaid services (the “dual eligible”), and to deliver services to these individuals in a more financially efficient manner, some states have undertaken demonstration programs to integrate Medicare and Medicaid services for dual-eligible individuals. The health plans participating in such demonstrations are referred to as MMPs. We operate MMPs in six states.

Contracts

We enter into Medicare and MMP contracts with CMS, in partnership with each state’s department of health and human services. Such contracts typically have terms of one to two years.

Status of Contract Renewals - MMP

MMP premium revenues for the California, Illinois, and Ohio health plans, whose duals demonstration programs currently expire on December 31, 2019, amounted to $189 million, $81 million, and $529 million, respectively, in the year ended December 31, 2018.

- California MMP. In 2018, the state submitted a one-year extension of its duals demonstration program with CMS, through December 31, 2020, and is currently in negotiations with CMS to extend the program for three years, through December 31, 2022.
- Illinois MMP. We believe the state is likely moving toward a three-year extension of its duals demonstration program with CMS. This potential extension is currently pending review with the state’s new administration.
- Ohio MMP. The state has submitted a three-year extension of its duals demonstration program with CMS, through December 31, 2022.

Member Enrollment and Marketing

Our Medicare members may be enrolled through auto-assignment, as described above under “Medicaid - Member Enrollment and Marketing,” or by enrolling in our plans with the assistance of insurance agents employed by Molina,

outside brokers, or via the Internet.

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

We employ our own insurance agents and contract with independent, licensed insurance agents to market our Medicare Advantage products. We have continued to expand our use of independent agents because the cost of these agents is largely variable and we believe the use of independent, licensed agents is more conducive to the shortened Medicare selling season and the open enrollment period. The activities of our independent, licensed insurance agents are also regulated by CMS. We also use direct mail, mass media and the Internet to market our Medicare Advantage products.

MARKETPLACE

Overview

Effective January 1, 2014, the ACA authorized the creation of Marketplace insurance exchanges, allowing individuals and small groups to purchase federally subsidized health insurance. We offer Marketplace plans in many of the states where we offer Medicaid health plans. Our plans allow our Medicaid members to stay with their providers as they transition between Medicaid and the Marketplace. Additionally, they remove financial barriers to quality care and keep members' out-of-pocket expenses to a minimum. In 2019, we participate in the Marketplace in California, Florida, Michigan, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin.

Contracts

We enter into contracts with CMS annually for the state Marketplace programs. These contracts have a one-year term ending on December 31 and must be renewed annually.

Member Enrollment and Marketing

Our Marketplace members enroll in our plans with the assistance of insurance agents employed by Molina, outside brokers, vendors, direct to consumer marketing and via the Internet.

While our Marketplace sales activities are regulated by CMS (such as eligibility determinations), our marketing activities are regulated by the individual states in which we operate. Some states require us to obtain prior approval of our marketing materials, others simply require us to provide them with copies of our marketing materials, and some states do not request our marketing materials. We are able to freely contact our own members and provide them with marketing materials as long as those materials are fair and do not discriminate.

Our Marketplace sales and marketing strategy is to provide high quality, affordable, compliant and consumer centric Marketplace products through a variety of distribution channels. Our Marketplace products are displayed on the Federally Facilitated Marketplace (“FFM”) and the State Based Marketplace (“SBM”) in the states in which we participate in the Marketplace. We also contract with independent, licensed insurance agents to market our Marketplace products. The activities of our independently licensed insurance agents are also regulated by both CMS and the departments of insurance in the states in which we participate. Our sales cycle typically peaks during the annual Open Enrollment Period (“OEP”) as defined and regulated by CMS and applicable FFM and SBM.

For 2019, we are currently estimating that our Marketplace end-of-year membership will range from 250,000-275,000. This estimated membership is lower than the 362,000 enrollment as of December 31, 2018, despite our return to Utah and Wisconsin, and we expect our Marketplace revenues to decrease in 2019 as a result.

BASIS FOR PREMIUM RATES

Medicaid

Under our Medicaid contracts, state government agencies pay our health plans fixed PMPM rates that vary by state, line of business, and demographics; and we arrange, pay for and manage health care services provided to Medicaid beneficiaries. Therefore, our health plans are at risk for the medical costs associated with their members’ health care. The rates we receive are subject to change by each state and, in some instances, provide for adjustments for health risk factors. CMS requires these rates to be actuarially sound. Payments to us under each of our Medicaid contracts are subject to the annual appropriation process in the applicable state. The amount of the premiums paid to our health plans may vary substantially between states and among various government

programs. For the year ended December 31, 2018, Medicaid program PMPM premium revenues ranged as follows: TANF and CHIP ranged from $130.00 to $340.00; Medicaid Expansion ranged from $290.00 to $520.00; and ABD ranged from $520.00 to $1,630.00.

Medicare

Under Medicare Advantage, managed care plans contract with CMS to provide benefits in exchange for a fixed PMPM premium payment that varies based on the county in which a member resides, and adjusted for demographic and health risk factors. CMS also considers inflation, changes in utilization patterns and average per capita fee-for-service Medicare costs in the calculation of the fixed PMPM premium payment. Amounts payable to us under the Medicare Advantage contracts are subject to annual revision by CMS, and we elect to participate in each Medicare service area or region on an annual basis. Medicare Advantage premiums paid to us are subject to federal government reviews and audits which can result, and have resulted, in retroactive and prospective premium adjustments. Compared with our Medicaid plans, Medicare Advantage contracts generate higher average PMPM revenues and health care costs. For the year ended December 31, 2018, Medicare program PMPM premium revenues ranged as follows: Medicare Advantage ranged from $590.00 to $1,370.00; and MMP ranged from $1,390.00 to $3,250.00.

Marketplace

For Marketplace, we develop each state's premium rates during the spring of each year for policies effective in the following calendar year. Premium rates are based on our estimates of projected member utilization, medical unit costs, member risk acuity, member risk transfer, and administrative costs, with the intent of realizing a target pretax percentage profit margin. Our actuaries certify the actuarial soundness of Marketplace premiums in the rate filings submitted to the various state and federal authorities for approval. For the year ended December 31, 2018, Marketplace program PMPM premium revenues ranged from $250.00 to $660.00.

PREMIUM REVENUE BY PROGRAM

	Year Ended December 31,		
	2018	2017	2016
	(In millions)		
TANF and CHIP	$5,508	$5,554	$5,403
Medicaid Expansion	2,884	3,150	2,952
ABD	5,231	5,135	4,666
Total Medicaid	13,623	13,839	13,021
MMP	1,443	1,446	1,321
Medicare	631	601	558
Total Medicare	2,074	2,047	1,879
Total Medicaid and Medicare	15,697	15,886	14,900
Marketplace	1,915	2,968	1,545
	$17,612	$18,854	$16,445

LEGISLATIVE AND POLITICAL ENVIRONMENT

PRESSURES ON MEDICAID FUNDING

Due to states' budget challenges and political agendas at both the state and federal levels, there are a number of different legislative proposals being considered, some of which would involve significantly reduced federal or state spending on the Medicaid program, constitute a fundamental change to the federal role in health care and, if enacted, could have a material adverse effect on our business, financial condition, cash flows and results of operations. These proposals include elements such as the following, as well as numerous other potential changes and reforms:

- Ending the entitlement nature of Medicaid (and perhaps Medicare as well) by capping future increases in federal health spending for these programs, and shifting much more of the risk for health costs in the future to states and consumers;

- Reversing the ACA's expansion of Medicaid that enables states to cover low-income childless adults;
- Changing Medicaid to a state block grant program, including potentially capping spending on a per-enrollee basis;
- Requiring Medicaid beneficiaries to work; and
- Limiting the amount of lifetime benefits for Medicaid beneficiaries.

AFFORDABLE CARE ACT

As a result of the election of President Trump, the GOP control of the Senate and the former GOP control of the House, several changes have been made to the provisions of the ACA, including reduced funding. Accordingly, the future of the ACA and its underlying programs are subject to continuing and substantial uncertainty, making long-term business planning exceedingly difficult. In December 2018, in a case brought by the state of Texas and nineteen other states, a federal judge in Texas struck down the ACA based on his determination that the ACA's individual mandate is unconstitutional and, since that mandate cannot be separated from the rest of the ACA, the judge ruled that the rest of the ACA is also unconstitutional. The decision has been appealed to the U.S. Court of Appeals for the Fifth Circuit. Other proposed changes and reforms to the ACA have included, or may include the following:

- Prohibiting the federal government from operating Marketplaces;
- Eliminating the advanced premium tax credits, and cost sharing reductions for low income individuals who purchase their health insurance through the Marketplaces;
- Expanding and encouraging the use of private health savings accounts;
- Providing for insurance plans that offer fewer and less extensive health insurance benefits than under the ACA's essential health benefits package, including broader use of catastrophic coverage plans, or short-term health insurance;
- Establishing and funding high risk pools or reinsurance programs for individuals with chronic or high cost conditions; and
- Allowing insurers to sell insurance across state lines.

Any final, not-appealable determination that the ACA is unconstitutional, or the passage of any of these changes or other reforms, would have a material adverse effect on our business, financial condition, cash flows and results of operations.

OPERATIONS

QUALITY

Our long-term success depends, to a significant degree, on the quality of the services we provide. As of December 31, 2018, 11 of our health plans were accredited by the National Committee for Quality Assurance ("NCQA"), including the Multicultural Health Care Distinction, which is awarded to organizations that meet or exceed NCQA's rigorous requirements for multicultural health care.

The table below presents our health plans' NCQA status, as well as their current scores as part of the Medicare Star Ratings, which measures the quality of Medicare plans across the country using a 5-star rating system.

We believe that these objective measures of quality are important to state Medicaid agencies, as a growing number of states link reimbursement and patient assignment to quality scores. Additionally, Medicare pays quality bonuses to health plans that achieve high quality.

PROVIDER NETWORKS

We arrange health care services for our members through contracts with a vast network of providers, including independent physicians and physician groups, hospitals, ancillary providers, and pharmacies. We strive to ensure that our providers have the appropriate expertise and cultural and linguistic experience.

The quality, depth and scope of our provider network are essential if we are to ensure quality, cost-effective care for our members. In partnering with quality, cost-effective providers, we utilize clinical and financial information derived by our medical informatics function, as well as the experience we have gained in serving Medicaid members, to gain insight into the needs of both our members and our providers.

Physicians

We contract with both primary care physicians and specialists, many of whom are organized into medical groups or independent practice associations. Primary care physicians provide office-based primary care services. Primary care physicians may be paid under capitation or fee-for-service contracts and may receive additional compensation by providing certain preventive care services. Our specialists care for patients for a specific episode or condition, usually upon referral from a primary care physician, and are usually compensated on a fee-for-service basis. When we contract with groups of physicians on a capitated basis, we monitor their solvency.

Hospitals

We generally contract with hospitals that have significant experience dealing with the medical needs of the Medicaid population. We reimburse hospitals under a variety of payment methods, including fee-for-service, per diems, diagnostic-related groups, capitation, and case rates.

Ancillary Providers

Our ancillary agreements provide coverage of medically-necessary care, including laboratory services, home health, physical, speech and occupational therapy, durable medical equipment, radiology, ambulance and transportation services, and are reimbursed on a capitation and fee-for-service basis.

Pharmacy

We outsource pharmacy benefit management services, including claims processing, pharmacy network contracting, rebate processing and mail and specialty pharmacy fulfillment services.

The following table provides the details of consolidated medical care costs by type for the periods indicated:

	Year Ended December 31,									
	2018			2017			2016			
	Amount	PMPM	% of Total	Amount	PMPM	% of Total	Amount	PMPM	% of Total	
	(In millions, except PMPM amounts)									
Fee-for-service	$11,278	$232.15	74.5 %	$12,682	$229.63	74.3 %	$10,993	$217.84	74.4 %	
Pharmacy	2,138	44.01	14.1	2,563	46.40	15.0	2,213	43.84	15.0	
Capitation	1,184	24.38	7.8	1,360	24.63	8.0	1,218	24.13	8.2	
Other [1]	537	11.05	3.6	468	8.48	2.7	350	6.94	2.4	
Total	$15,137	$311.59	100.0%	$17,073	$309.14	100.0%	$14,774	$292.75	100.0%	

(1) "Other" includes all medically related administrative costs, certain provider incentive costs, provider claims, and other health care expenses. Medically related administrative costs include, for example, expenses relating to health education, quality assurance, case management, care coordination, disease management, and 24-hour on-call nurses.

MEDICAL MANAGEMENT

Our experience in medical management extends back to our roots as a provider organization. Primary care physicians are the focal point of the delivery of health care to our members, providing routine and preventive care, coordinating referrals to specialists, and assessing the need for hospital care. We believe this model has proved to be an effective method for coordinating medical care for our members. The underlying challenge we face is to coordinate health care so that our members receive timely and appropriate care from the right provider at the appropriate cost.

We seek to ensure quality care for our members on a cost-effective basis through the use of certain key medical management and cost control tools. These tools include utilization management, case and health management, information technology, and centralized services.

Utilization Management

We continuously review utilization patterns with the intent to optimize quality of care and to ensure that appropriate services are rendered in the most cost-effective manner. Utilization management, along with our other tools of medical management and cost control, is supported by a centralized corporate medical informatics function which utilizes third-party software and data warehousing tools to convert data into actionable information. We use predictive modeling that supports a proactive case and health management approach both for us and our affiliated physicians.

Case and Health Management

We seek to encourage quality, cost-effective care through a variety of case and health management programs, including disease management programs, educational programs, and pharmacy management programs such as the following:

- Disease Management Programs. We develop specialized disease management programs that address the particular health care needs of our members. Our member assessment process evaluates the individual needs of the members and ensures that the appropriate level of services and support are provided to address the physical, behavioral and social determinants of health. This comprehensive and customized approach is designed to address our members' individual goals and improve their overall quality of life. For example, our comprehensive maternity programs are designed to improve pregnancy outcomes and enhance member satisfaction. "breathe with ease!" is a multi-disciplinary disease management program that provides health education resources and case management services to assist physicians caring for asthmatic members between the ages of three and 15.
- Educational Programs. Educational programs are an important aspect of our approach to health care delivery. These programs are designed to increase awareness of various diseases, conditions, and

methods of prevention in a manner that supports our providers while meeting the unique needs of our members. For example, we provide our members with information to guide them through various episodes of care. This information, which is available in several languages, is designed to educate members on the use of primary care physicians, emergency rooms, and nurse call centers.

- Pharmacy Management Programs. Our pharmacy programs are designed with the goal to be a trusted partner in improving member health and healthcare affordability. We do this by strategically partnering with the physicians and other healthcare providers who treat our members. This collaboration results in drug formularies and clinical initiatives that promote improved patient care. We employ full-time pharmacists and pharmacy technicians who work closely with providers to educate them on our formulary products, clinical programs and the importance of cost-effective care.

INFORMATION TECHNOLOGY

Our business is dependent on effective and secure information systems that assist us in, among other things, processing provider claims, monitoring utilization and other cost factors, supporting our medical management techniques, and providing data to our regulators. Our members and providers also depend upon our information systems for enrollment, primary care and specialist physician roster access, membership verifications, claims status, and other information.

We have partnered with third parties to support our information technology systems. This makes our operations vulnerable to adverse effects if such third parties fail to perform adequately. On February 4, 2019, we entered into a master services agreement with Infosys Limited pursuant to which Infosys will manage certain of our information technology infrastructure services including, among other things, our information technology operations, end-user services, and data centers. As a result of the agreement, we anticipate reducing our administrative expenses and improving the reliability of our information technology functions, while aiming to maintain targeted levels of service and operating performance. A segment of the infrastructure services will be provided on the Company’s premises, while other portions of the infrastructure services will be performed at Infosys facilities. Infosys will provide us with services required to migrate those information technology infrastructure operations that will be performed at Infosys facilities. As the infrastructure services currently performed by the Company are transitioned to Infosys, we expect to eliminate certain positions in our information technology group. Some of the employees in our information technology group may become employees of Infosys. The initial term of this agreement with Infosys is three years, commencing on February 4, 2019. We have the right to extend the agreement for up to two additional renewal terms of one year each.

CENTRALIZED SERVICES

We provide certain centralized medical and administrative services to our subsidiaries pursuant to administrative services agreements that include, but are not limited to, information technology, product development and administration, underwriting, claims processing, customer service, certain care management services, human resources, legal, marketing, purchasing, risk management, actuarial, underwriting, finance, accounting, legal and public relations.

COMPETITIVE CONDITIONS AND ENVIRONMENT

We face varying levels of competition. Health care reform proposals may cause organizations to enter or exit the market for government sponsored health programs. However, the licensing requirements and bidding and contracting procedures in some states may present partial barriers to entry into our industry.

We compete for government contracts, renewals of those government contracts, members, and providers. State agencies consider many factors in awarding contracts to health plans. Among such factors are the health plan’s provider network, quality scores, medical management, degree of member satisfaction, timeliness of claims payment, and financial resources. Potential members typically choose a health plan based on a specific provider being a part of the network, the quality of care and services available, accessibility of services, and reputation or name recognition of the health plan. We believe factors that providers consider in deciding whether to contract with a health plan include potential member volume, payment methods, timeliness and accuracy of claims payment, and administrative service capabilities.

Medicaid

The Medicaid managed care industry is subject to ongoing changes as a result of health care reform, business consolidations and new strategic alliances. We compete with national, regional, and local Medicaid service providers, principally on the basis of size, location, quality of the provider network, quality of service, and reputation. Our primary competitors in the Medicaid managed care industry include Centene Corporation, WellCare Health Plans, Inc., UnitedHealth Group Incorporated, Anthem, Inc., Aetna Inc., and other large not-for-profit health care organizations. Competition can vary considerably from state to state.

Medicare

While we expect to see strong growth in the Medicare program in coming years, the market is highly competitive across the country, with large competitors, such as UnitedHealth Group Incorporated, Humana Inc., and Aetna Inc., holding significant market share.

Marketplace

Low-income members who receive government subsidies comprise the vast majority of Marketplace membership, which is served by a limited number of health plans. Our primary competitor for low-income Marketplace membership is Centene Corporation.

REGULATION

Our health plans are highly regulated by both state and federal government agencies. Regulation of managed care products and health care services varies from jurisdiction to jurisdiction, and changes in applicable laws and rules occur frequently. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Such agencies have become increasingly active in recent years in their review and scrutiny of health insurers and managed care organizations, including those operating in the Medicaid and Medicare programs.

HIPAA

In 1996, Congress enacted the Health Insurance Portability and Accountability Act (“HIPAA”). All health plans are subject to HIPAA, including ours. HIPAA generally requires health plans to:

- Establish the capability to receive and transmit electronically certain administrative health care transactions, such as claims payments, in a standardized format;
- Afford privacy to patient health information; and
- Protect the privacy of patient health information through physical and electronic security measures.

We enforce an internal HIPAA compliance program, which we believe complies with HIPAA privacy and security regulations, and have dedicated resources to monitor compliance with this program.

Health care reform created additional tools for fraud prevention, including increased oversight of providers and suppliers participating or enrolling in Medicaid, CHIP, and Medicare. Those enhancements included mandatory licensure for all providers, and site visits, fingerprinting, and criminal background checks for higher risk providers.

FRAUD AND ABUSE LAWS AND THE FALSE CLAIMS ACT

Because we receive payments from federal and state governmental agencies, we are subject to various laws commonly referred to as “fraud and abuse” laws, including federal and state anti-kickback statutes, prohibited referrals, and the federal False Claims Act, which permit agencies and enforcement authorities to institute a suit against us for violations and, in some cases, to seek treble damages, criminal and civil fines, penalties, and assessments. Violations of these laws can also result in exclusion, debarment, temporary or permanent suspension from participation in government health care programs, or the institution of corporate integrity agreements. Liability under such federal and state statutes and regulations may arise if we know, or it is found that we should have known, that information we provide to form the basis for a claim for government payment is false or fraudulent, and some courts have permitted False Claims Act suits to proceed if the claimant was out of compliance with program requirements.

Fraud, waste and abuse prohibitions encompass a wide range of operating activities, including kickbacks or other inducements for referral of members or for the coverage of products (such as prescription drugs) by a plan, billing for unnecessary medical services by a provider, upcoding, payments made to excluded providers, improper

marketing, and the violation of patient privacy rights. In particular, there has recently been increased scrutiny by the Department of Justice on health plans' risk adjustment practices, particularly in the Medicare program. Companies involved in public health care programs such as Medicaid and Medicare are required to maintain compliance programs to detect and deter fraud, waste and abuse, and are often the subject of fraud, waste and abuse investigations and audits. The regulations and contractual requirements applicable to participants in these public-sector programs are complex and subject to change.

The federal government has taken the position that claims presented in violation of the federal anti-kickback statute may be considered a violation of the federal False Claims Act. In addition, under the federal civil monetary penalty statute, the U.S. Department of Health and Human Services ("HHS"), Office of Inspector General has the authority to impose civil penalties against any person who, among other things, knowingly presents, or causes to be presented, certain false or otherwise improper claims. Qui tam actions under federal and state law can be brought by any individual on behalf of the government. Qui tam actions have increased significantly in recent years, causing greater numbers of health care companies to have to defend a false claim action, pay fines, or be excluded from the Medicare, Medicaid, or other state or federal health care programs as a result of an investigation arising out of such action.

LICENSING AND SOLVENCY

Our health plans are licensed by the insurance departments in the states in which they operate, except our New York HMO, which is licensed as a prepaid health services plan by the New York State Department of Health, and our California HMO, which is licensed by the California Department of Managed Health Care.

Our health plans are subject to stringent requirements to maintain a minimum amount of statutory capital determined by statute or regulation, and restrictions that limit their ability to pay dividends to us. For further information, refer to the Notes to Consolidated Financial Statements, Note 17, "Commitments and Contingencies—Regulatory Capital Requirements and Dividend Restrictions."

OTHER INFORMATION

EMPLOYEES

As of December 31, 2018, we had approximately 11,000 employees. Our employee base is multicultural and reflects the diverse membership we serve.

AVAILABLE INFORMATION

Our principal executive offices are located at 200 Oceangate, Suite 100, Long Beach, California 90802, and our telephone number is (562) 435-3666. The Company also maintains corporate offices in New York City, New York. You can access our website at www.molinahealthcare.com to learn more about our Company. From that site, you can download and print copies of our Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q, and Current Reports on Form 8-K, along with amendments to those reports. You can also download our Corporate Governance Guidelines, Board of Directors committee charters, and Code of Business Conduct and Ethics. We make periodic reports and amendments available, free of charge, as soon as reasonably practicable after we file or furnish these reports to the SEC. We will also provide a copy of any of our corporate governance policies published on our website free of charge, upon request. To request a copy of any of these documents, please submit your request to: Molina Healthcare, Inc., 200 Oceangate, Suite 100, Long Beach, California 90802, Attn: Investor Relations. Information on or linked to our website is neither part of nor incorporated by reference into this Form 10-K or any other SEC filings.

RISK FACTORS

You should carefully consider the risks described below and all of the other information set forth in this Form 10-K, including our consolidated financial statements and accompanying notes. These risks and other factors may affect our forward-looking statements, including those we make in this annual report or elsewhere, such as in press releases, presentations to securities analysts or investors, or other communications made by or with the approval of one of our executive officers. The risks described below are not the only risks facing our Company. Additional risks that we are unaware of, or that we currently believe are not material, may also become important factors that

adversely affect our business. If any of the following risks actually occurs, our business, financial condition, results of operations, and future prospects could be materially and adversely affected. In that event, among other effects, the trading price of our common stock could decline, and you could lose part or all of your investment.

Risks Related to Our Business

If the responsive bids of our health plans for new or renewed Medicaid contracts are not successful, or if our government contracts are terminated or are not renewed on favorable terms or at all, our premium revenues could be materially reduced and our operating results could be negatively impacted.

We currently derive our premium revenues from health plans that operate in 14 states and the Commonwealth of Puerto Rico. Measured by premium revenue by health plan, our top four health plans were in California, Ohio, Texas, and Washington, with aggregate premium revenue of $10,143 million, or approximately 58% of total premium revenue, in the year ended December 31, 2018. If we are unable to continue to operate in any of our existing jurisdictions, or if our current operations in any portion of those jurisdictions are significantly curtailed or terminated entirely, our revenues could decrease materially.

Many of our government contracts for the provision of managed care programs to people receiving government assistance are effective only for a fixed period of time and may be extended for an additional period of time if the contracting entity or its agent elects to do so. When such contracts expire, they may be opened for bidding by competing healthcare providers, and there is no guarantee that the contracts will be renewed or extended. For example, our previous Medicaid contract with the Florida Agency for Health Care Administration ("AHCA") expired on December 31, 2018, as of which date the Florida health plan served approximately 272,000 Medicaid members. In June 2018, our Florida health plan was awarded a comprehensive Medicaid Managed Care contract by AHCA, effective January 1, 2019, for two regions in Florida (which consisted of approximately 98,000 Medicaid members as of December 31, 2018), as opposed to the eight regions covered by our previous contract.

As yet another example, our New Mexico health plan's Medicaid contract with the New Mexico Human Services Department ("HSD") expired on December 31, 2018. In January 2018, we were notified by the New Mexico Medicaid agency that we had not been selected for a tentative award of a 2019 Medicaid contract. A hearing was held on our judicial protest on October 17, 2018, and our protest was rejected. We filed an appeal with the New Mexico Court of Appeals on January 28, 2019. We are continuing to manage the business in run-off until the determination of these further appeals or our decision not to pursue our appeal rights. As of December 31, 2018, we served approximately 196,000 Medicaid members in New Mexico, and Medicaid premium revenue amounted to $1,181 million in the year ended December 31, 2018. Our New Mexico health plan continues to serve Medicare and Marketplace members, but, effective January 1, 2019, no longer has Medicaid members.

In any bidding process, our health plans may face competition from numerous other health plans, many with greater financial resources and greater name recognition than we have. For example, in November 2018, our Texas health plan submitted RFP responsive bids under the following two programs:

- The Texas Health and Human Service Commission ("HHSC") currently contracts with five STAR+PLUS (or "ABD") plans: Anthem, Cigna, Centene, United Healthcare, and Molina. Our Texas health plan served a total of approximately 87,000 STAR+PLUS members as of December 31, 2018. We expect the new Texas STAR+PLUS contracts to be awarded in the second quarter of 2019, and to become effective June 1, 2020.
- The HHSC currently contracts with many STAR (or "TANF" and "CHIP") plans, including Molina. Our Texas health plan served a total of approximately 122,000 STAR members as of December 31, 2018. We expect the new Texas STAR contracts to be awarded in the third quarter of 2019, and to become effective September 1, 2020.

If the RFP responsive bids of our Texas health plan are not successful, or if our Texas health plan's contracts with HHSC are not renewed, or if they are renewed but coverage is reduced, our revenues would be materially and adversely impacted.

Even if our responsive bids are successful, the bids may be based upon assumptions regarding enrollment, utilization, medical costs, or other factors which could result in the Medicaid contract being less profitable than we had expected or, in extreme cases, could result in a net loss. Furthermore, our government contracts contain certain provisions regarding, among other things, eligibility, enrollment and dis-enrollment processes for covered services, eligible providers, periodic financial and information reporting, quality assurance and timeliness of claims payment, and are

subject to cancellation if we fail to perform in accordance with the standards set by regulatory agencies.

If any of our governmental contracts are terminated, not renewed, renewed on less favorable terms, or not renewed on a timely basis, our business and reputation may be adversely impacted, and our financial position, results of

operations or cash flows could be materially and adversely affected. In addition, we may be unable to support the carrying amount of goodwill we have recorded for the applicable business, because its fair value is based on estimated future cash flows.

If we lose contracts that constitute a significant amount of our revenue, we will lose the administrative cost efficiencies that are inherent in a large revenue base. In such circumstances, we may not be able to reduce fixed costs proportionally with our lower revenue, and the financial impact of lost contracts may exceed the net income ascribed to those contracts.

We are currently able to spread the cost of centralized services over a large revenue base. Many of our administrative costs are fixed in nature, and will be incurred at the same level regardless of the size of our revenue base. If we lose contracts that constitute a significant amount of our revenue, we may not be able to reduce the expense of centralized services in a manner that is proportional to that loss of revenue. In such circumstances, not only will our total dollar margins decline, but our percentage margins, measured as a percentage of revenue, will also decline. This loss of cost efficiency, and the resulting stranded administrative costs, could have a material and adverse impact on our business, cash flows, financial position, or results of operations.

If, in the interests of maintaining or improving longer term profitability, we decide to exit voluntarily certain state contractual arrangements, make changes to our provider networks, or make changes to our administrative infrastructure, we may incur short- to medium-term disruptions to our business that could materially reduce our premium revenues and our net income.

Decisions that we make with regard to retaining or exiting our portfolio of state and federal contracts, and changes to the manner in which we serve the members attached to those contracts, could generate substantial expenses associated with the run out of existing operations and the restructuring of those operations that remain. Such expenses could include, but would not be limited to, goodwill and intangible asset impairment charges, restructuring costs, additional medical costs incurred due to the inability to leverage long-term relationships with medical providers, and costs incurred to finish the run out of businesses that have ceased to generate revenue.

If we are unable to successfully execute our profit maintenance and improvement initiatives and our restructuring plans, or if we fail to realize the anticipated benefits of those initiatives and plans, our business, cash flows, financial position, or results of operations could be materially and adversely affected.

In August 2017, we announced the implementation of a comprehensive restructuring and profitability improvement plan (the “2017 Restructuring Plan”). The 2017 Restructuring Plan included the streamlining of our organizational structure, including the elimination of over 2,000 positions, the re-design of certain core operating processes, the remediation of high cost provider contracts, the restructuring of our direct delivery operations, and the review of our vendor base in an attempt to insure that we were partnering with the lowest cost, most effective, vendors. Since the inception of the 2017 Restructuring Plan in August 2017 through December 31, 2018, we have reported restructuring and separation costs of $271 million under the 2017 Restructuring Plan.

In addition, in the second half of 2017, we launched several profit maintenance and improvement initiatives. We pursued additional profit maintenance and improvement initiatives throughout 2018, and have begun to implement a plan to outsource certain functions of our information technology department. As a part of that plan, on February 4, 2019, we entered into a master services agreement with Infosys Limited pursuant to which Infosys will manage certain of our information technology infrastructure services including, among other things, our information technology operations, end-user services, and data centers.

Our restructuring plan and profit improvement initiatives create numerous 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 or problems experienced as a result of the outsourcing of our information technology infrastructure services, 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, including reliance on third parties as is the case with our agreement with Infosys. 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.

A failure to accurately estimate incurred but not paid medical care costs may negatively impact our results of operations.

Because of the time lag between when medical services are actually rendered by our providers and when we receive, process, and pay a claim for those medical services, we must continually estimate our medical claims liability at particular points in time, and establish claims reserves related to such estimates. Our estimated reserves

for such incurred but not paid ("IBNP") medical care costs are based on numerous assumptions. We estimate our medical claims liabilities using actuarial methods based on historical data adjusted for claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our ability to accurately estimate claims for our newer lines of business or populations, is negatively impacted by the more limited experience we have had with those newer lines of business or populations.

The IBNP estimation methods we use and the resulting reserves that we establish are reviewed and updated, and adjustments, if deemed necessary, are reflected in the current period. Given the numerous uncertainties inherent in such estimates, our actual claims liabilities for a particular quarter or other period could differ significantly from the amounts estimated and reserved for that quarter or period. Our actual claims liabilities have varied and will continue to vary from our estimates, particularly in times of significant changes in utilization, medical cost trends, and populations and markets served.

If our actual liability for claims payments is higher than previously estimated, our earnings in any particular quarter or annual period could be negatively affected. Our estimates of IBNP may be inadequate in the future, which would negatively affect our results of operations for the relevant time period. Furthermore, if we are unable to accurately estimate IBNP, our ability to take timely corrective actions may be limited, further exacerbating the extent of the negative impact on our results.

We are subject to retroactive adjustment to our Medicaid premium revenue as a result of retroactive risk adjustment; retroactive changes to contract terms and the resolution of differing interpretations of those terms; the difficulty of estimating performance-based premium; and retroactive adjustments to "blended" premium rates to reflect the actual mix of members captured in those blended rates.

The complexity of some of our Medicaid contract provisions, imprecise language in those contracts, the desire of state Medicaid agencies in some circumstances to retroactively adjust for the acuity of the medical needs of our members; and state delays in processing rate changes, can create uncertainty around the amount of revenue we should recognize. A current example of exposure to this risk is in California. In the third and fourth quarters of 2018, we recognized adjustments of $57 million and $24 million, respectively, mainly related to the retroactive reinstatement of the Medicaid Expansion risk corridor requirement by the California Department of Health Care Services, mainly for the state fiscal years ended June 2017 and 2018. The risk corridor provision mandates a minimum loss ratio ("MLR") of 85% and a maximum MLR of 95%. The total impact of these adjustments resulted in a reduction to premium revenue totaling approximately $81 million in the year ended December 31, 2018.

Any circumstance such as those described above could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

If we fail to accurately predict and effectively manage our medical care costs, our operating results could be materially and adversely affected.

Our profitability depends to a significant degree on our ability to accurately predict and effectively manage our medical care costs. Historically, our medical care ratio, meaning our medical care costs as a percentage of our premium revenue, has fluctuated substantially, and has varied across our state health plans. Because the premium payments we receive are generally fixed in advance and we operate with a narrow profit margin, relatively small changes in our medical care ratio can create significant changes in our overall financial results. For example, if our overall medical care ratio of 85.9%, for the year ended December 31, 2018 had been one percentage point higher, or 86.9%, our net income per diluted share for the year ended December 31, 2018 would have been approximately $8.54 rather than our actual net income per diluted share of $10.61, a difference of $2.07.

Many factors may affect our medical care costs, including:

- the level of utilization of health care services,
- changes in the underlying risk acuity of our membership,
- unexpected patterns in the annual flu season,
- increases in hospital costs,

- increased incidences or acuity of high dollar claims related to catastrophic illnesses or medical conditions for which we do not have adequate reinsurance coverage,
- increased maternity costs,
- payment rates that are not actuarially sound,

- changes in state eligibility certification methodologies,
- relatively low levels of hospital and specialty provider competition in certain geographic areas,
- increases in the cost of pharmaceutical products and services,
- changes in health care regulations and practices,
- epidemics,
- new medical technologies, and
- other various external factors.

Many of these factors are beyond our control and could reduce our ability to accurately predict and effectively manage the costs of providing health care services. The inability to forecast and manage our medical care costs or to establish and maintain a satisfactory medical care ratio, either with respect to a particular state health plan or across the consolidated entity, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

If we are unable to collect health insurer fee ("HIF") reimbursement for 2018 from our state partners, our business, cash flows, financial position, or results of operations could be materially and adversely affected.

Because Medicaid is a government funded program, Medicaid health plans must request reimbursement for the HIF from respective state partners to offset the impact of this tax. When states reimburse us for the amount of the HIF, that reimbursement is itself subject to income tax, the HIF, and applicable state premium taxes. Because the HIF is not deductible for income tax purposes, our net income is reduced by the full amount of the assessment. The 2018 HIF assessment, related to our Medicaid business, was $257 million, with an expected tax gross-up effect from the reimbursement of the assessment of approximately $72 million. Therefore, the total reimbursement needed as a result of the Medicaid-related HIF was approximately $329 million. As of December 31, 2018, we have collected $188 million of this total, with reimbursements receivable of $141 million. The delay or failure of our state partners to reimburse us in full for the 2018 HIF and its related tax effects could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

An impairment charge with respect to our recorded goodwill, or our finite-lived intangible assets, could have a material impact on our financial results.

As of December 31, 2018, the carrying amounts of goodwill and intangible assets, net, amounted to $143 million, and $47 million, respectively.

Goodwill represents the excess of the purchase price over the fair value of net assets acquired in business combinations. Goodwill is not amortized but is tested for impairment on an annual basis and more frequently if impairment indicators are present. Such events or circumstances may include experienced or expected operating cash-flow deterioration or losses, significant losses of membership, loss of state funding, loss of state contracts, and other factors. Goodwill is impaired if the carrying amount of the reporting unit exceeds its estimated fair value. This excess is recorded as an impairment loss and adjusted if necessary for the impact of tax-deductible goodwill. The loss recognized may not exceed the total goodwill allocated to the reporting unit. Our reporting units consist of our individual health plans.

Finite-lived, separately-identified intangible assets acquired in business combinations are assets that represent future expected benefits but lack physical substance (such as purchased contract rights and provider contracts). Following the identification of any potential impairment indicators, to determine whether an impairment exists, we would compare the carrying amount of a finite-lived intangible asset with the greater of the undiscounted cash flows that are expected to result from the use of the asset or related group of assets, or its value under the asset liquidation method. If it is determined that the carrying amount of the asset is not recoverable, the amount by which the carrying value exceeds the estimated fair value is recorded as an impairment.

An event or events could occur that would cause us to revise our estimates and assumptions used in analyzing the value of our goodwill, and intangible assets, net. For example, if the responsive bid of one or more of our health plans is not successful, we will lose our Medicaid contract in the applicable state or states. If such state health plans have recorded goodwill and intangible assets, net, the contract loss would result in a non-cash impairment charge. Such a non-cash impairment charge could have a material adverse impact on our financial results.

We operate in an uncertain political and judicial environment which creates uncertainties with regard to the sources and amounts of our revenues, volatility with regard to the amount of our medical costs, and vulnerability to unforeseen programmatic or regulatory changes.

As a result of the election of President Trump, the GOP control of the Senate and the former GOP control of the House, several changes have been made to the provisions of the ACA, including reduced funding. Accordingly, the future of the ACA and its underlying programs are subject to continuing and substantial uncertainty, making long-

term business planning exceedingly difficult. In December 2018, in a case brought by the state of Texas and nineteen other states, a federal judge in Texas struck down the ACA based on his determination that the ACA's individual mandate is unconstitutional and, since that mandate cannot be separated from the rest of the ACA, the judge ruled that the rest of the ACA is also unconstitutional. The decision has been appealed to the U.S. Court of Appeals for the Fifth Circuit. Any final, not-appealable determination that the ACA is unconstitutional would have a material adverse effect on our business, financial condition, cash flows and results of operations.

We are unable to predict with any degree of certainty whether the ACA will be modified or repealed in its entirety, and if it is repealed, what it will be replaced with; nor are we able to predict when any such changes, if enacted, would become effective.

Currently, there are a number of different legislative proposals being considered, some of which would involve significantly reduced federal spending on the Medicaid program, and constitute a fundamental change in the federal role in health care. These proposals include elements such as the following: ending the entitlement nature of Medicaid (and perhaps Medicare as well) by capping future increases in federal health spending for these programs, and shifting much more of the risk for health costs in the future to states and consumers; reversing the ACA's expansion of Medicaid that enables states to cover low-income childless adults; changing Medicaid to a state block grant program, including potentially capping spending on a per-enrollee basis; requiring Medicaid beneficiaries to work; limiting the amount of lifetime benefits for Medicaid beneficiaries; prohibiting the federal government from operating Marketplaces; eliminating the advanced premium tax credits, and cost sharing reductions for low income individuals who purchase their health insurance through the Marketplaces; expanding and encouraging the use of private health savings accounts; providing for insurance plans that offer fewer and less extensive health insurance benefits than under the ACA's essential health benefits package, including broader use of catastrophic coverage plans, or short-term health insurance (Short-Term Medical or STM plans); establishing and funding high risk pools or reinsurance programs for individuals with chronic or high cost conditions; allowing insurers to sell insurance across state lines; and numerous other potential changes and reforms. Changes to or the repeal of the ACA, or the adoption of new health care regulatory laws, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

A reversal of the Medicaid Expansion would have a negative impact on our revenues.

In the states that have elected to participate, the ACA provided for the expansion of the Medicaid program to offer eligibility to nearly all individuals under age 65 with incomes at or below 138% of the federal poverty line. Since January 1, 2014, several of our health plans have participated in the Medicaid Expansion program under the ACA. At December 31, 2018, our membership included approximately 660,000 Medicaid Expansion members, or 17% of our total membership. If the Medicaid Expansion is reversed by repeal of the ACA or otherwise, we could lose this membership, which could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Our participation in the Marketplace creates certain risks which could adversely impact our business, financial position, and results of operations.

The ACA authorized the creation of marketplace insurance exchanges (the "Marketplace"), allowing individuals and small groups to purchase federally subsidized health insurance. As of December 31, 2018, we participated in the individual Marketplace in seven states which represented approximately 9% of our total membership. For 2019, we are currently estimating that our Marketplace end-of-year membership will range from 250,000-275,000. This estimated membership is lower than the 362,000 enrollment as of December 31, 2018, despite our return to Utah and Wisconsin, and we expect our Marketplace revenues to decrease in 2019 as a result.

A number of larger commercial insurance plans, including Humana Inc., have discontinued their participation in the Marketplace. The perceived instability and impending changes in the Marketplace could further promote reduced participation among the uninsured. Further, the withdrawal of cost sharing subsidies and/or premium tax credits, the elimination of the individual mandate to purchase health insurance in December 2017, the use of special enrollment periods, or any announcement that some or all of our health plans will be leaving the Marketplace, could additionally impact Marketplace enrollment. These market and political dynamics may increase the risk that our Marketplace products will be selected by individuals who have a higher risk profile or utilization rate than we anticipated when we

established the pricing for our Marketplace products, leading to financial losses.

The Medicare-Medicaid Duals Demonstration Pilot Programs could be discontinued or altered, resulting in a loss of premium revenue.

To coordinate care for those who qualify to receive both Medicare and Medicaid services (the “dual eligibles”), and to deliver services to these individuals in a more financially efficient manner, under the direction of CMS some

states implemented demonstration pilot programs to integrate Medicare and Medicaid services for the dual eligibles. The health plans participating in such demonstrations are referred to as Medicare-Medicaid Plans ("MMPs"). We operate MMPs in six states: California, Illinois, Michigan, Ohio, South Carolina, and Texas. At December 31, 2018, our membership included approximately 54,000 integrated MMP members, representing just over 1% of our total membership. However, the capitation payments paid to us for dual eligibles are significantly higher than the capitation payments for other members, representing 8% of our total premium revenues in 2018. If the states running the MMP pilot programs conclude that the demonstration pilot programs are not delivering better coordinated care and reduced costs, they could decide to discontinue or substantially alter such programs, resulting in a reduction to our premium revenues.

Continuing changes in health care laws, and in the health care industry, make it difficult to develop actuarially sound rates.

Comprehensive changes to the U.S. health care system make it more difficult for us to manage our business, and increase the likelihood that the assumptions we make with respect to our future operations and results will prove to be inaccurate. The continuing pace of change has made it difficult for us to develop actuarially sound rates because we have limited historical information on which to develop these rates. In the absence of significant historical information to develop actuarial rates, we must make certain assumptions. These assumptions may subsequently prove to be inaccurate. For example, rates of utilization could be significantly higher than we projected, or the assumptions of policymakers about the amount of savings that could be achieved through the use of utilization management in managed care could be flawed. Moreover, our lack of actuarial experience for a particular program, region, or population, could cause us to set our reserves at an inadequate level.

Our health plans operate with very low profit margins, and small changes in operating performance or slight changes to our accounting estimates will have a disproportionate impact on our reported net income.

A substantial portion of our premium revenue is subject to contract provisions pertaining to medical cost expenditure floors and corridors, administrative cost and profit ceilings, premium stabilization programs, and cost-plus and performance-based reimbursement programs. Many of these contract provisions are complex, or are poorly or ambiguously drafted, and thus are potentially subject to differing interpretations by ourselves and the relevant government agency with whom we contract. If the applicable government agency disagrees with our interpretation or implementation of a particular contract provisions at issue, we could be required to adjust the amount of our obligations under these provisions and/or make a payment or payments to such government agency. Any interpretation of these contract provisions by the applicable governmental agency that varies from our interpretation and implementation of the provision, or that is inconsistent with our revenue recognition accounting treatment, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

In addition, many of our contracts also contain provisions pertaining to at-risk premiums that require us to meet certain quality performance measures to earn all of our contract revenues. If we are unsuccessful in achieving the stated performance measure, we will be unable to recognize the revenue associated with that measure. Any failure of our health plans to satisfy one of these performance measure provisions could have a material adverse effect on our business, financial condition, cash flows or results of operations.

If we are unable to deliver quality care, and maintain good relations with the physicians, hospitals, and other providers with whom we contract, or if we are unable to enter into cost-effective contracts with such providers, our profitability could be adversely affected.

We contract with physicians, hospitals, and other providers as a means to ensure access to health care services for our members, to manage health care costs and utilization, and to better monitor the quality of care being delivered. We compete with other health plans to contract with these providers. We believe providers select plans in which they participate based on criteria including reimbursement rates, timeliness and accuracy of claims payment, potential to deliver new patient volume and/or retain existing patients, effectiveness of resolution of calls and complaints, and other factors. We cannot be sure that we will be able to successfully attract and retain providers to maintain a competitive network in the geographic areas we serve. In addition, in any particular market, providers could refuse to contract with us, demand higher payments, or take other actions which could result in higher health care costs, disruption to provider access for current members, a decline in our growth rate, or difficulty in meeting regulatory or

accreditation requirements.

The Medicaid program generally pays doctors and hospitals at levels well below those of Medicare and private insurance. Large numbers of doctors, therefore, do not accept Medicaid patients. In the face of fiscal pressures, some states may reduce rates paid to providers, which may further discourage participation in the Medicaid program.

In some markets, certain providers, particularly hospitals, physician/hospital organizations, and some specialists, may have significant market positions or even monopolies. If these providers refuse to contract with us or utilize their market position to negotiate favorable contracts which are disadvantageous to us, our profitability in those areas could be adversely affected.

Some providers that render services to our members are not contracted with our health plans. In those cases, there is no pre-established understanding between the provider and our health plan about the amount of compensation that is due to the provider. In some states, the amount of compensation is defined by law or regulation, but in most instances it is either not defined or it is established by a standard that is not clearly translatable into dollar terms. In such instances, providers may believe they are underpaid for their services and may either litigate or arbitrate their dispute with our health plan. The uncertainty of the amount to pay to such providers and the possibility of subsequent adjustment of the payment could adversely affect our business, financial condition, cash flows, or results of operations.

The exorbitant cost of specialty drugs and new generic drugs could have a material adverse effect on the level of our medical costs and our results of operations.

Introduction of new high cost specialty drugs and sudden costs spikes for existing drugs increase the risk that the pharmacy cost assumptions used to develop our capitation rates are not adequate to cover the actual pharmacy costs, which jeopardizes the overall actuarial soundness of our rates. Bearing the high costs of new specialty drugs or the high cost inflation of generic drugs without an appropriate rate adjustment or other reimbursement mechanism has an adverse impact on our financial condition and results of operations. For example, the FDA approved the first drug to treat patients with spinal muscular atrophy, Spinraza, in December 2016. After this approval, the distributor of Spinraza announced that one dose will have a list price of $125,000, which means the drug will cost between $650,000 and $750,000 to cover the five or six doses required in the first year, and approximately $375,000 annually thereafter, presumably for the life of the patient. The inordinate cost of Spinraza was not contemplated in the development of our 2017 capitation rates. In addition, evolving regulations and state and federal mandates regarding coverage may impact the ability of our health plans to continue to receive existing price discounts on pharmaceutical products for our members. Other factors affecting our pharmaceutical costs include, but are not limited to, geographic variation in utilization of new and existing pharmaceuticals, and changes in discounts. Although we will continue to work with state Medicaid agencies in an effort to ensure that we receive appropriate and actuarially sound reimbursement for all new drug therapies and pharmaceuticals trends, there can be no assurance that we will always be successful.

We rely on the accuracy of eligibility lists provided by state governments. Inaccuracies in those lists would negatively affect our results of operations.

Premium payments to our health plans are based upon eligibility lists produced by state governments. From time to time, states require us to reimburse them for premiums paid to us based on an eligibility list that a state later discovers contains individuals who are not in fact eligible for a government sponsored program or are eligible for a different premium category or a different program. Alternatively, a state could fail to pay us for members for whom we are entitled to payment. Our results of operations would be adversely affected as a result of such reimbursement to the state if we make or have made related payments to providers and are unable to recoup such payments from the providers.

Further, when a state implements new programs to determine eligibility, establishes new processes to assign or enroll eligible members into health plans, or chooses new subcontractors, there is an increased potential for an unanticipated impact on the overall number of members assigned to managed care health plans. Whenever a state effects an eligibility redetermination for any reason, there is generally a reduction in Medicaid membership associated with that exercise which could have an adverse effect on our premium revenues and results of operations.

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

We maintain a significant investment portfolio of cash equivalents and short-term and long-term investments in a variety of securities, which are subject to general credit, liquidity, market and interest rate risks and will decline in value if interest rates increase or one of the issuers' credit ratings is reduced. As a result, we may experience a

reduction in value or loss of our investments, which may have a negative adverse effect on our results of operations, liquidity and financial condition.

The insolvency of a delegated provider could obligate us to pay its referral claims, which could have a material adverse effect on our business, membership, cash flows, or results of operations.

Many of our primary care physicians and a small portion of our specialists and hospitals are paid on a capitated basis. Under capitation arrangements, we pay a fixed amount per member per month to the provider without regard to the frequency, extent, or nature of the medical services actually furnished. Due to insolvency or other circumstances, such providers may be unable or unwilling to pay claims they have incurred with third parties in connection with referral services provided to our members. The inability or unwillingness of delegated providers to pay referral claims presents us with both immediate financial risk and potential disruption to member care, as well as potential loss of members. Depending on states' laws, we may be held liable for such unpaid referral claims even though the delegated provider has contractually assumed such risk. Additionally, competitive pressures or practical regulatory considerations may force us to pay such claims even when we have no legal obligation to do so; or we have already paid claims to a delegated provider and such payments cannot be recouped when the delegated provider becomes insolvent. Liabilities incurred or losses suffered as a result of provider insolvency could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

State and federal budget deficits may result in Medicaid, CHIP, or Medicare funding cuts which could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Nearly all of our premium revenues come from the joint federal and state funding of the Medicaid, Medicare, and CHIP programs. The states in which we operate our health plans regularly face significant budgetary pressures. As discussed below, such budgetary pressures are particularly intense in the Commonwealth of Puerto Rico. State budgetary pressures may result in unexpected Medicaid, CHIP, or Medicare rate cuts which could reduce our revenues and profit margins. Moreover, some federal deficit reduction or entitlement reform proposals would fundamentally change the structure and financing of the Medicaid program. A number of these proposals include both tax increases and spending reductions in discretionary programs and mandatory programs, such as Social Security, Medicare, and Medicaid.

We are unable to determine how any future congressional spending cuts will affect Medicare and Medicaid reimbursement. We believe there will continue to be legislative and regulatory proposals at the federal and state levels directed at containing or lowering the cost of health care that, if adopted, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Receipt of inadequate or significantly delayed premiums could negatively affect our business, financial condition, cash flows, or results of operations.

Our premium revenues consist of fixed monthly payments per member, and supplemental payments for other services such as maternity deliveries. These premiums are fixed by contract, and we are obligated during the contract periods to provide health care services as established by the state governments. We use a large portion of our revenues to pay the costs of health care services delivered to our members. If premiums do not increase when expenses related to medical services rise, our medical margins will be compressed, and our earnings will be negatively affected. A state could increase hospital or other provider rates without making a commensurate increase in the rates paid to us, or could lower our rates without making a commensurate reduction in the rates paid to hospitals or other providers. In addition, if the actuarial assumptions made by a state in implementing a rate or benefit change are incorrect or are at variance with the particular utilization patterns of the members of one or more of our health plans, our medical margins could be reduced. Any of these rate adjustments in one or more of the states in which we operate could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Furthermore, a state or commonwealth undergoing a budget crisis may significantly delay the premiums paid to one of our health plans. Any significant delay in the monthly payment of premiums to any of our health plans could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

If a state fails to renew its federal waiver application for mandated Medicaid enrollment into managed care or such application is denied, our membership in that state will likely decrease.

States may only mandate Medicaid enrollment into managed care under federal waivers or demonstrations. Waivers and programs under demonstrations are approved for two- to five-year periods and can be renewed on an ongoing basis if the state applies and the waiver request is approved or renewed by CMS. We have no control over this renewal

process. If a state in which we operate a health plan does not renew its mandated program or the federal government denies the state's application for renewal, our business would suffer as a result of a likely decrease in membership.

The Commonwealth of Puerto Rico may fail to pay the premiums of our Puerto Rico health plan, which could negatively impact our business, financial condition, cash flows, or results of operations.

The government of Puerto Rico continues to struggle with major fiscal and liquidity challenges. The extreme financial difficulties faced by the Commonwealth may make it very difficult for ASES, the Puerto Rico Medicaid agency, to pay our Puerto Rico health plan under the terms of the parties' Medicaid contract. As of December 31, 2018, our Puerto Rico health plan served approximately 252,000 members, and had recognized premium revenue of approximately $147 million in the fourth quarter of 2018. A default by ASES on its payment obligations under our Medicaid contract, or a determination by ASES to terminate our contract based on insufficient funds available, could result in our having paid, or in our having to pay, provider claims in amounts for which we are not paid reimbursement, and could make it unfeasible for the Puerto Rico health plan to continue to operate. A default by ASES or termination of our Puerto Rico Medicaid contract could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Large-scale medical emergencies in one or more states in which we operate our health plans could significantly increase utilization rates and medical costs.

Large-scale medical emergencies can take many forms and be associated with widespread illness or medical conditions. For example, natural disasters, such as a major earthquake or wildfire in California, or a major hurricane affecting Florida, Puerto Rico, South Carolina or Texas, could have a significant impact on the health of a large number of our covered members. Other conditions that could impact our members include a virulent influenza season or epidemic, or newly emergent mosquito-borne illnesses, such as the Zika virus, the West Nile virus, or the Chikungunya virus, conditions for which vaccines may not exist, are not effective, or have not been widely administered.

In addition, federal and state law enforcement officials have issued warnings about potential terrorist activity involving biological or other weapons of mass destruction. All of these conditions, and others, could have a significant impact on the health of the population of wide-spread areas. We seek to set our IBNP reserves appropriately to account for anticipatable spikes in utilization, such as for the flu season. However, if one of our health plan states were to experience a large-scale natural disaster, a viral epidemic or pandemic, a significant terrorism attack, or some other large-scale event affecting the health of a large number of our members, our covered medical expenses in that state would rise, which could have a material adverse effect on our business, cash flows, financial condition, or results of operations.

If state regulators do not approve payments of dividends and distributions by our subsidiaries, it may negatively affect our business strategy.

We are a corporate parent holding company and hold most of our assets in, and conduct most of our operations through, our direct subsidiaries. As a holding company, our results of operations depend on the results of operations of our subsidiaries. Moreover, we are dependent on dividends or other intercompany transfers of funds from our subsidiaries to meet our debt service and other obligations. The ability of our subsidiaries to pay dividends or make other payments or advances to us will depend on their operating results and will be subject to applicable laws and restrictions contained in agreements governing the debt of such subsidiaries. In addition, our health plan subsidiaries are subject to laws and regulations that limit the amount of ordinary dividends and distributions that they can pay to us without prior approval of, or notification to, state regulators. In California, our health plan may dividend, without notice to or approval of the California Department of Managed Health Care, amounts by which its tangible net equity exceeds 130% of the tangible net equity requirement. In general, our other health plans must give thirty days' advance notice and the opportunity to disapprove "extraordinary" dividends to the respective state departments of insurance for amounts over the lesser of (a) ten percent of surplus or net worth at the prior year end or (b) the net income for the prior year. The discretion of the state regulators, if any, in approving or disapproving a dividend is not clearly defined. Health plans that declare ordinary dividends must usually provide notice to the regulators ten or fifteen days in advance of the intended distribution date of the ordinary dividend. We received $288 million, $245 million, and $100 million in dividends from our regulated health plan subsidiaries during 2018, 2017 and 2016, respectively. The aggregate additional amounts our health plan subsidiaries could have paid us at December 31, 2018 and 2017, without approval of the regulatory authorities, were approximately $126 million and $85 million, respectively. If the

regulators were to deny or significantly restrict our subsidiaries' requests to pay dividends to us, the funds available to our Company as a whole would be limited, which could harm our ability to implement our business strategy. For example, we could be hindered in our ability to make debt service payments under our senior notes or credit agreement ("Credit Agreement").

Our use and disclosure of personally identifiable information and other non-public information, including protected health information, is subject to federal and state privacy and security regulations, and our

failure to comply with those regulations or to adequately secure the information we hold could result in significant liability or reputational harm.

State and federal laws and regulations including, but not limited to, HIPAA and the Gramm-Leach-Bliley Act, govern the collection, dissemination, use, privacy, confidentiality, security, availability, and integrity of personally identifiable information ("PII"), including protected health information ("PHI"). HIPAA establishes basic national privacy and security standards for protection of PHI by covered entities and business associates, including health plans such as ours. HIPAA requires covered entities like us to develop and maintain policies and procedures for PHI that is used or disclosed, and to adopt administrative, physical, and technical safeguards to protect PHI. HIPAA also implemented the use of standard transaction code sets and standard identifiers that covered entities must use when submitting or receiving certain electronic health care transactions, including activities associated with the billing and collection of health care claims.

Mandatory penalties for HIPAA violations range from $100 to $50,000 per violation, and up to $1.5 million per violation of the same standard per calendar year. A single breach incident can result in violations of multiple standards, resulting in possible penalties potentially in excess of $1.5 million. If a person knowingly or intentionally obtains or discloses PHI in violation of HIPAA requirements, criminal penalties may also be imposed. HIPAA authorizes state attorneys general to file suit under HIPAA on behalf of state residents. Courts can award damages, costs, and attorneys' fees related to violations of HIPAA in such cases. While HIPAA does not create a private right of action allowing individuals to sue us in civil court for HIPAA violations, its standards have been used as the basis for a duty of care in state civil suits such as those for negligence or recklessness in the misuse or breach of PHI. We have experienced HIPAA breaches in the past, including breaches affecting over 500 individuals.

New health information standards, whether implemented pursuant to HIPAA, congressional action, or otherwise, could have a significant effect on the manner in which we must handle health care related data, and the cost of complying with standards could be significant. If we do not comply with existing or new laws and regulations related to PHI, PII, or non-public information, we could be subject to criminal or civil sanctions. Any security breach involving the misappropriation, loss, or other unauthorized disclosure or use of confidential member information, whether by us or a third party, such as our vendors, could subject us to civil and criminal penalties, divert management's time and energy, and have a material adverse effect on our business, financial condition, cash flows, or results of operations.

We are subject to extensive fraud and abuse laws that may give rise to lawsuits and claims against us, the outcome of which may have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Because we receive payments from federal and state governmental agencies, we are subject to various laws commonly referred to as "fraud and abuse" laws, including federal and state anti-kickback statutes, prohibited referrals, and the federal False Claims Act, which permit agencies and enforcement authorities to institute a suit against us for violations and, in some cases, to seek treble damages, criminal and civil fines, penalties, and assessments. Violations of these laws can also result in exclusion, debarment, temporary or permanent suspension from participation in government health care programs, or the institution of corporate integrity agreements. Liability under such federal and state statutes and regulations may arise if we know, or it is found that we should have known, that information we provide to form the basis for a claim for government payment is false or fraudulent, and some courts have permitted False Claims Act suits to proceed if the claimant was out of compliance with program requirements. Fraud, waste and abuse prohibitions encompass a wide range of operating activities, including kickbacks or other inducements for referral of members or for the coverage of products (such as prescription drugs) by a plan, billing for unnecessary medical services by a provider, upcoding, payments made to excluded providers, improper marketing, and the violation of patient privacy rights. In particular, there has recently been increased scrutiny by the Department of Justice on health plans' risk adjustment practices, particularly in the Medicare program. Companies involved in public health care programs such as Medicaid and Medicare are required to maintain compliance programs to detect and deter fraud, waste and abuse, and are often the subject of fraud, waste and abuse investigations and audits. The regulations and contractual requirements applicable to participants in these public-sector programs are complex and subject to change. The federal government has taken the position that claims presented in violation of the federal anti-kickback statute may be considered a violation of the federal False Claims Act. In addition, under the federal civil

monetary penalty statute, the U.S. Department of Health and Human Services ("HHS"), Office of Inspector General has the authority to impose civil penalties against any person who, among other things, knowingly presents, or causes to be presented, certain false or otherwise improper claims. Qui tam actions under federal and state law can be brought by any individual on behalf of the government. Qui tam actions have increased significantly in recent years, causing greater numbers of health care companies to have to defend a false claim action, pay fines, or be excluded from the Medicare, Medicaid, or other state or federal

health care programs as a result of an investigation arising out of such action. We have been the subject of qui tam actions in the past and other qui tam actions may be filed against us in the future. If we are subject to liability under a qui tam or other actions, our business, financial condition, cash flows, or results of operations could be adversely affected.

Failure to attain profitability in any new start-up operations could negatively affect our results of operations.

Start-up costs associated with a new business can be substantial. For example, to obtain a certificate of authority to operate as a health maintenance organization in most jurisdictions, we must first establish a provider network, have infrastructure and required systems in place, and demonstrate our ability to obtain a state contract and process claims. Often, we are also required to contribute significant capital to fund mandated net worth requirements, performance bonds or escrows, or contingency guaranties. If we are unsuccessful in obtaining the certificate of authority, winning the bid to provide services, or attracting members in sufficient numbers to cover our costs, the new business would fail. We also could be required by the state or commonwealth to continue to provide services for some period of time without sufficient revenue to cover our ongoing costs or to recover our start-up costs.

Even if we are successful in establishing a profitable health plan in a new jurisdiction, increasing membership, revenues, and medical costs will trigger increased mandated net worth requirements which could substantially exceed the net income generated by the health plan. Rapid growth in an existing jurisdiction will also result in increased net worth requirements. In such circumstances, we may not be able to fund on a timely basis, or at all, the increased net worth requirements with our available cash resources. The expenses associated with starting up a health plan in a new jurisdiction, or expanding a health plan in an existing jurisdiction could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Failure to maintain effective internal controls over financial reporting could have a material adverse effect on our business, operating results, stock price, and result in our inability to maintain compliance with applicable stock exchange listing requirements.

A material weakness is a deficiency, or a combination of deficiencies, in internal control over financial reporting, such that there is a reasonable possibility that a material misstatement of the annual or interim financial statements will not be prevented or detected on a timely basis.

The Sarbanes-Oxley Act of 2002 requires, among other things, that we maintain effective internal control over financial reporting. In particular, we must perform system and process evaluation and testing of our internal controls over financial reporting to allow management to report on, and our independent registered public accounting firm to attest to, our internal controls over financial reporting as required by Section 404 of the Sarbanes-Oxley Act of 2002. Our future testing, or the subsequent testing by our independent registered public accounting firm, may reveal deficiencies in our internal controls over financial reporting that are deemed to be material weaknesses.

We have identified material weaknesses in our internal control over financial reporting in the past, which have subsequently been remediated. If additional material weaknesses in our internal control over financial reporting are discovered or occur in the future, our consolidated financial statements may contain material misstatements and we could be required to restate our financial results.

Our compliance with Section 404 will continue to require that we incur substantial accounting expense and expend significant management time and effort. Moreover, if we are unable to comply with the requirements of Section 404 in a timely manner, or if we or our independent registered public accounting firm identify deficiencies in our internal control over financial reporting that are deemed to be material weaknesses, the market price of our stock could decline and we could be subject to sanctions or investigations by the New York Stock Exchange, SEC, or other regulatory authorities which would require additional financial and management resources.

This Form 10-K reflects management's conclusion regarding the effectiveness of our disclosure controls and procedures and internal control over financial reporting as of December 31, 2018. See Item 9A, “Controls and Procedures–Management’s Evaluation of Disclosure Controls and Procedures and Management’s Report on Internal Control Over Financial Reporting.”

We are dependent on the leadership of our chief executive officer and other executive officers and key employees.

In late 2017, the board hired Joe Zubretsky as our chief executive officer. Mr. Zubretsky, in turn, has hired other senior level executives. Under the leadership and direction of Mr. Zubretsky, our executive team has launched a

vigorous turnaround plan, including many profit improvement initiatives. Our turnaround plan and operational improvements are highly dependent on the efforts of Mr. Zubretsky and our other key executive officers and

employees. The loss of their leadership, expertise, and experience could negatively impact our operations. Our ability to replace them or any other key employee may be difficult and may take an extended period of time because of the limited number of individuals in the health care industry who have the breadth and depth of skills and experience necessary to operate and lead a business such as ours. Competition to hire from this limited pool is intense, and we may be unable to hire, train, retain, or motivate these personnel. If we are unsuccessful in recruiting, retaining, managing, and motivating such personnel, our business, financial condition, cash flows, or results of operations may be adversely affected.

We face various risks inherent in the government contracting process that could materially and adversely affect our business and profitability, including periodic routine and non-routine reviews, audits, and investigations by government agencies.

We are subject to various risks inherent in the government contracting process. These risks include routine and non-routine governmental reviews, audits, and investigations, and compliance with government reporting requirements. Violation of the laws, regulations, or contract provisions governing our operations, or changes in interpretations of those laws and regulations, could result in the imposition of civil or criminal penalties, the cancellation of our government contracts, the suspension or revocation of our licenses, the exclusion from participation in government sponsored health programs, or the revision and recoupment of past payments made based on audit findings. If we are unable to correct any noted deficiencies, or become subject to material fines or other sanctions, we could suffer a substantial reduction in profitability, and could also lose one or more of our government contracts. In addition, government receivables are subject to government audit and negotiation, and government contracts are vulnerable to disagreements with the government. The final amounts we ultimately receive under government contracts may be different from the amounts we initially recognize in our financial statements.

If we sustain a cyber-attack or suffer privacy or data security breaches that disrupt our information systems or operations, or result in the dissemination of sensitive personal or confidential information, we could suffer increased costs, exposure to significant liability, reputational harm, loss of business, and other serious negative consequences.

As part of our normal operations, we routinely collect, process, store, and transmit large amounts of data, including sensitive personal information as well as proprietary or confidential information relating to our business or third parties. To ensure information security, we have implemented controls to protect the confidentiality, integrity and availability of this data and the systems that store and transmit such data. However, our information technology systems and safety control systems are subject to a growing number of threats from computer programmers, hackers, and other adversaries that may be able to penetrate our network security and misappropriate our confidential information or that of third parties, create system disruptions, or cause damage, security issues, or shutdowns. They also may be able to develop and deploy viruses, worms, and other malicious software programs that attack our systems or otherwise exploit security vulnerabilities. Because the techniques used to circumvent, gain access to, or sabotage security systems can be highly sophisticated and change frequently, they often are not recognized until launched against a target, and may originate from less regulated and remote areas around the world. We may be unable to anticipate these techniques or implement adequate preventive measures, resulting in potential data loss and damage to our systems. Our systems are also subject to compromise from internal threats such as improper action by employees including malicious insiders, vendors, counterparties, and other third parties with otherwise legitimate access to our systems. Our policies, employee training (including phishing prevention training), procedures and technical safeguards may not prevent all improper access to our network or proprietary or confidential information by employees, vendors, counterparties, or other third parties. Our facilities may also be vulnerable to security incidents or security attacks, acts of vandalism or theft, misplaced or lost data, human errors, or other similar events that could negatively affect our systems and our and our members' data.

Moreover, we face the ongoing challenge of managing access controls in a complex environment. The process of enhancing our protective measures can itself create a risk of systems disruptions and security issues. Given the breadth of our operations and increasing sophistication of cyberattacks, a particular incident could occur and persist for an extended period of time before being detected. The extent of a particular cyberattack and the steps that we may need to take to investigate the attack may take a significant amount of time before such an investigation could be completed and full and reliable information about the incident is known. During such time, the extent of any harm or how best to

remediate it might not be known, which could further increase the risks, costs, and consequences of a data security incident. In addition, our systems must be routinely updated, patched, and upgraded to protect against known vulnerabilities. The volume of new software vulnerabilities has increased substantially, as has the importance of patches and other remedial measures. In addition to remediating newly identified vulnerabilities, previously identified vulnerabilities must also be updated. We are at risk that cyber attackers exploit these known

vulnerabilities before they have been addressed. The complexity of our systems and platforms that we operate, the increased frequency at which vendors are issuing security patches to their products, our need to test patches, and in some instances, coordinate with third-parties before they can be deployed, all could further increase our risks. The increased use of mobile devices and other technologies can heighten these and other risks.

Furthermore, certain aspects of the security of various technologies are unpredictable or beyond our control. For example, on February 4, 2019, we entered into a master services agreement with Infosys Limited pursuant to which Infosys will manage certain of our information technology infrastructure services including, among other things, our information technology operations, end-user services, and data centers. The security of these services will depend in part on Infosys's ability to perform the contracted functions and services, including with respect to data security, in a timely, satisfactory, and compliant manner. The Infosys transaction will require us to devote significant resources to transition from our existing systems infrastructure, and if we are unable to successfully execute and manage this transition, any movement of data during the transition may enhance the information management and data security risks we currently face.

The cost to eliminate or address the foregoing security threats and vulnerabilities before or after a cyber-incident could be significant. We may need to expend significant additional resources in the future to continue to protect against potential security breaches or to address problems caused by such attacks or any breach of our systems. Our remediation efforts may not be successful and could result in interruptions, delays, or cessation of service, and loss of members, vendors, and state contracts. Further, our remediation efforts may be delayed or complicated as a result of our desire to cooperate with law enforcement agencies. In addition, breaches of our security measures and the unauthorized dissemination of sensitive personal information or proprietary information or confidential information about our members could expose our members to the risk of financial or medical identity theft, or expose us or other third parties to a risk of loss or misuse of this information, result in litigation and potential liability for us (including but not limited to material fines, damages, consent orders, penalties and/or remediation costs, mandatory disclosure to the media and regulators, or enforcement proceedings), damage our reputation, or otherwise have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Any changes to the laws and regulations governing our business, or the interpretation and enforcement of those laws or regulations, could require us to modify our operations and could negatively impact our operating results.

Our business is extensively regulated by the federal government and the states in which we operate. The laws and regulations governing our operations are generally intended to benefit and protect health plan members and providers rather than managed care organizations. The government agencies administering these laws and regulations have broad latitude in interpreting and applying them. These laws and regulations, along with the terms of our government contracts, regulate how we do business, what services we offer, and how we interact with members and the public. For instance, some states mandate minimum medical expense levels as a percentage of premium revenues. These laws and regulations, and their interpretations, are subject to frequent change. The interpretation of certain contract provisions by our governmental regulators may also change. Changes in existing laws or regulations, or their interpretations, or the enactment of new laws or regulations, could reduce our profitability by imposing additional capital requirements, increasing our liability, increasing our administrative and other costs, increasing mandated benefits, forcing us to restructure our relationships with providers, requiring us to implement additional or different programs and systems, or making it more difficult to predict future results. Changes in the interpretation of our contracts could also reduce our profitability if we have detrimentally relied on a prior interpretation.

Potential divestitures of businesses or product lines may materially adversely affect our business, financial condition, cash flows, or results of operations.

As a part of our business strategy, we continually review our products and business lines across all geographies to identify opportunities for performance improvement. Depending on the particular circumstances, we may determine that a divestiture of one or more businesses or product lines would be the best means to further our plan to improve and sustain profitability and enhance our focus on the execution of our business plan. For example, in late 2018 we sold two of our former wholly owned subsidiaries: Molina Information Systems, LLC d/b/a Molina Medicaid Solutions, and Pathways Health and Community Support LLC.

Divestitures involve risks, including: difficulties in the separation of operations, services, products and personnel; the diversion of management's attention from other business concerns; the disruption of our business; the potential loss of key employees; the retention of uncertain contingent liabilities related to the divested business or product line; and the failure of our efforts to divest any such business or product line on the terms and time frames desired by management, or at all. Furthermore, we may be unsuccessful in finding a replacement for any lost revenue or

income previously derived from the divested business or product line. In addition, divestitures may result in significant impairment charges, including those related to goodwill and other intangible assets, all of which could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

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

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

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

Our business depends on our information and medical management systems, and our inability to effectively integrate, manage, update, and keep secure our information and medical management systems could disrupt our operations.

Our business is dependent on effective and secure information systems that assist us in, among other things, processing provider claims, monitoring utilization and other cost factors, supporting our medical management techniques, and providing data to our regulators. Our members and providers also depend upon our information systems for enrollment, primary care and specialist physician roster access, membership verifications, claims status, and other information. If we experience a reduction in the performance, reliability, or availability of our information and medical management systems, our operations, ability to pay claims, and ability to produce timely and accurate reports could be adversely affected.

We have partnered with third parties to support our information technology systems. This makes our operations vulnerable to adverse effects if such third parties fail to perform adequately. For example, on February 4, 2019, we entered into a master services agreement with Infosys Limited pursuant to which Infosys will manage certain of our information technology infrastructure services including, among other things, our information technology operations, end-user services, and data centers. If Infosys or any licensor or vendor of any technology which is integral to our operations were to become insolvent or otherwise fail to support the technology sufficiently, our operations could be negatively affected.

Our information systems and applications require continual maintenance, upgrading, and enhancement to meet our operational needs. On an ongoing basis, we evaluate the ability of our existing operations to support our current and future business needs and to maintain our compliance requirements. As a result, we periodically consolidate, integrate, upgrade and expand our information systems capabilities as a result of technology initiatives, industry trends and recently enacted regulations, and changes in our system platforms. Our information systems require an ongoing commitment of significant resources to maintain, protect and enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving systems and regulatory standards and changing customer preferences. Any inability or failure by us or our vendors to properly maintain information management systems; any failure to efficiently and effectively consolidate our information systems, including to renew technology, maintain technology currency, keep pace with evolving industry standards or eliminate redundant or obsolete applications; or any inability or failure to successfully update or expand processing capability or develop new capabilities to meet our business needs, could result in operational disruptions, loss of existing members, providers, and customers, difficulty in attracting new members, providers, and customers, disputes with members, providers, and customers, regulatory or other legal or compliance problems, and significant increases in administrative

expenses and/or other adverse consequences. If for any reason there is a business continuity interruption resulting in loss of access to or availability of data, we may, among other things,

not be able to meet the full demands of our customers and, in turn, our business, results of operations, financial condition and cash flow could be adversely impacted.

Moreover, business acquisitions require transitions to or from, and the integration of, various information systems. If we experience difficulties with the transition to or from information systems or are unable to properly implement, maintain, upgrade or expand our systems, we could suffer from, among other things, operational disruptions, loss of members, difficulty in attracting new members, regulatory problems, and increases in administrative expenses.

Because our corporate headquarters are located in Southern California, our business operations may be significantly disrupted as a result of a major earthquake or wildfire.

Our corporate headquarters is located in Long Beach, California. In addition, some of our health plans' claims are processed in Long Beach. Southern California is exposed to a statistically greater risk of a major earthquake and wildfires than most other parts of the United States. If a major earthquake or wildfire were to strike the Los Angeles area, our corporate functions and claims processing could be significantly impaired for a substantial period of time. If there is a major Southern California earthquake or wildfire, there can be no assurances that our disaster recovery plan will be successful or that the business operations of our health plans, including those that are remote from any such event, would not be substantially impacted.

We face claims related to litigation which could result in substantial monetary damages.

We are subject to a variety of legal actions, including provider disputes, employment related disputes, health care regulatory law-based litigation, breach of contract actions, qui tam or False Claims Act actions, and securities class actions. If we incur liability materially in excess of the amount for which we have insurance coverage, our profitability would suffer. Even if any claims brought against us are unsuccessful or without merit, we may have to defend ourselves against such claims. The defense of any such actions may be time-consuming and costly, and may distract our management's attention.

Furthermore, claimants often sue managed care organizations for improper denials of or delays in care, and in some instances improper authorizations of care. Claims of this nature could result in substantial damage awards against us and our providers that could exceed the limits of any applicable insurance coverage. Successful claims asserted against us, our providers, or our employees could adversely affect our business, financial condition, cash flows, or results of operations.

We cannot predict the outcome of any lawsuit. Some of the liabilities related to litigation that we may incur may not be covered by insurance, the insurers could dispute coverage, or the amount of insurance could be insufficient to cover the damages awarded. In addition, insurance coverage for all or certain types of liability may become unavailable or prohibitively expensive in the future or the deductible on any such insurance coverage could be set at a level which would result in us effectively self-insuring cases against us. The litigation to which we are subject could have a material adverse effect on our business, financial condition, results of operations, and cash flows.

We are subject to competition which negatively impacts our ability to increase penetration in the markets we serve.

We operate in a highly competitive environment and in an industry that is subject to ongoing changes from business consolidations, new strategic alliances, and aggressive marketing practices by other managed care organizations and service providers. Our health plans compete for members principally on the basis of size, location, and quality of provider network; benefits supplied; quality of service; and reputation. A number of these competitive elements are partially dependent upon and can be positively affected by the financial resources available to us. Many other organizations with which we compete, including large commercial plans and other service providers, have substantially greater financial and other resources than we do. For these reasons, we may be unable to grow our business, or may lose business to third parties.

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. For example, on February 4, 2019, we entered into a master services agreement with Infosys Limited pursuant to which Infosys will manage certain of our information technology infrastructure services including, among other things, our information technology operations, end-user services, and data centers. Our arrangements with third party vendors and service providers such as Infosys 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 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 could result in 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 experience significant 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, and 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, unanticipated costs or expenses, 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, and results of operations.

We are subject to a number of risks in connection with our decision to enter into a master services agreement with Infosys for the management of certain of our information technology infrastructure functions.

On February 4, 2019, we entered into a master services agreement with Infosys Limited pursuant to which Infosys will manage certain of our information technology infrastructure services including, among other things, our information technology operations, end-user services, and data centers.

Given the scope of services that will be provided by Infosys, the transition of services presents considerable execution risk inherent to large scale strategic and operational initiatives, including, among others, with respect to the efficient and secure transfer of information and data and the management of our workforce, which will require us to coordinate with Infosys and monitor the transition. We have incurred costs and will continue to incur costs and devote substantial resources during the transition to prepare for Infosys's services. If we are unable to efficiently, effectively and successfully carry out the transition of our information technology infrastructure activities to Infosys in a coordinated and timely manner, including securely transferring information and data between the parties, such failures or delays in the start of Infosys's services could materially impact the amount of the intended cost savings and other intended benefits of the Infosys transaction.

The success of our business will depend in part on Infosys's ability to perform the contracted functions and services, including with respect to data security, in a timely, satisfactory, and compliant manner. To protect our expectations regarding Infosys' performance, the agreement has minimum service levels that Infosys must meet or exceed. In the event of an expiration of our agreement with Infosys or upon termination of the agreement for any reason, we have the right to obtain disengagement assistance from Infosys to facilitate the transition of the infrastructure services from Infosys to another supplier or back to the Company itself. We would be required to pay for any disengagement assistance based on a combination of pre-determined charges and hourly fees for services for which there is no pre-determined charge. We retain the right to terminate the agreement with Infosys, in whole or in part, for, among

other things, cause, convenience, and, if certain criteria are met, a change in the control of Infosys. However, we will be required to pay varying termination charges if we terminate the agreement for certain reasons other than for cause. Depending upon the circumstances of the termination, the termination charge may be material.

Furthermore, changes in Infosys's operations, security posture or vulnerabilities, financial condition, or other matters outside of our control could adversely affect the provision of their services to the Company. If we experience a loss or disruption in the provision of any of these functions or services, or they are not performed in a timely, satisfactory or compliant manner, we may not fully achieve anticipated cost savings or other expected benefits of the transaction; we may be subject to regulatory enforcement actions; we may be vulnerable to security breaches that threaten the security and confidentiality of our information and data; we may not be able to meet the full demands of our customers and members or be subject to claims against us by our members and providers; and we may have difficulty in finding alternate providers in a timely manner on terms and conditions favorable to us upon expiration or termination of the agreement, or at all. Furthermore, the contractual remedies and indemnification obligations for Infosys's failures may not fully compensate us for any losses suffered as a result of Infosys's failure to satisfy its obligations to us. Any of the foregoing could have a material and adverse impact on our business.

Our substantial indebtedness could adversely affect our ability to raise additional capital to fund our operations, limit our ability to react to changes in the economy or our industry, expose us to interest rate risk to the extent of any variable rate debt, and prevent us from meeting our obligations under our outstanding indebtedness.

We have a significant amount of indebtedness. As of December 31, 2018, our total indebtedness was approximately $1,458 million, including lease financing obligations. As of December 31, 2018, we also had $493 million available for borrowing under our Credit Facility. On January 31, 2019, we entered into a Sixth Amendment to the Credit Agreement that provides for a delayed draw term loan facility in an aggregate principal amount of $600 million (the "Term Loan"), under which we may request up to ten advances, each in a minimum principal amount of $50 million, until 18 months after January 31, 2019.

Our substantial indebtedness could have significant consequences, including:

- increasing our vulnerability to adverse economic, industry, or competitive developments;
- requiring a substantial portion of our cash flows from operations to be dedicated to the payment of principal and interest on our indebtedness, therefore reducing our ability to use our cash flows to fund operations, make capital expenditures, and pursue future business opportunities;
- exposing us to the risk of increased interest rates to the extent of any future borrowings, including borrowings under our Credit Agreement, at variable rates of interest;
- making it more difficult for us to satisfy our obligations with respect to our indebtedness, including our Credit Agreement and our outstanding senior notes, and any failure to comply with the obligations of any of our debt instruments, including restrictive covenants and borrowing conditions, could result in an event of default under the indenture governing our outstanding senior notes and the agreements governing such other indebtedness;
- restricting us from making strategic acquisitions or causing us to make non-strategic divestitures;
- limiting our ability to obtain additional financing for working capital, capital expenditures, product and service development, debt service requirements, acquisitions, and general corporate or other purposes; and
- limiting our flexibility in planning for, or reacting to, changes in our business or market conditions and placing us at a competitive disadvantage compared to our competitors who are less highly leveraged and who, therefore, may be able to take advantage of opportunities that our substantial indebtedness may prevent us from exploiting.

The terms of our debt impose, and will impose, restrictions on us that may affect our ability to successfully operate our business and our ability to make payments on our outstanding senior notes.

The indentures governing our outstanding senior notes and the Credit Agreement governing our revolving Credit Facility and Term Loan contain various covenants that could materially and adversely affect our ability to finance our future operations or capital needs and to engage in other business activities that may be in our best interest. These covenants limit our ability to, among other things:

- incur additional indebtedness or issue certain preferred equity;
- pay dividends on, repurchase, or make distributions in respect of our capital stock, prepay, redeem, or repurchase certain debt or make other restricted payments;
- make certain investments;
- create certain liens;
- sell assets, including capital stock of restricted subsidiaries;

- enter into agreements restricting our restricted subsidiaries' ability to pay dividends to us;
- consolidate, merge, sell, or otherwise dispose of all or substantially all of our assets;

- enter into certain transactions with our affiliates; and
- designate our restricted subsidiaries as unrestricted subsidiaries.

All of these covenants may restrict our ability to pursue our business strategies. Our ability to comply with these covenants may be affected by events beyond our control, such as prevailing economic conditions and changes in regulations, and if such events occur, we cannot be sure that we will be able to comply. A breach of these covenants could result in a default under the indentures for our outstanding senior notes and/or the Credit Agreement governing our Credit Facility and Term Loan including, as a result of cross default provisions and, in the case of our Credit Agreement, permit the lenders to cease making loans to us. If there were an event of default under the indentures governing our outstanding senior notes and/or the Credit Agreement governing our Credit Facility and Term Loan, holders of such defaulted debt could cause all amounts borrowed under these instruments to be due and payable immediately. Our assets or cash flow may not be sufficient to repay borrowings under our outstanding debt instruments in the event of a default thereunder.

In addition, the restrictive covenants in the Credit Agreement governing our Credit Facility and Term Loan require us to maintain specified financial ratios and satisfy other financial condition tests. Our ability to meet those financial ratios and tests will depend on our ongoing financial and operating performance, which, in turn, will be subject to economic conditions and to financial, market, and competitive factors, many of which are beyond our control.

If our operating performance declines, we may be required to obtain waivers from the lenders under our Credit Agreement governing our Credit Facility and Term Loan, from the holders of our outstanding senior notes or from the holders of other obligations, to avoid defaults thereunder. For example, in February 2017, to avoid default under our Credit Agreement as a result of our failure to comply with certain financial covenants therein applicable to the three months ended December 31, 2016, we sought, and obtained, a waiver of such defaults by the required lenders under our Credit Agreement.

If we are not able to obtain such waivers, our creditors could exercise their rights upon default, and we could be forced into bankruptcy or liquidation.

We may not be able to generate sufficient cash to service all of our indebtedness and may be forced to take other actions to satisfy our obligations under our indebtedness, which may not be successful.

Our ability to make scheduled payments on or to refinance our debt obligations depends on our financial condition and operating performance, which is subject to prevailing economic and competitive conditions and to certain financial, business, and other factors beyond our control. We may not be able to maintain a level of cash flows from operating activities sufficient to permit us to pay the principal, and interest on our indebtedness.

If our cash flows and capital resources are insufficient to fund our debt service obligations, we may be forced to reduce or delay investments and capital expenditures, or to sell assets, seek additional capital, or restructure or refinance our indebtedness. Our ability to restructure or refinance our debt will depend on the condition of the capital markets and our financial condition at such time. Any refinancing of our debt could be at higher interest rates and may require us to comply with onerous covenants, which could further restrict our business operations. The terms of existing or future debt instruments, including our Credit Agreement, and the indentures governing our outstanding senior notes, may restrict us from adopting some of these alternatives. In addition, any failure to make payments of interest and principal on our outstanding indebtedness on a timely basis would likely result in a reduction of our credit rating, which would harm our ability to incur additional indebtedness. These alternative measures may not be successful and may not permit us to meet our scheduled debt service obligations.

A lowering or withdrawal of the ratings assigned to our debt securities by rating agencies may increase our future borrowing costs and reduce our access to capital.

There can be no assurance that any rating assigned by the rating agencies to our debt or our corporate rating will remain for any given period of time or that a rating will not be lowered or withdrawn entirely by a rating agency if, in that rating agency’s judgment, future circumstances relating to the basis of the rating, such as adverse changes, so warrant. In 2017, both Moody’s and Standard and Poor’s downgraded our debt ratings. In February 2018, both S&P and Moody’s downgraded our corporate and debt ratings further to BB- and B3, respectively, with modest negative impact on future borrowing cost. A further lowering or withdrawal of the ratings assigned to our debt securities by rating agencies would likely increase our future borrowing costs and reduce our access to capital, which could have a

materially adverse impact on our business, financial condition, cash flows, or results of operations.

Risks Related to Our Common Stock

Future sales of our common stock or equity-linked securities in the public market could adversely affect the trading price of our common stock and our ability to raise funds in new stock offerings.

We may issue equity securities in the future, or securities that are convertible into or exchangeable for, or that represent the right to receive, shares of our common stock. Sales of a substantial number of shares of our common stock or other equity securities, including sales of shares in connection with any future acquisitions, could be substantially dilutive to our stockholders. These sales may have a harmful effect on prevailing market prices for our common stock and our ability to raise additional capital in the financial markets at a time and price favorable to us. Moreover, to the extent that we issue restricted stock/units, stock appreciation rights, options, or warrants to purchase our common stock in the future and those stock appreciation rights, options, or warrants are exercised or as the restricted stock/units vest, our stockholders may experience further dilution. Holders of our shares of common stock have no preemptive rights that entitle holders to purchase a pro rata share of any offering of shares of any class or series and, therefore, such sales or offerings could result in increased dilution to our stockholders. Our certificate of incorporation provides that we have authority to issue 150 million shares of common stock and 20 million shares of preferred stock. As of December 31, 2018, approximately 62 million shares of common stock and no shares of preferred or other capital stock were issued and outstanding.

It may be difficult for a third party to acquire us, which could inhibit stockholders from realizing a premium on their stock price.

We are subject to the Delaware anti-takeover laws regulating corporate takeovers. These provisions may prohibit stockholders owning 15% or more of our outstanding voting stock from merging or combining with us. In addition, any change in control of our state health plans would require the approval of the applicable insurance regulator in each state in which we operate.

Our certificate of incorporation and bylaws also contain provisions that could have the effect of delaying, deferring, or preventing a change in control of our Company that stockholders may consider favorable or beneficial. These provisions could discourage proxy contests and make it more difficult for our stockholders to elect directors and take other corporate actions. These provisions could also limit the price that investors might be willing to pay in the future for shares of our common stock. These provisions include:

- a staggered board of directors, so that it would take three successive annual meetings to replace all directors,
- prohibition of stockholder action by written consent, and
- advance notice requirements for the submission by stockholders of nominations for election to the board of directors and for proposing matters that can be acted upon by stockholders at a meeting.

In addition, changes of control are often subject to state regulatory notification, and in some cases, prior approval of such state regulatory agencies.

Further, our board of directors or a committee thereof has the power, without stockholder approval, to designate the terms of one or more series of preferred stock and issue shares of preferred stock. The ability of our board of directors or a committee thereof to create and issue a new series of preferred stock could impede a merger, takeover or other business combination involving us or discourage a potential acquirer from making a tender offer for our common stock, which, under certain circumstances, could reduce the market price of our common stock.

PROPERTIES

As of December 31, 2018, the Health Plans segment leased a total of 66 facilities. We own a 186,000 square-foot office building in Troy, Michigan, a 24,000 square-foot mixed use facility in Pomona, California, and a 26,700 square foot data center in Albuquerque, New Mexico. While we believe our current and anticipated facilities will be adequate to meet our operational needs for the foreseeable future, we continue to periodically evaluate our employee and operational growth prospects to determine if additional space is required, and where it would be best located.

LEGAL PROCEEDINGS

Refer to the Notes to Consolidated Financial Statements, Note 17, “Commitments and Contingencies—Legal Proceedings,” for a discussion of legal proceedings.

MARKET FOR REGISTRANT’S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

STOCK REPURCHASE PROGRAMS

Purchases of common stock made by us, or on our behalf during the quarter ended December 31, 2018, including shares withheld by us to satisfy our employees’ income tax obligations, are set forth below:

	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Approximate Dollar Value of Shares Authorized to Be Purchased Under the Plans or Programs
October 1 — October 31	—	$ —	—	$ —
November 1 — November 30	—	$ —	—	$ —
December 1 — December 31	—	$ —	—	$ —
	—	$ —	—	

STOCK PERFORMANCE GRAPH

The following graph and related discussion are being furnished solely to accompany this Annual Report on Form 10-K pursuant to Item 201(e) of Regulation S-K and shall not be deemed to be “soliciting materials” or to be “filed” with the U.S. Securities and Exchange Commission (“SEC”) (other than as provided in Item 201) nor shall this information be incorporated by reference into any future filing under the Securities Act or the Exchange Act, whether made before or after the date hereof and irrespective of any general incorporation language contained therein, except to the extent that we specifically incorporate it by reference into a filing.

The following line graph compares the percentage change in the cumulative total return on our common stock against the cumulative total return of the Standard & Poor’s Corporation Composite 500 Index (the “S&P 500”) and a peer group index for the five-year period from December 31, 2013 to December 31, 2018. The comparison assumes $100 was invested on December 31, 2013, in our common stock and in each of the foregoing indices and assumes reinvestment of dividends. The stock performance shown on the graph below represents historical stock performance and is not necessarily indicative of future stock price performance.

The peer group index consists of Centene Corporation (CNC), Cigna Corporation (CI), DaVita HealthCare Partners, Inc. (DVA), Humana Inc. (HUM), Magellan Health, Inc. (MGLN), Team Health Holdings, Inc. (TMH), Tenet Healthcare Corporation (THC), Triple-S Management Corporation (GTS), Universal American Corporation (UAM), Universal Health Services, Inc. (UHS) and WellCare Health Plans, Inc. (WCG).

STOCK TRADING SYMBOL AND DIVIDENDS

Our common stock is listed on the New York Stock Exchange under the trading symbol “MOH.” As of February 15, 2019, there were 14 holders of record of our common stock.

To date we have not paid cash dividends on our common stock. We currently intend to retain any future earnings to fund our projected business operations. However, we intend to periodically evaluate our cash position to determine whether to pay a cash dividend in the future.

Our ability to pay dividends is partially dependent on, among other things, our receipt of cash dividends from our regulated subsidiaries. The ability of our regulated subsidiaries to pay dividends to us is limited by the state departments of insurance in the states in which we operate or may operate, as well as requirements of the government-sponsored health programs in which we participate. Additionally, the indentures governing our outstanding senior notes and the Credit Agreement governing the revolving Credit Facility and Term Loan contain various covenants that limit our ability to pay dividends on our common stock.

Any future determination to pay dividends will be at the discretion of our board of directors and will depend upon, among other factors, our results of operations, financial condition, capital requirements and contractual and regulatory restrictions. For more information regarding restrictions on the ability of our regulated subsidiaries to pay dividends to us, please see the Notes to Consolidated Financial Statements, Note 17, “Commitments and Contingencies—Regulatory Capital Requirements and Dividend Restrictions.”

SELECTED FINANCIAL DATA

	Year Ended December 31,				
	2018	2017	2016	2015	2014
	(In millions, except per-share data, percentages and membership)				
Premium revenue	$17,612	$18,854	$16,445	$13,261	$9,035
Total revenue	$18,890	$19,883	$17,782	$14,178	$9,667
Operating income (loss)	$1,131	$(555)	$306	$387	$193
Income (loss) before income taxes	$999	$(612)	$205	$322	$135
Net income (loss)	$707	$(512)	$52	$143	$62
Basic net income (loss) per share [1]	$11.57	$(9.07)	$0.93	$2.75	$1.33
Diluted net income (loss) per share [1]	$10.61	$(9.07)	$0.92	$2.58	$1.29
Weighted average shares outstanding:					
Basic	61.1	56.4	55.4	52.2	46.9
Diluted	66.6	56.4	56.2	55.6	48.3
Operating Statistics:					
Medical care ratio [2]	85.9%	90.6%	89.8%	88.9%	89.4%
G&A ratio [3]	7.1%	8.0%	7.8%	8.1%	7.9%
Effective income tax expense (benefit) rate	29.2%	(16.4)%	74.8%	55.5%	53.8%
Pre-tax margin [3]	5.3%	(3.1)%	1.2%	2.3%	1.4%
After-tax margin [3]	3.7%	(2.6)%	0.3%	1.0%	0.6%
Ending Membership by Government Program:					
Medicaid	3,361,000	3,537,000	3,605,000	3,235,000	2,541,000
Medicare	98,000	101,000	96,000	93,000	67,000
Marketplace	362,000	815,000	526,000	205,000	15,000
	3,821,000	4,453,000	4,227,000	3,533,000	2,623,000

(1) Source data for calculations in thousands.

(2) Medical care ratio represents medical care costs as a percentage of premium revenue.

(3) G&A ratio represents general and administrative expenses as a percentage of total revenue. Pre-tax margin represents net income (loss) before income taxes as a percentage of total revenue. After-tax margin represents net income (loss) as a percentage of total revenue.

	December 31,				
	2018	2017	2016	2015	2014
	(In millions)				
Balance Sheet Data:					
Cash and cash equivalents	$2,826	$3,186	$2,819	$2,329	$1,539
Total assets	7,154	8,471	7,449	6,576	4,435
Medical claims and benefits payable	1,961	2,192	1,929	1,685	1,201
Long-term debt, including current portion [1]	1,458	2,169	1,645	1,609	887
Total liabilities	5,507	7,134	5,800	5,019	3,425
Stockholders' equity	1,647	1,337	1,649	1,557	1,010

(1) Also includes lease financing obligations.

MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS ("MD&A")

OVERVIEW

Molina Healthcare, Inc., a FORTUNE 500, multi-state healthcare organization, arranges for the delivery of health care services to individuals and families who receive their care through the Medicaid and Medicare programs, and through the state insurance marketplaces (the "Marketplace"). Through our locally operated health plans in 14 states and the Commonwealth of Puerto Rico, we served approximately 3.8 million members as of December 31, 2018. These health plans are operated by our respective wholly owned subsidiaries in those states and in the Commonwealth of Puerto Rico, each of which is licensed as a health maintenance organization ("HMO").

We currently have two reportable segments: our Health Plans segment and our Other segment. We manage the vast majority of our operations through our Health Plans segment. Our Other segment includes the historical results of the Pathways behavioral health subsidiary, which we sold in the fourth quarter of 2018, and certain corporate amounts not allocated to the Health Plans segment. Effective in the fourth quarter of 2018, we reclassified the historical results relating to our Molina Medicaid Solutions ("MMS") segment, which we sold in the third quarter of 2018, to the Other segment. Previously, results for MMS were reported in a stand-alone segment.

2018 HIGHLIGHTS

In summary, we produced pretax earnings of $999 million and net income of $707 million for the full year ending December 31, 2018, resulting in an after-tax margin of 3.7%. These results include, on a consolidated basis, a medical cost ratio ("MCR") of 85.9% and a general and administrative ("G&A") expense ratio of 7.1%. The improved performance in 2018 across all of our programs, health plans, operating metrics, and the actions we took with respect to capital management, are summarized below.

Program Performance. The improved performance in 2018 demonstrates the effectiveness of our margin recovery and sustainability plan.

- Our Medicaid program, with $13.6 billion in premium revenue, ended the year with a 90.0% MCR, both improved when compared with 2017. Several factors contributed to this result, including our ability to manage medical costs, our success in executing on a variety of profit improvement initiatives, including network contracting, front-line utilization management, and retaining increased levels of revenue at risk for quality scores.
- Our Medicare program also delivered improved results in 2018 when compared to 2017. We earned premium revenues of $2.1 billion in 2018 and attained an MCR of 84.5%. We believe we have proved our ability to manage high-acuity members who have complex medical conditions and co-morbidities, and we believe we have proved to be proficient at managing long-term services and supports benefits, an important and fast-growing benefit across all of our products. Additionally, we increased revenues tied to member risk scores to be more commensurate with the acuity of our membership.
- Our Marketplace program was a significant contributor to our results in 2018, with approximately $1.9 billion in premium revenue and an MCR of 58.9%. In 2017 and prior years, the performance in our Marketplace program was challenged, and we executed corrective pricing actions of nearly 60% in 2018 to improve our results. Our prices were competitive, even with the significant increases over 2017; which enabled us to retain higher membership in 2018 than we expected. Lastly, execution of the core managed care fundamentals that are also applicable to our other programs, and an increase in revenues tied to member risk scores to be commensurate with the acuity of our membership, also helped to produce the results that we attained.

Health Plan Performance. In summary, we believe our health plan portfolio is performing well. In 2017, more than 25% of our premium revenue related to plans that were not profitable. In 2018, all these plans were profitable. We significantly improved the performance and balance of our locally operated health plans in 2018. Our largest health plans from a membership standpoint (going forward in 2019)–California, Ohio, Michigan, Texas, and Washington–continued to perform well. Florida and New Mexico were challenges due to contract losses, but performed well considering they faced the run-off of large proportions of membership and revenues. Additionally, our Washington health plan began to improve its profitability midway through 2018 and we believe is now well-positioned to improve its pretax margins on an expanded revenue base.

Operational Improvements. We implemented operational improvements that enabled us to gain operating efficiencies. We continued to improve our G&A cost profile, managing to a G&A expense ratio of 7.1% for the full year of 2018, which is a 90 basis-point improvement compared to 2017. We reduced our core business workforce by more than 800 full-time equivalents, or nearly 7% from the beginning of the year. More importantly, we continued to invest in the business. We improved the performance of our core processes: claims, payment integrity, member and provider services and a host of others, all of which create lasting effects. Finally, in 2018, we set the stage for ongoing improvement by making significant progress on a variety of outsourcing initiatives, including the recently announced outsourcing of certain information technology infrastructure functions to Infosys, which will benefit us in 2019 and beyond.

Balance Sheet and Capital Management. Our improved operating performance in 2018 allowed our business to dividend approximately $300 million to the parent company. We deployed approximately $1.2 billion to retire convertible debt and repay the outstanding amount drawn on our revolving Credit Facility. This reduced earnings per share volatility and lowered our debt-to-capital ratio to approximately 47%.

FINANCIAL SUMMARY

	Year Ended December 31,		
	2018	2017	2016
	(Dollars in millions, except per-share amounts)		
Premium revenue	$17,612	$18,854	$16,445
Premium tax revenue	417	438	468
Health insurer fees reimbursed	329	—	292
Investment income and other revenue	125	70	38
Medical care costs	15,137	17,073	14,774
General and administrative expenses	1,333	1,594	1,393
Premium tax expenses	417	438	468
Health insurer fees	348	—	217
Restructuring and separation costs	46	234	—
Impairment losses	—	470	—
Loss on sales of subsidiaries, net of gain	(15)	—	—
Operating income (loss)	1,131	(555)	306
Interest expense	115	118	101
Other expenses (income), net	17	(61)	—
Income tax expense (benefit)	292	(100)	153
Net income (loss)	707	(512)	52
Net income (loss) per diluted share	$10.61	$(9.07)	$0.92
Operating Statistics:			
Ending total membership	3,821,000	4,453,000	4,227,000
Medical care ratio [1]	85.9%	90.6%	89.8%
G&A ratio [2]	7.1%	8.0%	7.8%
Premium tax ratio [1]	2.3%	2.3%	2.8%
Effective income tax expense (benefit) rate	29.2%	(16.4)%	74.8%
After-tax margin [2]	3.7%	(2.6)%	0.3%

(1) Medical care ratio represents medical care costs as a percentage of premium revenue; premium tax ratio represents premium tax expenses as a percentage of premium revenue plus premium tax revenue.

(2) G&A ratio represents general and administrative expenses as a percentage of total revenue. After-tax margin represents net income (loss) as a percentage of total revenue.

CONSOLIDATED RESULTS

See tables below, under “Summary of Significant Items,” for details relating to significant non-run rate items, such as impairment losses, restructuring costs and material out of period adjustments to premiums or medical care costs.

NET INCOME AND OPERATING INCOME

2018 vs. 2017

Net income amounted to $707 million, or $10.61 per diluted share in 2018, compared with a net loss of $512 million, or $9.07 per diluted share in 2017. The year-over-year improvement was mainly driven by a decline in the medical care ratio (“MCR”) and the general and administrative (G&A) expense ratio. Additionally, results for 2017 reflect $704 million in impairment losses and restructuring costs, or $8.87 per diluted share.

2017 vs. 2016

Net loss was $512 million, or $9.07 per diluted share in 2017 compared with net income of $52 million, or $0.92 per diluted share in 2016. The substantial decline in 2017 was mainly due to $704 million in impairment losses and restructuring costs, as mentioned above.

PREMIUM REVENUE

2018 vs. 2017

Premium revenue decreased $1,242 million in 2018 when compared with 2017. Lower premium revenue was mainly driven by a decrease in Marketplace membership, and lower premiums in Medicaid, including retroactive California Medicaid Expansion risk corridor adjustments, partially offset by Marketplace premium rate increases.

2017 vs. 2016

Premium revenue increased $2,409 million in 2017 when compared with 2016, due to a 10% increase in membership, mainly in Marketplace, and a 5% increase in the overall premium revenue PMPM.

PREMIUM TAX REVENUE AND EXPENSES

2018 vs. 2017

The premium tax ratio (premium tax expense as a percentage of premium revenue plus premium tax revenue) remained consistent in 2018 when compared to 2017 and was 2.3% in both years. The decrease in expense is consistent with the decline in premiums.

2017 vs. 2016

The premium tax ratio decreased to 2.3% in 2017 from 2.8% in 2016, mainly due to the significant revenue growth at our Florida health plan in 2017 and 2016, which operates in a state with no premium tax, and growth in MMP revenue. The Medicare portion of MMP revenue is not subject to premium tax.

INVESTMENT INCOME AND OTHER REVENUE

2018 vs. 2017

Investment income and other revenue increased to $125 million in 2018, compared with $70 million in 2017, primarily for two reasons. First, investment income increased due to improved annualized portfolio yields and higher average invested assets in 2018. In addition, other revenue increased in 2018 due to administrative services fees earned by our Washington health plan, following that state’s decision to transition the management of Medicaid pharmacy benefits to an administrative services-based arrangement in 2018.

2017 vs. 2016

Investment income and other revenue increased to $70 million in 2017 compared with $38 million in 2016, mainly due to an increase in average invested assets.

MEDICAL CARE RATIO (“MCR”)

2018 vs. 2017

Overall, the MCR improved to 85.9% in 2018, from 90.6% in 2017. Excluding the retroactive California Medicaid Expansion risk corridor adjustments, and the combined benefit of the 2017 Marketplace risk adjustment and CSR

benefit, the MCR for 2018 would have been 86.3%. Excluding several, substantial out-of-period items that are discussed further below, the MCR for 2017 would have been 89.3%. The improvement was due to a decrease in the MCRs across our Medicaid, Medicare and Marketplace programs.

2017 vs. 2016

The medical care ratio increased to 90.6% in 2017, from 89.8% in 2016. Our 2017 medical care ratio was burdened by substantial unfavorable out-of-period items, including $150 million of medical margin deterioration resulting from unfavorable prior period claims development, the related need to replenish margins for adverse development in our liability for medical claims and benefits payable, increased reserves for premiums we expect to repay to state Medicaid agencies, and approximately $90 million of unfavorable Marketplace items, most notably the lack of CSR reimbursement in the fourth quarter of 2017. Absent these items, our medical care ratio for 2017 would have been approximately 89.3%.

GENERAL AND ADMINISTRATIVE ("G&A") EXPENSES

2018 vs. 2017

The G&A expense ratio improved to 7.1% in 2018 compared with 8.0% in 2017. This year-over-year improvement was primarily the result of continued G&A cost containment, partially offset by decreased leverage resulting from the decline in premium revenues.

2017 vs. 2016

The G&A expense ratio increased to 8.0% in 2017 compared with 7.8% in 2016 due to increased spending related to growth in our Marketplace membership, partially offset by the benefit of increased leverage resulting from the associated increase in premium revenues.

HEALTH INSURER FEES ("HIF")

Health insurer fees amounted to $348 million, and health insurer fees reimbursed amounted to $329 million in 2018. There were no HIF expensed or reimbursed in 2017 due to the moratorium under the Consolidated Appropriations Act of 2016. A new moratorium will be in effect in 2019.

IMPAIRMENT LOSSES

In the year ended December 31, 2017, we recorded impairment losses relating to goodwill and intangible assets, net, of $470 million. These losses included $269 million recorded in the Health Plans segment, and $201 million recorded in the Other segment, relating to our recently divested Pathways and Molina Medicaid Solutions subsidiaries.

RESTRUCTURING AND SEPARATION COSTS

In 2018, we incurred restructuring and separation costs of $46 million, including $37 million of additional costs related to implementation of our restructuring and profit improvement plan in 2017 (the "2017 Restructuring Plan"), and $9 million related to our IT restructuring plan that was commenced in 2018. In 2017, we incurred restructuring and separation costs of $234 million as a result of the implementation of our 2017 Restructuring Plan.

LOSS ON SALES OF SUBSIDIARIES, NET OF GAIN

Molina Medicaid Solutions. We closed on the sale of Molina Medicaid Solutions ("MMS") to DXC Technology Company on September 30, 2018. The net cash selling price for the equity interests of MMS was $233 million. As a result of this transaction, we recognized a pretax gain, net of transaction costs, of $37 million. The gain, net of income tax expense, was $28 million.

Pathways. We closed on the sale of our Pathways behavioral health subsidiary to Pyramid Health Holdings, LLC on October 19, 2018, for a nominal purchase price. As a result of this transaction, we recognized a pretax loss of $52 million. The loss, net of income tax benefit, was $32 million.

INTEREST EXPENSE

2018 vs. 2017

Interest expense decreased to $115 million for the year ended December 31, 2018, compared with $118 million for the year ended December 31, 2017. As further described below in “Liquidity,” we reduced the principal amount of outstanding debt by $759 million in 2018.

Interest expense includes non-cash interest expense relating to the amortization of the discount on our long-term debt obligations, which amounted to $22 million and $32 million, and $31 million for the years ended December 31, 2018, 2017, and 2016 respectively. See further discussion in Notes to Consolidated Financial Statements, Note 11, “Debt.”

2017 vs. 2016

Interest expense increased to $118 million for the year ended December 31, 2017, compared with $101 million for the year ended December 31, 2016. The increase was due primarily to our issuance of $330 million aggregate principal amount of senior notes (the “4.875% Notes”) due June 15, 2025, and $300 million borrowed under our Credit Facility in the third quarter of 2017.

OTHER EXPENSES (INCOME), NET

In 2018, we recorded other expenses of $17 million, primarily due to the loss on debt extinguishment resulting from our 1.125% Convertible Notes repayments and the 1.625% Convertible Notes exchange. These transactions are described further in Notes to Consolidated Financial Statements, Note 11, “Debt.” In early 2017, we received a $75 million fee in connection with a terminated Medicare acquisition.

INCOME TAXES

2018 vs. 2017

Income tax expense amounted to $292 million in 2018, or 29.2% of pretax income, compared with an income tax benefit of $100 million in 2017, or 16.4% of the pretax loss.

The effective tax rate for 2018 differs from 2017 mainly due to: 1) the reduction in the federal statutory rate from 35% to 21% under the Tax Cuts and Jobs Act of 2017 (“TCJA”); and 2) higher non-deductible expenses in 2018, primarily related to the non-deductible HIF, as a percentage of pre-tax income (loss). The HIF was not applicable in 2017 due to the 2017 HIF moratorium.

The revaluation of deferred tax assets in connection with the TJCA resulted in $54 million additional income tax expense in the year ended December 31, 2017. In addition, the effective tax benefit rate for 2017 was less than the statutory tax benefit due to the relatively large amount of reported expenses that were not deductible for tax purposes, primarily relating to goodwill impairment losses and separation costs.

2017 vs. 2016

The income tax benefit amounted to $100 million in 2017, or 16.4% of the pretax loss, compared with an income tax expense of $153 million in 2016, or 74.8% of pretax income.

As discussed above, the effective tax benefit rate in 2017 was impacted by a revaluation of deferred tax assets and relatively large amounts of nondeductible expenses. The effective tax rate of 74.8% in 2016 mainly reflected the relatively large impact of the non-deductible HIF expenses relative to pretax income.

SUMMARY OF SIGNIFICANT ITEMS

The tables below summarize the impact of certain items significant to our financial performance in the periods presented. The individual items presented below increase (decrease) income (loss) before income tax expense (benefit).

	Year Ended December 31, 2018	
	Amount	Per Diluted Share (1)
	(In millions)	
Retroactive California Medicaid Expansion risk corridor	$(81)	$(0.95)
Marketplace risk adjustment, for 2017 dates of service	56	0.66
Marketplace CSR subsidies, for 2017 dates of service	81	0.95
Loss on sales of subsidiaries, net of gain	(15)	(0.05)
Restructuring costs	(46)	(0.54)
Loss on debt extinguishment	(22)	(0.29)
	$(27)	$(0.22)

	Year Ended December 31, 2017	
	Amount	Per Diluted Share (1)
	(In millions)	
Termination of CSR subsidy payments for the fourth quarter of 2017	$(73)	$(0.82)
Marketplace adjustments related to risk adjustment, CSR subsidies, and other items for 2016 dates of service	(47)	(0.52)
Change in Marketplace premium deficiency reserve for 2017 dates of service	30	0.33
Impairment losses	(470)	(6.01)
Restructuring and separation costs	(234)	(2.86)
Loss on debt extinguishment	(14)	(0.24)
Fee received for terminated Medicare acquisition	75	0.84
	$(733)	$(9.28)

(1) Except for permanent differences between GAAP and tax (such as certain expenses that are not deductible for tax purposes), per diluted share amounts are generally calculated at the statutory income tax rate of 22% for 2018, and 37% for 2017.

REPORTABLE SEGMENTS

HOW WE ASSESS PERFORMANCE

We derive our revenues primarily from health insurance premiums. Our primary customers are state Medicaid agencies and the federal government.

One of the key metrics used to assess the performance of our Health Plans segment is the MCR, which represents the amount of medical care costs as a percentage of premium revenue. Therefore, the underlying margin, or the amount

earned by the Health Plans segment after medical costs are deducted from premium revenue, is the most important measure of earnings reviewed by management.

Margin for our Health Plans segment is referred to as “Medical Margin,” and for Other, as “Service Margin.” Management’s discussion and analysis of the changes in the individual components of Medical Margin and Service Margin follows.

See Notes to Consolidated Financial Statements, Note 18, “Segments,” for more information.

SEGMENT SUMMARY

	2018	2017	2016
	(In millions)		
Medical Margin [(1)]	$2,475	$	